Chapter 8
Responding to Patient Cues: Advanced Empathy and Confrontation Skills

Learning Objectives

1. Define advanced empathy and confrontation.
2. Differentiate advanced empathy and confrontation from primary empathy.
3. Determine guidelines for effectively communicating advanced empathy and confrontation.
4. Identify examples of patient themes appropriate for advanced empathy and confrontation.
5. Develop advanced empathy and confrontation skills through self-reflection, practice, and feedback.

This chapter discusses two fairly advanced helping skills: advanced empathy and confrontation. Typically, genetic counselors use these two types of skills less frequently than other skills such as attending, primary empathy, and questioning. Advanced empathy and confrontation can be very powerful responses when used strategically and sparingly.

8.1 Advanced Empathy Skills

> "…Advanced empathy is necessary. Empathy is a really complicated concept. And it's not a set of behaviors that you can [fully] specify. It's like trying to put your hands on light or something." (Master genetic counselor clinician; Miranda et al. 2016, pp. 771–772).

P. McCarthy Veach et al., *Facilitating the Genetic Counseling Process*,
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8.1.1 Definition and Functions of Advanced Empathy

Advanced empathy, variously known as additive empathy, reframing (Kessler 1997), and interpretation, is a helping skill that consists of two components: (1) the genetic counselor's understanding of the underlying, implicit aspects of patient experience and (2) the response or reply the counselor constructs to communicate this understanding. Advanced empathy responses go beyond surface patient expressions by identifying less conscious patient feelings, thoughts, and perceptions (Neukrug et al. 2013). Advanced empathy responses are tentative hypotheses, inference, or hunches about the patient's experience (MacDonald 1996) that reflect "… deeper meanings and/or broader themes" (Bayne et al. 2012, p. 73).

Interpretation about patients and their experiences "requires thinking in a complex way about [their] dynamics and underlying motivations…" (Hill et al. 2014, p. 710). With advanced empathy responses, you "read between the lines," going beyond what the patient has directly expressed by presenting your perspective of her or his experience. You move from patient descriptions of their experiences to offer a deeper and/or new meaning or reason for their feelings, thoughts, and/or behaviors (Kessler 1997; Neukrug et al. 2013). Your intent with advanced empathy expands the ways in which the patient views her or his situation (Hackney and Bernard 2017; Hill et al. 2014; Jackson et al. 2014). With advanced empathy, you become more directive about the discussion, having decided that your patient would benefit from hearing your perspective.

Advanced empathy responses may serve a variety of functions. Psychotherapy research has consistently demonstrated that skillfully used advanced empathy has a positive impact on both processes and outcomes, for example, facilitating patient progress in counseling (Neukrug et al. 2013). When accurate and well timed, advanced empathy responses "…help clients achieve new insights and may facilitate movement towards new ways of thinking about issues…" (Bayne et al. 2012, p. 73). Patients often come to genetic counseling with a vague awareness of their inner thoughts and feelings. Even when they have an idea of what they think and feel, they may hesitate to share this information because they fear judgment, worry that what they have to say is too risky, and/or do not consider such sharing to be culturally appropriate (Hill 2014). When you have reason to believe there is more beneath the surface of your patients' stories, advanced empathy can be helpful because it more directly identifies their inner experience.

In addition to providing patients with greater insight into their thoughts and feelings, advanced empathy can help them clarify their values, thus promoting greater self-understanding. It can also give patients permission to express certain feelings or opinions, which may ultimately help them be more accepting of those feelings and thoughts, thus facilitating their goal setting and decision-making. Advanced empathy can provide patients with an "…explanation [that] can make experiences seem less confusing, haphazard, or inexplicable and give [them] a sense of mastery, security, and self-efficacy" (Jackson et al. 2014, p. 779).

Despite the potential benefits of advanced empathy, there may be risks as "novel information shared and received in the interpretation process may also frighten anger or sadden clients" (Jackson et al. 2014, p. 779). Because advanced empathy addresses hidden or implied content, it can increase patient anxiety (e.g., "Will the genetic counselor judge me now that s/he knows this about me?"; "Do I want to get into this issue with the counselor?"; "Will I completely break down if I say more about how I'm really feeling?"). For these reasons, advanced empathy tends to occur later in the genetic counseling session once you have developed rapport and built trust with a patient.

8.1.2 Distinctions Between Primary and Advanced Empathy

When considering the distinctions between primary empathy and advanced empathy, we like to use the analogy of a dimmer switch on a light fixture. Primary empathy responses are at the lower end of the dimmer feature—they shed some light on a patient's situation. Advanced empathy responses are at a higher level of the dimmer switch—they provide greater illumination, allowing the patient to see even more clearly what is "in the shadows."

Chapter 4 depicted primary empathy on a continuum ranging from minimal encouragers to reflections of content and affect. If we extend that continuum, advanced empathy would be farther to the right.

8.1.3 The Primary and Advanced Empathy Continuum and Distinctions

Minimal encourager	Paraphrase	Summary	Reflect content	Reflect affect	Content and affect reflection	Advanced empathy

Primary and advanced empathy differ in several ways:

Primary empathy	Advanced empathy
• Interchangeable or synonymous with what the patient is saying	Additive—goes beyond what the patient directly states
• Deals with surface content and feelings	Deals with hidden, implied content and feelings
• Reflects patient point of view	Reflects counselor point of view
• Counselor is responsive to discussion	Counselor takes initiative to direct discussion
• Patient is more aware of feelings and thoughts before the counselor reflects them	Patient is less aware of feelings and thoughts until the counselor reflects them

Primary empathy	Advanced empathy
• Reassures patient	Challenges patient
• Lowers patient anxiety	Raises patient anxiety
• Provides clarification and builds trust	Provides insight and promotes change
• May occur throughout session	Usually occurs later in the session
• Used frequently	Used sparingly

Advanced empathy responses are a more leading type of intervention. Clark (2010) describes Welfel and Patterson's (2005) "continuum of lead" that differentiates counselor responses in terms of client awareness and frame of reference. Clark notes that "Particular counselor interventions at one end of the continuum, such as silence and reflection, are minimally leading and are close to perspectives aligned with a client's frame of reference. When a counselor demonstrates empathic understanding in these instances, empathy serves to affirm a client's experiencing. In contrast, other interventions at the other end of the continuum, such as…interpretation, may largely be outside of a client's awareness, and [advanced] empathy provides a means to acknowledge a client's experiencing of new perspectives" (p. 353). According to Clark, the extent of a counselor's leading responses typically increases as the quality of the relationship develops and the counselor more fully understands the client.

8.1.4 Guidelines for Using Advanced Empathy

Skillful advanced empathy requires accurate understanding of and sensitive responding to patients. We recommend the following strategies for formulating and communicating advanced empathy responses:

Generate Hypotheses About Patient Situations, Thoughts, and Feelings

- Do a "psychosocial" case prep. When you have access to patient information prior to the genetic counseling session, review the file. Spend a few minutes formulating tentative hypotheses based on patient demographics (age, gender, culture, etc.), medical data, and reasons for seeking genetic counseling.
- Look for cues when you first meet a patient (e.g., How relaxed or tense is the patient? How eager or reluctant to speak? Whom did the patient bring along to the session?).
- Draw upon past experiences with genetic counseling patients and your knowledge of psychosocial theories to anticipate underlying patient affect and content (see Clark's (2010) objective empathy later in this chapter).

- Use your own professional and personal experiences. In personal essays describing "defining moments" (significant events that comprise a turning point in one's professional development (McCarthy Veach and LeRoy 2012)), many of the genetic counselor authors described enhanced empathy. The impetus for greater empathy included meaningful patient encounters (e.g., Bodurtha 2012; Chin 2012; Knutzen 2012; Lakhani 2012; Oswald 2012) and personal life events involving pain and loss (e.g., Anonymous 2008; Bellcross 2012; Glessner 2012). Peters et al. (2004) similarly found that genetic counselors who had themselves received genetic counseling reported subsequently experiencing increased empathy for their patients (e.g., greater ability to understand patients' decisions), greater connection with certain patients, and a greater emphasis on providing psychosocial support.
- Put yourself in the patient's place, and ask yourself how you might feel if you were this patient. But be careful not to project your feelings onto the patient (see Clark's (2010) subjective empathy later in this chapter).
- Pay attention to patient verbal and nonverbal behaviors.
- Listen for themes and repetitive patterns. Novices often make the mistake of thinking different pieces of information only go together if the patient talks about them at the same time (Mayfield et al. 1999). Patients may provide related information at different points in the session, so you need to fit the pieces together to see the themes. For example, a woman whose mother died of HD comes to clinic for testing. She states that she is concerned about passing HD on to a child. At various points in the session, she mentions her anger with her father who is opposed to her being tested. When the genetic counselor asks the patient to think about why she wants testing, the patient responds, "I cannot imagine watching a child suffer from this condition." The counselor "connects the dots" and uses advanced empathy to help the patient realize this is her father's fear as well. Perhaps that is why he does not want her to be tested, that is, he's likely afraid to find out if she has the condition like his wife.
- Ask yourself, "What is my patient trying to tell me that s/he can't say directly?" (MacDonald 1996). For example, you are seeing a patient with a history of infertility. In reviewing the family history, the patient states that she had an elective abortion when she was a teenager. Later in the session as you discuss the various etiologies for infertility, including both male and female factors, the patient comments, "I'm sure that it's not my husband's fault." You might say, "I wonder if there is something in particular that makes you feel this is *your* fault?" Your interpretation, stated in a tentative (questioning) way, may allow her to say she believes her abortion is the cause of the infertility. If she does not make that connection, and instead says something like, "I don't know, I just know," you might consider tentatively saying, "Some patients think that having an abortion causes infertility." This interpretation opens the door for further discussion of her belief.
- Remember that cultural and individual differences mean no two patients will react to the same experience in the same way. Avoid going overboard with theories that fail to match your patient's experience. Identifying feelings or thoughts incorrectly, referred to as "subtractive empathy," can be worse than saying nothing

(Neukrug et al. 2013). Additionally, it's important to listen for the patient's understanding of illness within her/his cultural context (Lewis 2010). Oosterwal (2009) notes that each ethnocultural group is characterized by its own specific cultural code—"a set of values, assumptions, notions and beliefs that shape the ways that people from diverse cultures act and think, relate and communicate; what they consider right or wrong, good or bad, sacred or profane, important or unimportant. This cultural code shapes the ways that people from diverse cultures interpret disease, death, genetic disorders, and disabilities; perceive of pregnancy and parenting; respond to pain; define family, kinship and ideal marriage partners; share or conceal information; use or refuse certain food and medications; and relate to their counselors and caregivers" (p. 332). Multiculturally competent genetic counselors "…use empathy in all genetic counseling sessions to understand the client's experiences, emotions, and perceptions of the world, and [to] determine how [their] client's behaviors and decisions are influenced" (Steinberg Warren and Wilson 2013, p. 7).

Share Your Hypotheses Through Carefully Formulated Responses

- Be concise, clear, and specific.
- Use responses that are nonjudgmental and nonpresumptive.
- Be tentative. Allow a patient the chance to deny or modify your statement. For example, "Correct me if I'm wrong, but it seems that you're saying…" You can also lead up to advanced empathy response by first asking for the patient's interpretation (Hill 2014). For instance, "What do you think is getting in the way of making this decision?"
- Formulate responses that are moderate in depth. Several psychotherapy studies indicate that interpretations that are of a moderate depth rather than too superficial or too deep have the most positive effect on processes and outcomes (Hill 2014). Refrain from jumping in with dramatic interpretations that will be off-putting to your patients.
- Be sure your response is suitable for a given patient. One way in which genetic counseling patients differ is in their degree of psychological-mindedness. Some patients are more psychologically minded than others and likely will respond well to interpretations about their inner experience; other patients are less interested in the why of their experience, and may be more interested in support, and information (cf. Sarangi et al. 2005). Clearly, you would use fewer advanced empathy responses with the latter type of patients. Another way in which patients differ is in how trusting they are. Some patients are very mistrustful and suspicious; you should stay close to the surface with them, using primary empathy (Martin 2015). Relatedly, in most cases the setting for genetic counseling is a medical clinic. Patients may not be expecting or may be unwilling to share on an emotional level in this setting.

- Give a well-timed response. Usually you will make an advanced empathy statement only after you've built some rapport through other skills such as attending and primary empathy and when you have enough impressions about the patient to be able to trust your hypothesis. Make advanced empathy statements when patients seem to be ready (i.e., have clearly stated their concerns and said there are some things they do not understand and seem eager to understand) (Hill 2014). Also, you should anticipate how your patient will react to your interpretation before giving it (Martin 2015).
- Use advanced empathy sparingly. Psychotherapy research indicates advanced empathy occurs much less frequently than primary empathy (Hill 2014), probably because it is such a powerful response. Patients can usually deal with only a limited number of insights at one time because insights often have a strong emotional impact, such as increased anxiety or sadness.
- Observe the extent to which your patient appears to accept your advanced empathy. Your response has likely missed the mark if your patient rejects what you said, becomes silent and withdrawn, or quickly changes the subject (Martin 2015). Possible patient reactions to advanced empathy include (1) agreeing with your interpretation and exploring its meaning; (2) agreeing, but avoiding, any further exploration; (3) asking for further information about your basis for making the statement; and (4) denying the accuracy of your statement.
- Follow up with primary empathy and questions. Summarize patients' responses by reflecting their emotional reaction to and thoughts about your advanced empathy statement. Then use questions to gather further details about the patient's reactions and their implications. For instance, "What are your thoughts about that….? How is that affecting your decision about….?"

Sources of Advanced Empathy

Clark (2010) proposes a model of empathy that involves "…understanding through three ways of knowing: Subjective empathy, interpersonal empathy, and objective empathy. Clark describes *subjective empathy* as: "…a counselor's awareness of his or her...internal reactions in response to the experiencing of a client. Through a form of personal knowing, a counselor vicariously experiences, for a momentary period of time, what it is like to be the client [by engaging in processes involving] identification, imagination, intuition, and felt-level experiencing..." (p. 349).

Through identification, a counselor engages in a partial and transitory assumption of a client's experiences as if they were his or her own. Use of imagination has the "potential to broaden an empathic understanding of clients in situations or conditions that counselors may personally perceive as culturally distant…[For instance,] the counselor can only imagine the pain that is incurred when one is morbidly obese, chronically disabled, or experiencing a life-threatening illness" (Clark 2010, pp. 349–350). Within genetic counseling, you may need to call on your imagination to understand, for example, the daily physical, cognitive, and emotional challenges a patient experiences as his retinitis pigmentosa progresses. A counselor's intuition

"…enables a counselor to rapidly generate impressions and hunches relating to a client's functioning. Finally, felt-level experiencing refers to a counselor's sensitivity to somatic or physical reactions that arise when empathically listening to a client" (Clark 2010, p. 349). For example, you may find yourself feeling tearful as you listen to a mother describing her child's sudden and unexpected death due to long QT syndrome.

Interpersonal empathy occurs when "…a counselor [is able] to empathically understand a client on an immediate here-and-now basis and also develop a general sense of how the client experiences life from an extended empathic perspective…" (Clark 2010, p. 350). For example, a 25-year-old woman, during a work-up for multiple miscarriages, learns that she carries a balanced chromosome translocation. When she tells her parents about this, they reveal that the translocation was found by amniocentesis when her mother was pregnant with her. She is angry that her parents knew this and didn't tell her. The counselor reflects the patient's immediate feelings of anger and betrayal at what she perceives as her parents' dishonesty and speculates that the patient fears her husband may not be honest with her about his reactions to her diagnosis.

Counselors engage in *objective empathy* when they draw from "…theoretically informed resources to enhance an empathic understanding of a client…." (Clark 2010, p. 351). Examples of resources include multicultural research findings. For example, "familiarity with…a general way that persons experience cultural forces enables a counselor to assess how an individual client responds to influences within his or her particular culture (Ivey et al. 2007; Sciarra 1999)…" (Clark 2010, p. 351).

Clark cautions that the various ways of engaging empathically are vulnerable to bias and distortion. Distortions in subjective and interpersonal empathy may be due to clients' perspectives, and/or the counselor's perspective, and distortions in objective empathy may be due to stereotyping clients based on normative data.

8.1.5 Types of Advanced Empathy Responses

There are several different types of advanced empathy responses that you might use with patients:

- Reflections of feelings and content not directly stated by the patient. For example, you observe the patient's nonverbal behaviors (clenched fists, red face) and comment, "I noticed your fists are clenched pretty tightly…like you might be angry?"
- Reflections of feelings that underlie emotions the patient has expressed. For example, "You say you're angry, but I wonder if you're also scared."
- Clear and direct statements about experiences the patient is guarded or confused about. For example, "You've mentioned a few times that if the test result is positive, you'll have to do something about it. Do you mean terminate the pregnancy?"

- Statements that summarize earlier feelings and content into a meaningful whole. For example, "You've said that since your diagnosis you've lost your appetite, cry a lot, and have trouble concentrating. It sounds like you're feeling depressed."
- Descriptions of patterns or recurring themes. Pay close attention to issues or questions a patient repeatedly raises. For example, to a mother of a newborn with trisomy 13, "You've asked a few times about things you did during your pregnancy, like drinking coffee, eating tuna and having a few drinks before you knew you were pregnant. Are you worried your behaviors may have caused this?"
- Connections between various parts of the patient's problems. For example, "Perhaps some of the difficulty deciding about genetic testing is that, at some level, you're angry with your mother because her cancer put you at risk. Maybe you're worried that if the test comes back positive, your daughter will be angry with you?"
- Logical conclusions to what the patient is saying. For example, "If you decide not to share your test results with your family, then you will not have to deal with their reaction."
- Alternative ways for the patient to view her or his experience. For example, "You said finding out you have the gene would be awful. You've also said it's *pure hell* to be always wondering. Is it possible the test might relieve some of that distress?"

Neukrug et al. (2013, p. 38) describe six types of responses that can express empathy, including responses they characterize as more "creative." Modified slightly for genetic counseling, they are:

1. Reflecting deeper feelings—Of which the patient has little or no awareness. For example, you might say "I hear how frustrated you are that the test results will take a while to come back, yet I also hear how scared you are that you have the gene for spino-cerebellar ataxia."
2. Pointing out conflicts—For example, "I hear that having a child is very important to you, yet I also hear that having an affected child would be too much for you to bear."
3. Visual analogy—A visual image may help patients recognize their nuanced and complex emotions and thoughts. For example, "As I listen to you describe how you will feel if your test is negative for HD, given your sisters' tests were positive, I have an image of you alone on the shore while your family is floating out to sea in a boat."
4. Nonvisual analogy—Not all analogies are visual ones. For instance, with parents who have pursued a diagnostic odyssey, attempting unsuccessfully to obtain a diagnosis for their child, you might say "It's as if you've been trapped in a huge maze, full of twists and turns. And just when you think you've found the way out, you run into another dead end."
5. Metaphors—For example, "When I listen to you talk about your risk for cancer, it sounds like you feel as though you've already been dealt this hand, and you can't do anything about it."
6. Targeted self-disclosure—You might say "You know, as you are speaking, I find my chest tightening, like there is a boulder sitting on it. I wonder if that's what you're feeling – a huge pressure to go through with testing."

8.1.6 Possible Patterns or Themes to Address with Advanced Empathy

With experience, you will begin to recognize patterns or themes that are fairly common to your patients. These generally fall into four broad categories of nonverbal behaviors, affect, attitudes or beliefs, and defenses. In these sections, we briefly cover these themes. Patient emotions, defense mechanisms, and coping are discussed in greater detail in Chap. 9.

Patient Nonverbal Behavior Patterns

- *Patient laughter when discussing painful situations*: Genetic counseling patients may engage in joking and other forms of levity when they in fact are experiencing intense emotions such as grief, anxiety, or fear. Their laughter may create a safe distance between them and you, prevent them from losing their composure, or hide what they regard as unacceptable feelings. You might say, "I notice you're smiling, perhaps because you're afraid you might break down right now?"
- *Omissions*: Listen for omissions of significant information. For instance, a prenatal patient does not mention her partner's thoughts and feelings. You say, "I notice you haven't said anything about your partner's opinion."
- *Other nonverbal behaviors*: Watch for nonverbals that indicate there is more beneath the patient's calm verbal presentation (e.g., sweating, teary-eyed, trembling chin or hands). Counselor: "You say you're OK, but you look like you're ready to cry."
- *Patient word choice*: Certain words or phrases reveal the feelings and relationships among people. For example, does your patient refer to her fetus as a "fetus," "my baby," or "it"? These words can give you clues about the extent to which she is distancing from or bonding with the pregnancy. Do couples refer to each other by first name or as "the wife" or "him"? These words can provide clues about their level of closeness or distance.

Patient Affective Themes

- *Anger*: Anger is frequently the surface expression of sadness and grief. Anger may also be "…coming from a place that's scared, anxious and powerless, and we can bond with patients over those feelings" (Schema et al. 2015, p. 724). Some patients (especially males and patients from some cultural backgrounds) regard certain emotions as evidence of weakness (Schema et al. 2015); anger can be a defense against their perceived weaknesses. You might address their unspoken emotion by saying, "This must be devastating for you."

Schema et al. (2015) investigated genetic counselors' experience of and management of patient anger directed at the counselor. Prevalent counselor strategies for addressing anger included advanced empathy statements about its origins. For instance, "I usually acknowledge their anger and the situation is basically not of their doing, they must feel out of control, and all they want to do is protect the people they love, and…they just can't do that" (p. 724).

- *Depression*: Feelings underlying depression may be anger, sadness, and despair/hopelessness. Depression typically is a reaction to a real or perceived loss of control. You could address underlying feelings by saying, for example, "It must be so discouraging to feel like there's nothing you can do."
- *Shame/guilt*: Patients who pass on genetic conditions to their children often feel guilt and shame, and patients who have a genetic condition may feel shame about being "defective" or "damaged goods" (McAllister et al. 2007). A genetic counselor might say: "It seems like you feel it's your fault your son has Marfan syndrome."

Sheets et al. (2011) recommend that when counseling parents who have received a diagnosis of Down syndrome, you "Assess the emotional reactions of the parents, and validate these feelings. Use active listening and empathic responses to support the parents" (p. 436). They further recommend you "Be empathic and address potential guilt issues" (p. 439).

- *Apprehension/anxiety*: Most individuals experience at least some anxiety in new situations (e.g., genetic counseling), as well as anxiety about what they may learn. Often, they will not tell you that this is how they feel. Counselor: "I wonder if you feel nervous about being here."
- *Despair/fear*: The patient feels there is no solution, no hope, and no way of coping. An example of addressing this feeling is, "Are you afraid you won't be able to deal with the diagnosis?"
- *Feeling threatened*: Of note, feelings of threat (due to the loss of a loved one, physical deterioration, possible rejection by others, etc.) tend to underlie all negative emotions. With advanced empathy, you attempt to reach that deeper level to determine what is threatening for patients and then discuss how that threat may be hindering their ability to hear necessary information, reach a decision, and/or cope with their situation. Counselor: "You keep mentioning how angry your husband gets that you have to spend so much time with your daughter. Are you afraid he might leave?"

Patient Attitude or Belief Patterns

- *Patients who ask you what to do*: Genetic counselors can view these types of questions as "an opportunity to identify and address a key issue that confronts the counselee and/or the genetic counseling process" (Weil 2000, p. 149). Djurdjinovic

(2009) suggests that a "simple and genuine inquiry on the part of the counselor, 'I would like to understand your question better,' sets aside the question and returns the focus on to the counselee" (p. 140).

- *Externalizing beliefs*: Some patients may blame others for their situation. For example, "This wouldn't be so hard if I didn't have to wait this long for an appointment with you!" or "I'd be able to decide about having Huntington's testing if my mother didn't get so hysterical every time I mentioned it." or "My doctor told me I was NOT at risk for cancer, but you are telling me I am!" We suggest you side step these externalizations as they are very difficult to modify and instead steer the conversation toward the patient: "It sounds as if you've been feeling very troubled about your condition"; "Do you feel guilty about burdening your mother with your condition?"; or "I can imagine how difficult it is to talk about these risks."
- *Patient believes fate, destiny, or a higher power brought about the situation*: Such patients may believe they are being punished for some transgression (which they usually cannot articulate). Furthermore, some cultural groups believe strongly in fate or karma. It is important to assess the extent to which this belief underlies the patient's experience. You might say, "I get the impression you think having a child with spina bifida is some sort of punishment" or "I wonder if in your culture, albinism is considered part of your destiny." Later in this chapter, we offer additional suggestions for working within these types of cultural perspectives.
- *Unrealistic expectations*: Some patients believe they should be able to make decisions easily and without any distress, or they may think it is silly or abnormal to feel so distressed. You could point out the unreasonableness of their expectations. For example, "Maybe you're being a little hard on yourself by expecting to have figured everything out already."
- *Feeling too responsible*: Patients may blame themselves for every aspect of their situation. Patient: "I would never have miscarried if I'd quit drinking coffee." Counselor: "It almost seems like you're looking for a reason to blame yourself. Are you feeling responsible?"
- *Forceful family members*: Lafans et al. (2003) interviewed prenatal genetic counselors about how they managed problematic paternal involvement in prenatal sessions. The prenatal counselors used advanced empathy to address overly involved behaviors. For example, "...[I] tried to make him know I'd heard what he was saying...] 'Alright, you're saying if your wife has this amnio and the baby has Down Syndrome, there's no way that you're going to raise a baby with Down Syndrome, and that you'll leave her. Is that what you're saying?'... once he got a chance to talk about his strong feelings... I could turn to her and say 'Ok, I hear what your husband's saying, and he's very clear, but I get the feeling you feel very differently'" (p. 228).
- *Couples or families may want you to take sides*: To be effective, you need to remain as supportive as you can toward each participant (Schoeffel et al. 2018). You might say, "It seems like you want me to agree with you. It's important that you all have a chance to speak and to hear each other." Relatedly, do not let patients speak for each other. At the beginning of the session, state that it is

important to hear from everyone, and then during the session, invite each participant to speak. Exceptions are patients whose cultural practices require that one person do most of the talking. It may also be appropriate for someone to speak on behalf of patients with limited intellectual and/or verbal functioning.
- *Believing their feelings are wrong*: You should validate what patients are feeling when their emotions are appropriate to the situation. For example, "It sounds like you have good reasons for feeling angry."

Patient Defense Patterns

- *Patients who sound as if they are working from a script*: Some patients present with "rehearsed stories" (Fine and Glasser 1996). This may happen if your patient has had to repeat the same information to numerous health-care professionals, family members, and friends. Try breaking into the script. For example, you could say, "You must have felt so angry when your father-in-law said you shouldn't have any more children." This redirects the patient to feelings and away from the rehearsed script.
- *Rationalization*: The patient is trying to justify her or his feelings, beliefs, or choices. You might say, "You keep saying that you're worried about how your wife will feel if you find out you're at increased risk for early onset Alzheimer disease. I wonder if you're worried about how *you* will handle this information."
- *Projection*: Patients may attribute their feelings or attitudes to others. Patient: "Everyone will think I'm selfish if I terminate this pregnancy because the baby has trisomy 18." In fact, it is the patient who feels that she is being selfish. Counselor: "Perhaps you're afraid that *you* are being selfish."
- *Either-or thinking*: For example, in a prenatal genetic counseling session, both partners are carriers for cystic fibrosis (CF). They see two options—risk having an affected child or do not have children—because abortion is not an option for them. The couple has not mentioned any other reproductive options. You could introduce the possibility of other options by saying, "So you see only two options, risk having an affected child, or have no children. I wonder if there are any other options you haven't considered."

8.1.7 Challenges in Using Advanced Empathy

Beginning genetic counselors usually find that advanced empathy is a complex and difficult skill to learn to use effectively. Common advanced empathy mistakes include:

- Going overboard with too many interpretations that overwhelm the patient. For example, some counselors may need to come across as all knowing, or insightful (Hill 2014).

- Making advanced empathy statements before patients are ready for them and/or making your statements too long.
- Inaccurately projecting your own experiences onto your patients (Clark 2010; MacDonald 1996).
- Lacking theoretical and personal frameworks to see the bigger picture and give patients alternative hypotheses (Hill et al. 2014; Jackson et al. 2014).
- Avoiding advanced empathy responses because you're afraid of being wrong about the patient; you are scared of how the patient will react; you are concerned you might damage the genetic counseling relationship; you fear you are being too intrusive (Jackson et al. 2014); or you don't want to hurt or embarrass your patients (Hill 2014).
  "At some level clients are well aware of their own feelings and perceptions of what has happened to them. We do not need to protect them against the pain of their lives. They have their own defenses to deal with that. More often, they need a witness to hear their pain, their concern, their anger—not someone to change or deflect it" (Fontaine and Hammond 1994, p. 223).

8.1.8 Some Cultural Considerations in Using Advanced Empathy

In some cultures, it is important to be less direct in making advanced empathy responses (Hackney and Bernard 2017; Pedersen and Ivey 1993). A less direct approach helps the patient "save face" (This approach can be effective with defensive patients as well). Consider, for example, the following subtle ways to address patient inner experience:

- "In the past when I've had patients in a situation similar to yours, some of them have felt…"
- "Some people might feel [think, do]…if they were in your situation."
- "Some people find it very difficult to…and they choose to…"
- "You say you're fine with this news, but I want you to know it's OK if you're not. I hope you'll talk it over with me or, if you're not comfortable discussing it here, then talk with someone close to you."
- "If I were in your situation, I might be thinking about the following…What do you think?"

Generally speaking, it is not a good idea to challenge a person's cultural perspective (e.g., that a genetic condition is God's will). First, it is very ethnocentric to believe your way of viewing reality is better for patients than their own way. Second, patients are quite unlikely to change their perspective based on one or two genetic counseling sessions. Third, this sort of challenge will probably damage any trust you have established. Try to work with patients within their cultural perspectives. For example, "I understand that you regard your child's metabolic condition as

God's will. You may be wondering how we can be of any help. Our team can certainly help manage your child's condition."

8.2 Confrontation Skills

8.2.1 Definition and Functions of Confrontation

Confrontation involves responses in which you directly challenge patients to view themselves and their situations differently. Confrontations are a type of feedback that is discrepant with or contrary to the patient's self-understanding, and they usually involve behaviors the patient has neither publicly nor privately acknowledged. Confrontation responses can include identification of patient self-defeating behaviors as well as patient strengths. Indeed, Kessler (1997) stresses the importance of genetic counselors' identifying "key areas of client functioning which they use throughout the session to strengthen the latter's sense of competence. This might involve parenting, work, interpersonal, or other issues and requires the professional to say rewarding things to the client" (p. 381). Confrontations ultimately are intended to help patients consider changing their behavior.

Confrontations can challenge discrepancies, contradictions, defenses, or irrational beliefs, encourage individuals to think or feel in new ways (Hackney and Bernard 2017; Hill 2014), and/or challenge patients to recognize and use their strengths or potentials. By helping patients explore hidden feelings, attitudes, and beliefs, confrontation can remove some of the barriers to goal setting and decision-making. Confrontation shares similarities with advanced empathy, as both are counselor-initiated attempts to elicit greater patient self-understanding. An important distinction, however, is that advanced empathy expresses part of the patient's experience she/he is vaguely aware of, whereas confrontation points out experiences that are discrepant with or contradictory to the patient's self-understanding. Returning to our analogy of a dimmer switch, with confrontations, the switch is turned up to its maximum, meaning the brightest amount of light possible. As such, confrontation has the potential to be both a more powerful and a more threatening response. Confrontation should occur infrequently, even less often than advanced empathy. You must be extremely careful when using confrontation in genetic counseling.

8.2.2 Guidelines for Effective Confrontation

When making a confrontation, you should attempt to be *with* rather than *against* your patient (Miller and Rose 2009). We recommend the following strategies when using confrontation:

Formulate a Response

- *Time your response*: Use confrontation when your patient is likely to be open to it. Direct confrontations at the very beginning have been found to be ineffective in consultation relationships (Dougherty et al. 1997). Rapport and trust must be present before patients are likely to hear confrontations. Lafans et al. (2003) found that genetic counselor confrontation was sometimes an ineffective management strategy for problematic paternal involvement and concluded that confrontation should occur only after you have some understanding of the patient's experience and culture and the couple's dynamics. As those researchers reported, "Indeed, several participants noted that some mothers seem to accept their partner's under- or over-involvement, and they tried to read the mother in deciding what to do about the father's involvement" (p. 239).
- *Begin with accurate empathy*: You must understand your patient's experience before you can detect and raise issues of discrepancies or distortions.
- *Moderate the depth*: Decide how big a difference there is between what you want to say and what the patient believes to be true. If the difference is too big, your patient will be more likely to reject your confrontation.
- *Anticipate impact*: Estimate your patient's ability to handle the confrontation before you intervene. If your patient seems to be confused or disorganized, you should wait until she/he is in a more receptive state.
- *Use successive approximations*: Introduce confrontation gradually; begin with small aspects the patient has some likelihood of being able to take into consideration. Describe your patient's behavior and its significance and/or consequences.
- *Choose your vocabulary and syntax carefully*: Confrontation responses can sound accusatory or patronizing. You should speak tentatively ("I wonder if…"; "Perhaps…"; "Maybe…"; etc.) and use a questioning tone that leaves the patient room to disagree.
- *Check your motivation*: Use confrontation to help the patient, not to be right, to release your anger or impatience, to get back at the patient, or to put your patient in her or his place. It is not appropriate to confront a patient because you are bored, anxious, need to feel in control, or want to dominate the interaction.
- *Be sincerely concerned*: Communicate your confrontation in a way that demonstrates you have a sincere interest in your patient's welfare. Confrontation should be grounded in empathic understanding. For example, "You seem very anxious, and I wonder if we could talk about how that may be part of the reason you're so undecided about testing." Furthermore, if your confrontations imply criticism, that is, if patients think you're accusing them or getting into a power struggle, your relationship and the session can quickly deteriorate (Martin 2015).
- *Put your feedback skills to work*: Since confrontation is a type of feedback, it is useful to consider guidelines for delivering feedback effectively. As discussed in Chap. 1, Danish and D'Augelli (1980) suggest a skillful feedback giver:
  - Is focused on behavior rather than on the patient's personal characteristics.
  - Gives only as much information as the patient is ready to handle.

- Makes the confrontation as soon as possible after the behavior has happened.
- Is concise, tentative, and descriptive rather than judgmental and only confronts about behavior that she/he believes the patient can control or change. For instance, it is judgmental and does no good to ask a patient who says they did not want to be pregnant again if they used birth control.
- States the consequences of the behavior for the patient and/or family members (e.g., "You said you resent not knowing you were at such a high risk for cancer, but now that you know, you're finding it difficult to talk to your brother. How do you think he will feel about not knowing his risk?").
- Focuses on both strengths and weaknesses, asks the patient to respond to the confrontation, and is willing to modify it based on the patient's feedback.
- Is definite (i.e., does not give the feedback and then take it back).

Follow Up on a Confrontation Response

- *Monitor the impact of your confrontation*: Sometimes patients perceive your statements differently from the way you intended them (e.g., you may intend to point out a discrepancy in your patient's story, while the patient thinks you're saying she/he is too confusing or stupid). To check out the impact of a confrontation, you could ask, "What do you think about what I just said?" or "How do you feel about what I just said?"
- *Be supportive after a confrontation*: Confrontations can be threatening and painful to hear. You should follow up with supportive empathy statements that acknowledge your patient's experience. For example, "I know this is hard for you. I can see why you try to cut me off when I'm telling you these painful things. Let's try to go more slowly, so you can take this in gradually."
- *Don't expect miracles*: Not all confrontations produce insights that lead to change (Pedersen and Ivey 1993).

8.2.3 Possible Patient Behaviors to Confront

Discrepancies in Information

Confrontation of discrepancies is important for preventing confusion and to verify the accuracy of information. This type of confrontation is common in genetic counseling because you must gather accurate data in order to help patients set goals and make decisions. Three types of information discrepancies might be addressed:

- *Gaps*: an issue usually associated with a particular genetic situation the patient does not raise. Parents of a child with NF who never mention that they also have multiple neurofibromas, even though you asked about this specifically in gathering the family history.

- *Omissions*: the patient fails to include relevant information in her or his personal narrative. Patient is being seen for genetic counseling about a family history of Duchenne muscular dystrophy. She fails to mention that she is currently pregnant.
- *Inconsistencies*: in what the patient says at different times in the session. For example, "Earlier you told me this is your first pregnancy, but now you mentioned several miscarriages."

Discrepancies Between Ideas and Actual Behavior

It's not unusual to think one thing and do another thing. For instance, a prenatal patient's partner says, "I only want what's best for my wife" but argues strongly against testing, even though the wife says this is what she wants. You respond, "You say you only want what's best for her. It sounds like she wants testing, but you don't agree."

Ambivalence

Ambivalence is a common human experience, and patients should be given permission to feel uncertain (Fine and Glasser 1996). For example, "You say you want to have the testing done, but you keep canceling your appointment. I wonder if you have mixed feelings." Or the patient says, "I'm only here because my doctor sent me. But since it took me hours to get here, and since I'm here already, I might as well go ahead and have the test." Counselor: "That's not a good enough reason. Let's consider the reasons you might and might not want this test."

Discrepancies Between What the Patient Says and the Real-World Context

For example, your patient says, "My child is just a little developmentally delayed, but the doctors told me he'll catch up if we just work with him." You might respond, "You say he's going to catch up, but your medical records indicate that he has Prader Willi syndrome, which is known to be associated with intellectual deficits."

In the Lafans et al. (2003) study, some of the prenatal genetic counselor participants confronted under-involved fathers through education. For example, "[I say] 'This is a couple decision...whatever happens with the amnio has ramifications for both of you.' He says, 'Well, she's the one who gets the needle in her belly.' I said, 'Well, that's true, but it's a minimal part of the amnio experience.' "Did he feel he could support her if she chose to have it?..." (p. 255).

Discrepancies Within the Patient's Messages and/or Internal Dialogue

"You've said you could never have an abortion; you've also said you couldn't deal with another child who has cystic fibrosis." Or "You've said you want to know if you have an increased risk for breast cancer, but you've also said you would be devastated by a positive test result."

Discrepancy Between Patient Self-Perceptions and Genetic Counselor Perceptions of the Patient

The patient says, "I'll never be able to make a decision by myself!" You say, "And yet, you made the decision to come here and to have the testing done even though your family was against it, which suggests to me that you can be strong and decisive."

Distortions

"I'm wondering if blaming your child's condition on the way he was delivered keeps you from having to acknowledge your own medical history."

Evasions/Avoidance

"You've told me you've forgotten to ask your siblings to be tested. Is this perhaps because you know it would mean a more definite answer about your own cancer risk?" Or the patient was supposed to request that his medical record be sent to the genetic counselor. Patient: "I really didn't have a chance to call the doctor's office." Counselor: "I'm wondering if you're sure you want to pursue testing."

Lafans et al. (2003) found behaviors that characterized partner under involvement in prenatal genetic counseling sessions included lack of affect and comments such as "It's her body; it's her decision." Counselor confrontations included saying: "You seem withdrawn, uncomfortable, or confused about how to make this decision...to allow him to say either, 'I don't care,' or 'I don't want an amnio, and that's why I'm doing this.'..."; "I don't think you're hearing what she's saying ...paraphrase what she said and ask her... 'Is that what you're saying?'; then to him, 'Is that what you're hearing?'"; and "'What would you do if you were making the decision all by yourself"...that will get just about any male to state an opinion, and then...you can start discussion in coming to a compromise" (p. 230). Some counselors also used humor. For example, "[I] say to them, 'You realize you're talking to a counselor. I'm not going to let you get away with not talking about your feelings'" (p. 255).

Nonverbal Contradictions

The patient says, with tears in her eyes, "I'm OK with these test results." You reply, "You say you are OK, but you look very sad."

Some prenatal counselors in the Lafans et al. (2003) study confronted paternal nonverbals. For example, "…'your wife is crying and you're not really...looking at her. What's going on with you?'[and] ...some just want to read the newspaper; I'll address that—'I'd like you to be part of this'" (p. 255).

Games, Tricks, and Smoke Screens

You say, "I wonder if interrupting me lets you protect yourself from hearing this painful information?" Or, if the patient repeatedly says "Yes, but…," you could respond, "I notice you say 'Yes, but…' every time I suggest a resource for you to learn more about fragile X syndrome. Perhaps you don't feel ready to learn more about the condition?"

Self-Defeating Statements

Patient: "I can't think of anything I could say to my sister to convince her that genetic testing is in both of our best interests."
Counselor: "I think you've raised several persuasive points in talking with me."

Patient: "I'm just not strong enough to face a test result that says I have a gene for breast cancer."
Counselor: "You say you're too weak to handle that sort of news. However, you seem strong and able to reach out to others for support."

Lafans et al. (2003) found that with overly involved fathers (who spoke for the mother and/or otherwise dominated the conversation), some prenatal counselors used confrontation to encourage them to "own" their behavior, separately from their partner's behavior. For example, "...[I] bring it back to the wife and say, 'Do you have strong feelings about that?... How do you think [his feelings] affect your relationship as a couple?'" (p. 228).

8.2.4 Possible Patient Reactions to Counselor Confrontation

Egan (1994) describes six ways patients could respond to a confrontation:

- *Deny the feedback*: Your patient may calmly tell you that your feedback is wrong or angrily refuse to accept what you said.

- *Discredit the source*: A common genetic counseling patient response might be, "You don't understand. After all, you don't have Huntington's disease in your family."
- *Try to change your mind*: Your patient might try to argue you into believing her or his point of view (e.g., "Oh, if you knew me better, you'd realize I really can't handle this type of news!").
- *Devalue the topic*: For example, "I'm only kidding when I say our daughter's genetic condition is my husband's fault. I don't really mean anything by it."
- *Seek support elsewhere*: "Well, all of my family members and friends agree with me!"
- *Your patient may pretend to agree with you*: "You're probably right. Of course, you have more experience than I do with this disease."

Pedersen and Ivey (1993) identify several additional ways patients might respond:

- Patient is willing to admit to part of what you have confronted.
- Patient agrees with the confrontation but refuses to do anything about it.
- The patient chooses to compromise or accommodate the problem.
- The patient hears the confrontation and uses the insight to change the behavior.

It is important to realize that it may take time for patients to respond fully to confrontation. Their full reactions may not be evident in the genetic counseling session.

Prior to using confrontation, it is important that you assess your patient's general demeanor. Research suggests that you should generally avoid confronting patients who are high on reactance (resistant to giving up control in interpersonal interactions) and/or angry patients (Karno and Longabaugh 2005; Schema et al. 2015). Confrontation may intensify their emotions.

8.2.5 Challenges in Using Confrontation

Confrontation is not an easy intervention. If you look up "confrontation" in a thesaurus, you will see terms such as challenge, oppose, antagonize, provoke, meet, threaten, defy, tackle, face, encounter, handle, face up to, deal with, and meet head-on. Some of these terms sound quite negative, suggesting behaviors to avoid doing.

Moreover, when confrontations are about difficult issues, we may want to avoid them because we fear patient's negative reactions, and/or it makes us feel bad or uncomfortable to think we've caused someone else's pain. Moreover, "Beginning counselors tend to avoid confronting…because it deviates from what they have been taught is polite behavior; therefore, they fear that doing so might damage the relationship" (Hackney and Bernard 2017, p. 29).

Similarly, in genetic counseling you may avoid using confrontation with your patients because:

- You want to be liked and are afraid patients won't like you after you confront them.
- You don't want to hurt or embarrass patients (especially likely if you regard patients as fragile and vulnerable). In reality, patients are already experiencing pain and conflict; rather than directly causing their distress, your honesty allows it to come out in the open (Wilbur and Wilbur 1986).
- You have a cultural belief that confrontation is a rude or otherwise inappropriate behavior.
- You might be off base, that is, you're afraid you are biased against or wrong about the patient.
- You might open yourself up to feedback from the patient.
- Your patient might get angry, shut down, or even get up and leave!
- You are unsure how to confront in a way that is supportive while also being direct (Chui et al. 2014).
- Confrontation is not just difficult when it's about painful issues. You may also be afraid of sounding phony if you confront patients about their strengths (e.g., you feel uncomfortable giving compliments) or you think your opinion will not matter to them.

8.2.6 Cultural Considerations in Using Confrontation

You cannot use confrontation in the same ways with patients from all cultural groups. You need to be sensitive to cultural differences and modify your approach depending on a patient's background. For instance, direct challenges with Asian, Latino, and indigenous American patients generally should be avoided (Ivey 1994). Additionally, cultural practices for some Chinese individuals involve being extremely careful not to hurt another person or to make the person "lose face." Another implication of these differences is patients from some cultural groups might feel compelled to agree with your confrontations because they don't want to hurt you. The appropriateness of confrontation also differs between men and women across cultures (e.g., a female genetic counselor communicating with a male from the Middle East should be particularly careful about using this type of intervention).

Pedersen and Ivey (1993) recommend addressing the different rules that various cultures have about confrontation by:

- Being aware of your own cultural assumptions as well as those of your patient's culture.
- Framing confrontations in ways that make it appropriate to your patient's culture. Change the words or the process of communicating the confrontation; translate it into the patient's cultural style, so your confrontation can be understood. For example, the use of the word *problem* might be ineffective for a patient who comes from a culture where it is unacceptable to have a weakness.

- Trying not to be "distracted by behaviors—no matter how discrepant they might seem—until they are understood from the viewpoint of the patient's values and expectations" (Pedersen and Ivey 1993, p. 196). For instance, some African American patients may look away when listening to you.

You will encounter many different types of beliefs and practices that are culturally based. Consider the following example:

> A Middle Eastern couple is counseled regarding prenatal testing. The husband does all the talking but states that it is his wife's decision. The wife keeps her eyes on the floor and says nothing. Counselor: "Mr.—, you've said several times that it's up to your wife to decide about testing this pregnancy, yet she has said very little today. Help me understand how she will make this decision."

In this example, it is important to assess the reason for the woman's silence. For instance, Awwad et al. (2008) interviewed native Palestinians and first-generation, Palestinian Americans and asked them to imagine themselves as patients in hypothetical premarital and prenatal situations. Among their results, they found most interviewees preferred a joint decision-making process with their partner; this process, however, would happen at home, not during a genetic counseling session. Furthermore, if the couple was in strong disagreement, most Palestinian Americans said the decision should be made by the woman, while most native Palestinians preferred the decision either remain a joint one or that the man should decide. These results demonstrate clear differences in culture and acculturation that might be one explanation for the perceived discrepancy in the above example.

Keep in mind that confrontation is unlikely to work when patients hold strong cultural beliefs. In such situations, you need to respect their view and move on. For example, a couple from Pakistan who has a child with Friedreich's ataxia does not believe their consanguinity caused this condition. You could say, "I understand that you do not think your child's condition happened because you and your wife are related. Can we talk about some tests that would tell us if the next baby will have the same thing?" This accomplishes the genetic counseling goal of offering options to patients, without disrespecting their beliefs.

Remain flexible in using confrontation with patients whose cultural backgrounds differ from yours. You generally should strive to make your confrontations gentle, as such feedback is difficult for most individuals to hear. Remember it is always appropriate to ask patients to help you understand their cultural perspective on an issue. It may be sufficient to say, "You and I come from different cultures. Can you help me understand how we can approach this issue together?"

Note that there will be times when you can incorporate your patient's cultural beliefs into the session. For example, Greeson et al. (2001) interviewed Somali women immigrants and found unanimous belief that "…Allah, not inheritance, makes a person disabled" (p. 375). The researchers recommended that instead of confronting this belief, genetic counselors could "mesh science and religion by… [helping] Somali patients consider risk by using the example that Allah decides which gene the child gets, but that there are four choices" (p. 375).

Religious beliefs comprise another cultural variable that may present inconsistencies, and you might think the beliefs are impeding the genetic counseling process. Knapp et al. (2010), speaking about psychologists, recommend that practitioners "…(a) consider carefully how to identify a belief as religious; (b) listen carefully to their clients; (c) recognize that religious beliefs, like other beliefs, may be fluid and changing; and (d) accept that religious beliefs are multifaceted and multi-determined" (p. 406). They further assert that "…situations where it is necessary to directly challenge a client's religious beliefs are exceptional" (p. 409).

8.3 Closing Comments

Advanced empathy and confrontation are less frequent responses than other genetic counseling behaviors such as primary empathy, questioning, and information giving. Nevertheless, when used strategically, they can foster patient insights about themselves and their situations. Often these insights will help patients achieve greater acceptance of their feelings, thoughts, and actions. They may also prompt changes in behaviors that are getting in the way of patient goal-setting and decision-making processes. As a beginning genetic counselor, you may feel anxious about using these powerful responses. With supervised practice, you will gradually become more comfortable incorporating advanced empathy and confrontation skills into your counseling repertoire.

8.4 Class Activities

Activity 1: Empathy and Confrontation Discussion

Students talk about what they think advanced empathy and confrontation are, how the two skills are similar and how they differ, and the functions each serves in genetic counseling. This discussion can be started by having students respond to the questions in dyads.

Estimated time: 10–15 min.

Activity 2: Conceptualizing Patients (Small Group Exercise)

In small groups, each student selects and reads aloud a patient statement (listed below) then discusses what it might be like to be this patient. The student generates as many ideas as she or he can about:

- The patient's surface feelings, thoughts, and issues
- The patient's underlying feelings, thoughts, and issues