

Communication Matters

Can empathy be learned? Lessons from ninjas and neuroscience

Being a student of empathy is a privilege and a source of endless fascination. There are so many ways to look at empathy: as a biologically-mediated ingredient in relationships and social order, an underpinning of morality and the not-so-secret sauce that ensures patients feel the "care" in clinical care.

Thank you for joining our exploration of some of the arguments in the debate about whether or not empathy can be learned.

Empathically yours,

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Across the spectrum of human endeavors, a growing research literature, and IHC's extensive experience emerges a promising premise: **empathic behaviors can be taught, learned and assessed** (Henry SG 2013).

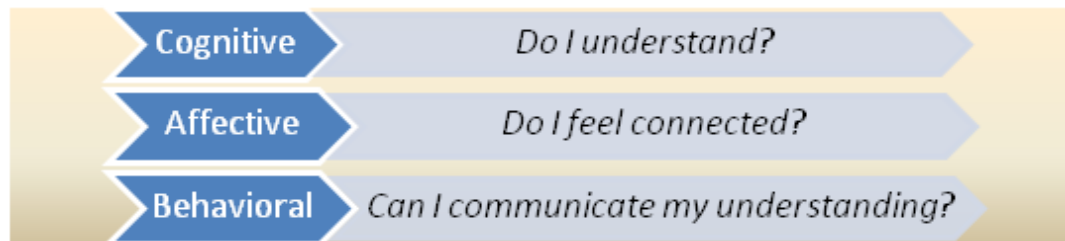
Despite the compelling body of evidence, there remains some skepticism. We examine two commonly-cited arguments against "learning empathy":

- (1) you are born with empathy (or not), and
- (2) even if empathy can be learned, that must happen in early childhood or it won't be effective.

First, we should clarify that we are not proposing-nor do we believe it is reasonable-to learn "how to feel" in a given situation. We feel the way we feel in response to situations and interactions. It is, however, possible and reasonable-and highly productive-to learn specific communication behaviors. Behaviors that convey empathy are documented to be highly valued by patients, correlated with better health outcomes, and beneficial to clinicians who practice those behaviors.

Empathy has cognitive, emotional and behavioral components. The cognitive aspects include the ability to understand another's situation, perspective, feelings and motives. The affective domain is the appreciation and emotional reaction to the perceived experiences.

And the behavioral component is the capability to communicate this understanding to the other person through verbal and non-verbal expression.



These domains of empathy interact and are embedded in every interpersonal interaction. Viewed as a cognitive strategy (rather than an emotional response), empathy provides a pathway for appreciating—without getting caught up in—others' emotions (Batio 2013).

Argument #1: You are born with empathy (or not)

A simmering debate—a variant of the "nature vs. nurture" camps of understanding human behavior—continues around the question of whether or not empathic behaviors can be learned. The "nature" camp holds that just as some people have superior hand-eye coordination, some individuals have an innate capacity for empathy.

An intriguing line of neuroscience research suggests that specialized brain cells, "mirror neurons," may be partially or substantially responsible for humans' ability to understand others' actions and feelings. The "broken mirror hypothesis" of autism posits that malfunctioning mirror neurons "are likely responsible for the lack of empathy ... found in severely autistic people" (Thomas 2012). Scientific advances such as this hold hope for the development of new brain-based treatments. They do not, however, support the notion that certain individuals cannot learn empathy because of inborn brain architecture or functioning. While some people have greater difficulty than others mastering empathic behaviors, that doesn't mean it is pointless to try. Individuals whose innate capacities for empathy are lower will need to work harder to acquire and express empathy, just as people endowed with less-than-perfect hand-eye coordination must work to master eating with chopsticks or playing tennis.

Argument #2: Even if empathy can be learned, that must happen in early childhood or it won't be effective

A segment of the "nurture" camp acknowledges that empathic behaviors are learned, and they are best (and perhaps only) learned in early childhood. This perspective may be expressed in the belief that if individuals do not learn empathic behaviors by a certain age or developmental stage (age 6? age 12? adolescence?), they will have missed their chance to do so.

By all means, learning skills earlier in life provides added opportunities to practice and hone those skills. Kids who learn to read music, be polite, pitch a softball or speak French enjoy measurable and temporary advantages over their peers who do not learn such skills early on. Behaviors that we do over and over become habitual, so they require minimal conscious effort; in this way hard tasks get easier over time. This is particularly true of communication behaviors, which are closely linked to our sense of identity and our way of operating in the world. Behavioral science offers reassuring clues that **it is never too late to acquire new skills and habits**. Habits are, in fact, malleable throughout our lives (Duhigg 2012) and a growing research and popular literature defines specific habits for cultivating empathy (Krznicaric 2012).

No two people grow up in identical environments, so it stands to reason that individuals develop with differing ideas and skill sets in their interactions with others. This is particularly true for empathic behaviors, which are not valued equally in all settings. **A key**

premise of IHC communication training is that we can all improve our communication skills, whatever our background, experience and innate capacities.

As much as patients appreciate empathic providers, there is compelling evidence that **clinicians frequently miss opportunities to express empathy** with patients. One study found that surgical residents and attending physicians missed 70% of empathic opportunities in visits with patients (Easter 2004). Further, the research literature documents troubling declines in empathy among physicians as their training progresses. Chen and co-authors, for example, found that "Empathy scores of students in preclinical years were higher than in clinical years" (Chen DC 2012). There is a pervasive traditional belief that clinicians risk losing their objectivity if they are not detached. In fact, objectivity and empathy are not mutually exclusive. **The good news is that just as detached behaviors can be learned, so can empathic behaviors.** Ample evidence shows that **well thought-out and comprehensive communication training is highly effective** raising clinicians' scores on validated empathy scales (Bonvicini KA 2009). The pathway toward improved clinician-patient communication is clear; however, challenges abound:

- **Learning empathic behaviors is challenging because of the affective component.** It can be difficult for clinicians-in-training to learn to regulate their emotions, particularly in the face of patients' suffering. When we frame the choice as one between detachment and sharing in one's patients' suffering (sympathy), the choice of detachment is understandable. Detachment is part of a traditional and widespread approach, modeled by many teachers and clinicians in practice, and valued as protective of the clinician's impartiality. In fact, **both detachment and sympathy are emotionally damaging to clinicians and counterproductive for quality medical care.** The secret is shifting the perspective away from sympathy and toward empathy. Expressing empathy is not the same as taking on a patient's suffering; instead, it is a tool used by skilled clinicians to enhance communication and delivery of care. Empathy has been described as the clinician's most basic and most powerful diagnostic and therapeutic tool.

"Just as plants have been shown to change their electrical properties in response to other plants in distress, our bodies respond to the patient's suffering whether we acknowledge it or not. Empathy is a mechanism to release that stress and allows us to remain present in the moment. This provides benefit to both the clinician and the patient." (Batio 2013).

- **The healthcare environment—including clinical training—has not always acknowledged the importance of empathy.** A host of pressures experienced by clinicians (in training and in practice) work against the development of empathic behaviors. Time pressures, the mythology of detachment, training traditions and behavior modeling are among the factors cited anecdotally and in the literature. This is changing, with growing recognition on the part of patients, payers, regulators, educators and clinicians that empathy—as part of a constellation of effective communication skills—matters profoundly. The US healthcare system is in a transitional moment: productivity pressures are prominent and traditions of detachment persist, while pressures toward enhanced empathy are also growing.

Empathy is the not-so-secret sauce that improves care, boosts patient satisfaction, helps to make clinical visits more efficient and helps clinicians gain greater satisfaction in their work. Alone, it is not sufficient to affect individual patient care or cure all the ills of modern healthcare, but it is a necessary component to enhance healthcare at all levels.

How does one strengthen empathic behaviors?

Part of the equation is focused teaching, part is positive modeling, and part is the personal exploration of new ways of behaving. A useful approach is, "**Fake it till you make it**," defined by Urban Dictionary as:

To act like you are something so you can, in fact, become that thing.

A ready example is demonstrating respectful listening when someone is saying angry words that irritate you. Your impulse may be to roll your eyes, grimace and try to shut down the speaker. This is a formula for a heated argument! With conscious practice, you can maintain eye contact, keep your facial expression neutral and nod your head, and, when there is a break in the tirade, say, "I hear you." Without in any way negating your feelings, your empathic response will de-escalate the encounter.

Ninjas know that a stance of confidence confers confidence. Similarly, empathic behaviors convey empathy. A handful of basic skills, practiced on a consistent basis, become part of a clinician's way of interacting with patients. **Positive nonverbal communication speaks volumes.** For example, eye contact between clinicians and patients is strongly correlated with patients' perceptions of clinicians' empathy (Montague 2013). Clinicians whose habitual responses to patients' pain, fear, anxiety, anger or bewilderment are open, curious and non-judgmental discover that their empathic responses do not draw them into patients' suffering. Rather, they invite patients' participation and help to allay patients' fears and anxieties.

There are a number of strategies for conveying empathy. Each can be learned and practiced and honed over time.

Non-verbal strategies

- Voice tone
- Facial expression
- Pausing
- Eye contact
- Touch
- Posture

Verbal strategies

- Inviting input
- Open-ended questions
- Reflective listening
- Not interrupting
- Checking for understanding
- Asking permission



If we think of empathy as "an emotional and thinking muscle that becomes stronger the more we use it" (Martinuzzi 2013), then IHC can be your personal trainer, providing knowledge, guidance and encouragement.

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