Empathy and Language in the Clinician Patient Relationship: Improving the Translation of Evidence to Practice

Cynthia Geyer, MD[1]

Abstract

For clinicians, effective communication goes beyond the delivery of scientific information to include an understanding of who the patient is and what they value; treating them with respect; and acknowledging their emotional and social realities. Recognizing our own implicit biases and cultivating a more mindful approach to the impact of language, especially around weight and food, and using verbal and nonverbal approaches to convey empathic concern can improve our relationships with our patients. Patients who feel seen and respected are more likely to follow through with recommendations including dietary change, leading to improved health and quality of life.

Introduction

Translating evidence into real life behavior change for patients requires more than just a clear articulation of the strength of the science behind recommendations. This may be particularly relevant in working with patients to encourage changes in diet and nutritional intake, now recognized as one of the largest modifiable contributors to morbidity and mortality. Physicians have historically been trained in a more directive approach to care, in which recommendations and treatment plans are given and the patient is expected to comply or adhere to them. While this may be appropriate in an acute care setting, it is not effective in working with patients around lifestyle factors including (and perhaps especially) diet.[1,2] People eat for reasons beyond just satisfying hunger and fueling their bodies. Food and dietary patterns have cultural, social, and emotional contexts that vary among individuals, families and communities. Dietary recommendations or prescriptions that fail to take these into account are likely to be met with resistance or ignored. In addition, both stress and sleep deprivation impact food choices through multiple mechanisms, including changes in ghrelin and leptin and a shift in decision making from a thoughtful, reflective approach regulated by the prefrontal cortex to a more reflexive, emotionally driven response from the amygdala and related subcortical structures.[3-4] This results in a "default to habit" and preference for highly palatable, more energy dense foods.[5] Addressing stress and sleep may be prerequisites to support patient's efforts to engage and sustain (or reengage) in dietary change.

The impact of the social determinants of health in exacerbating health care disparities have been reviewed extensively elsewhere, and these include factors affecting diet such as differences in access to healthcare, lack of availability of fruits and vegetables, and higher concentrations of fast food restaurants in communities with lower socioeconomic status.[6-7] Factors related to the clinician-patient relationship may contribute to patient stress, disengagement, and reduced willingness to consider or embrace dietary change. These include implicit bias, mismatched agendas, not recognizing or attending to people's social and emotional realities, and using language that is potentially shaming or blaming.[8-10]

Establishing a relationship based on trust and attempting to understand patients' goals, values, readiness to change, perceived challenges or barriers, and social supports provides a foundation to facilitate bidirectional, respectful communication. In a 2009 review of the research on patient adherence to recommendations, aspects of the clinician: patient relationship that were consistently associated with improved adherence included a clinician's perceived empathy and emotional support; treating patients with respect and as equal partners; and giving reassurance.[11] Empathic concern, increasing awareness of one's hidden biases, and a more mindful approach to language by clinicians may reduce discord and disconnect, improve engagement and increase the likelihood of patients' willingness to adopt dietary change to improve their health and well-being.

Empathy

Empathy has been associated with improved physician-patient relationships and health outcomes. However, there are challenges with varying definitions of empathy that make it difficult to quantify and track.[12] In its narrowest sense, empathy refers to the experiencing or sharing of emotions that match another individuals emotions. A broader definition includes cognitive empathy, which is also known as perspective taking or theory of mind, and involves the capacity to intentionally adopt or imagine another person's perspective to better understand their subjective experience.[13] What may be most relevant in the clinical encounter is empathic concern (sometimes used interchangeably with compassion), which does not necessarily rely on shared emotions.[14] Empathic concern is characterized by feelings of warmth and care for another, coupled with a strong motivation to improve their well-being.[12] This mirrors what patients often perceive as empathy. Empathic concern can be conveyed through language and also nonverbal cues such as eye contact, a nod, or a warm look.

Motivational Interviewing, a foundational component of health and lifestyle coaching, and patient centered communication are 2 examples of overlapping frameworks that can facilitate dialogue in an empathetic and nonjudgmental way.[1,15-17] Both address psychological needs such as autonomy, relatedness and competence that predict greater adherence to recommended health behaviors. Simply asking what a person values can be an effective way to gain deeper understanding of how they see their health and how they cope when their values may be threatened.[18] This contributes to their feeling seen and heard, and also improves the ability to tailor lifestyle recommendations in a way that is congruent with those values.

[1] Canyon Ranch, Lenox, MA, USA

Corresponding Author:
Cynthia Geyer, Canyon Ranch, 165 Kemble St, Lenox, MA, USA.
Email: cgeyer@canyonranch.com

Implicit Bias

Implicit bias refers to associations outside our conscious awareness and usually refers to those that can lead to negative evaluation of a person based on characteristics such as gender, age, ethnicity, or weight. A 2017 review found that health care providers exhibited the same level of implicit bias as the general population.[19] Of particular relevance related to diet and nutrition are the observations of weight bias, and bias against patients perceived to have contributed to their injury or condition. Weight related stigma is associated with numerous negative health effects, including reduced trust of health care providers and avoidance of appointments; stress, anxiety and depression; potential disordered eating; and low self-esteem, substance misuse and suicidal ideation.[20] Young adults who reported a pre pandemic experience of weight stigma were more likely to express higher levels of depressive symptoms during the COVID-19 pandemic, use eating as a coping strategy, and have a higher likelihood of binge eating.[21] How can clinicians improve their awareness of their own hidden biases about weight and more effectively work with patients who are overweight or obese? Meditation and mindfulness practices have been proposed to help through the development of skills that include improved awareness of and ability to control responses to implicit bias once activated.[22] Mindfulness has also been associated with increased self-compassion and compassion toward patients.

The Impact of Language

How we use language around food can also affect behavior and well-being. Labeling foods as ''good'' or ''bad'' in an attempt to influence patients dietary choices may have unintended consequences. For example, I have had patients respond when asked to describe a typical day's diet, ''do you mean when I am being good or being bad?'' Tying one's self worth to his or her food choices is stressful and shaming, and eating perceived ''bad'' foods may contribute to self punishment.[22] Dieters who read negative messages about dessert had more positive thoughts about the foods and consumed 40% more cookies than those who read a positive or neutral message.[23] Flexible (as opposed to rigid) eating restraint correlated with better long term weight control, and may reflect the importance of autonomy and self efficacy as predictors of lasting behavior change.[24] More recently, a survey of 800 participants in the United States on the relationship between perceived stress, emotional eating and food choices during the COVID-19 pandemic found that a majority (74%) reported moderate to high levels of perceived stress. Perceived stress was associated with emotional eating and a greater desire for foods labeled as ''comfort foods.''[25] As clinicians, acknowledging the inordinate levels of stress people are feeling; showing empathic concern for their emotional distress; normalizing the desire to reach for something that feels nostalgic, indulgent or soothing; not judging people for having this response (and potentially gaining weight), and working together to find additional or alternative strategies to help cope will likely have greater benefit than reminding people of the potential adverse health effects and why they shouldn't eat those foods.[26-27]

Recently published results from the PROPEL study (Promoting Successful Weight Loss in Primary Care in Louisiana) provide an example of how a collaborative care approach can improve adherence to intensive lifestyle recommendations and improve outcomes in an underserved population.[28-29] The intensive lifestyle program was delivered by health coaches imbedded in primary care clinics. After 24 months, participants lost significantly more weight and had lower total cholesterol and metabolic syndrome scores compared to usual care. While not specifically measured, the program design likely reduced implicit bias and ensured that language was culturally informed and nonjudgmental through the use of patient advisory boards: individuals representative of the patient population were involved in the designing and adaptation of sessions, educational materials and interventions.

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Empathy and Our Contentment, Cooperation, and Compassion

Horacio Sanchez[1]

Abstract

Empathy is the cornerstone of healthy relationships and the ability to navigate complex social situations. The cognitive system that produces empathy, the left ventral striatum, ventrolateral prefrontal cortex, and supplemental motor area, motivates cooperation with others. Indications that empathy is on the decline should concern each individual because it is essential for our social and emotional wellbeing. Without empathy, we lose the ability to be compassionate. Empathy is many things, explaining why it can produce contradictory outcomes simultaneously. The evolutionary mandate of empathy might be the source of racial strife as well as the key to achieving racial harmony.

Empathy refers to a cognitive process that enables an individual to put oneself into the mind of another person to understand what he or she is feeling.[1] Empathy is almost as crucial as procreation in ensuring the continuation of the human race. Infants are born fully dependent on their caretakers for their survival. It is empathy that enables parents to meet the need of infants who are unable to verbalize requests. Empathy trigger oxytocin, which promotes lactation, the bonding hormone. The empathy-oxytocin sequence triggers dopamine in the limbic reward and motivation circuits, ensuring continued caring for infants.[2] It is dopamine reinforcement that helps us formulate new habits. Infants in the first year of life demonstrate the capacities to share the emotions of others and respond to express empathic concerns.[3] The elevated empathy response demonstrated by parents of newborns triggers social cognition changes in the infant that seem crucial for parental bonding, appropriate care of a newborn, and infant-mother attachment.[4] Due to a child's dependency on their caretaker, the quality of the social bond is not only predictive of their health and contentment but survival itself. Longitudinal research shows that the ability to develop a secure attachment to a primary caregiver is a protective factor against social and emotional maladjustment.[5]

Empathy has steadily declined between 1979 and 2009.[6] Additional analyses showed that the declines in empathy are more pronounced after 2000. The average person is less empathic than three-quarters of the people living in 1970.[7] In addition, recent research found that texting reduces the number of face-to-face interactions, further eroding empathy skills. Although we are born with the capacity for empathy, it requires a certain level of quality social interactions to mature. Humanity's ability to survive is based on social skills that promote interpersonal understand and cooperation with others. The essential capacity for cooperation is reliant on the ability to understand others through the representation of their mental and emotional states. Without this skill, humans would have never formed clans and established communities. Researchers conclude that the capacity for empathy might be the primary component for sustaining cooperation necessary for communal living.[8]

Although empathy promotes compassion and cooperation, its link to survival produces a bias, creating a deeper social bond to close relations

[1] Resiliency Inc, Durham, NC, USA

Corresponding Author:
Horacio Sanchez, Resiliency Inc., 506 Braden Dr, Durham, NC 27713, USA.
Email: linkedin.com/in/hsanchezceo