Narrative Empathy and How Dealing with Stories Helps: Creating a Space for Empathy in Culturally Diverse Care Settings

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...We start our lives as if they were momentous stories, with a beginning, a middle and an appropriate end, only to find that they are mostly middles.

Anatole Broyard¹

...Everything is possible again ...We could retell our stories and make them better, more representative or aspirational. Or we could choose to tell different stories. The world itself has a chance.

Jonathan Safran Foer²

The universe is made of stories, not of atoms.

Muriel Rukeyser³

Empathy is essential to patient-centered care and is a crucial component of effective clinician-patient communication.⁴–²⁰ Evidence suggests that empathy in medical practice may be on the decline.²¹–²⁹ The growing popularity of palliative care can be understood as one response to this problem. In this article, we briefly describe the importance of narrative empathy. We suggest that dealing with stories and becoming aware of the high and low contexts of communication can aid in the development of a shared language and culturally tailored experience that can enhance the clinician-patient relationship.

Narrative Empathy and Why Stories Matter

Empathy has been described as the ability to share, appreciate, and understand the affective, cognitive, existential, and experiential worlds of other people.⁶,⁷,¹⁶–¹⁸,²⁰,²⁷,²⁹–³² Evolutionary, developmental, sociocultural, and neurobiological perspectives highlight the significance of empathy as a survival benefit for our species.³⁰–³² There is evidence that somatic sensorimotor resonance in pain-processing areas between other and the self may trigger empathic concern and feelings of sympathy.³³ Pain serves as a warning signal.³³ This signal may constitute a “threat” to the clinician that can lead to “personal distress or even compassion fatigue.”³⁴ If a clinician does not become self-aware (i.e., self-regulation), this distress can be costly, both psycho-physiologically and sociopsychologically, and can eventually conflict with the capacity to be of assistance to others.³⁴

Yet, other studies note that an active (conscious) regulation of negative emotion (i.e., decreased empathy) also has adverse physiological and sociopsychological costs.³⁴ Active regulation of negative emotion has been shown to disrupt patterns of communication and other aspects of social exchange, increase blood pressure, and create stress for both the regulator and the interaction partner.¹⁸,³⁴ In the clinical context, empathy also has been
associated with other positive health benefits and outcomes, including increased patient satisfaction, the efficacy patient-centered treatment, decreased malpractice lawsuits, better adherence and compliance to medical treatment, quality of care, and decreased clinician burnout. Moreover, by positively investing in interpersonal relationships, by becoming aware of our own and others’ emotions, desires, intentions, and by sharing experiences and meaning, mutual empathy and understanding are enhanced.

Narratives are valued across all cultural groups, as one method of promoting mutual understanding. Patients with chronic illness also experience the meaning in their lives and themselves as part of a larger life narrative, a story, which may have been disrupted or fragmented by illness and associated pain and suffering. Narrative models the flow of life, provides a social commentary, and helps us to understand and share our lives with others. We live, survive, thrive, and die in the context of a larger life narrative, woven together by personal stories of caring. However, in the context of illness and pain, personal identities and story lines often become destabilized and may even break. Narrative is crucial to the process of recognizing and integrating repressed and alienated selves that suffer. Narrative also can become an important tool to probe, resurrect, and forge new identities within new story lines, and thereby promote healing. Any new identity requires a “new” understanding of self, a self that arises through empathy and union with others.

Charon and others have argued that, along with scientific expertise, clinicians need to acquire narrative competence or the ability to listen to the narrative of the patient, responding to these context and culturally specific narratives with empathy. Narrative empathy addresses culture as the primary frame of reference, and the needs and goals of another person can be communicated, ideally allowing the clinician to respond appropriately. In the clinical encounter, narrative empathy can occur as a result of the clinician’s effort and imaginative engagement with the patient’s story. Through an awareness of one’s own and the other’s behavior, the clinician and patient also can come to recognize and understand each other’s predicament. Through this insight together, they also may choose to construct new stories of healing.

High and Low Context in the Culture of Biomedicine

Cultural groups vary in the types of stories they most value, and in some cases privilege to listen to or hear when communicating. Cross-cultural misunderstandings and miscommunication occur when people from different groups talk “past” each other by using very different narrative styles, which can lead to misunderstandings and misperceptions about whether empathy exists in encounters. Emerging from primarily Northern European roots, biomedicine is a culture unto itself. In the case of chronic illness, modern biomedicine has historically tended to focus on clinical distance and detached concern amidst measured hope as an appropriate response to human suffering.

Detachment is Janus faced, in that it is deemed to work by protecting the physician from being overwhelmed by the pain and suffering of the patient and also by protecting the patient from any potential bias that might contaminate otherwise objective medical decisions. In the world of biomedicine, good decision making and quality care has focused on objective reality and the use of related technology and eschews subjective aspects of reality and human relations. In the language of the anthropologic field intercultural communication, this is a low-context approach to healing. Low-context communication emphasizes just such objective aspects of reality and tends to be task oriented. In contrast, high-context communication focuses more on the context within which people are communicating and specifically on the relationships among and between people.

So what does such a low-context approach to medicine have to do with storytelling? In biomedicine, stories are still told and heard by people who often care deeply about outcomes. However, the stories themselves lack people. There are no heroes, villains, or other actors in this human drama. Biomedical stories emphasize mechanistic causality. Stories of illness are told in terms of disease processes arising
from particular interactions of disordered physiologies within broken bodies. The predominant message or “moral” of such stories is that if we understand where physiologic chains have become broken, we can fix them and rebuild the body from the ground up. Thus, biomedical stories fit well into the paradigm of low-context communication, as first proposed by Hall. Yet, even where the biomedical framing of disease is cognitively accepted, illness itself is experienced as a drama, rich in symbols, feelings, and meanings, involving many characters and plot twists. As such, illnesses, especially advanced or terminal illness, are inherently high-context events.

Both high- and low-context approaches to understanding and sharing the experience of illness are important and necessary. Problems arise when people attempt to use these very different styles as they communicate with one another. Paraphrasing George Bernard Shaw, too often there is only an illusion of communication. By way of example, a clinician may talk with a patient about a new illness and propose a particular treatment. The clinician may understand and tell his or her story by way of a tale of deranged physiology, and how to make it right by the proposed treatment. Such would be a rational low-context approach. The patient may hear this story and reinterpret it in terms of a more personal high-context communicative framing.

What are the implications of this illness on that person’s life narrative and the interwoven narratives of loved ones? While the clinician may speak of causalities and probabilities, the patient may listen and understand in terms of personal story line themes. As an example, one study of hormone replacement therapy found that many women paid little attention to probabilities of benefits or burdens of possible therapy. Instead, what they decided to do was based on how someone they knew had done on the therapy. Thus, the functioning story line for a particular patient might be, “My aunt did well (or poorly) on the drug, so I will (won’t) take the medicine.”

We suggest that such problems of communication are very common when clinicians encounter patients and families in the midst of serious illness. When communication breaks down, often involved parties complain that the other side just did not “get it.” Clinicians, especially in end-of-life situations, may complain that patients or families are “in denial,” although we suspect true denial is rarely a major factor. Patients and families may complain that clinicians do not listen to them. We suspect that most clinicians do listen, but that they are often working along such different story lines that what is heard is poorly understood or deemed irrelevant. In cases of advanced illness, palliative care consultants may be brought in. Much of the good work that consultants do probably arises from acting as cultural and narrative brokers among protagonists working along alien high- and low-context story lines.

What then of narrative empathy, in terms of this framing of high- and low-context communication? One way to understand narrative empathy is in terms of resonance. By way of metaphor, a high C note on a piano when hit will cause other C notes to vibrate slightly because of resonance. Perhaps the human equivalent of this is compassion. Compassion means to suffer with and as such represents a type of resonance. Like resonance, compassion arises without will. Yet, proper tuning is required to maximize its potential, which we may call narrative empathy. This process of tuning or alignment in clinical practice can be considered a medical virtue. A good doctor or other clinician tunes and retunes his or her instrument seeking alignment with the patient. It is clear that clinician and patient may not be on the same note. However, they need to mutually recognize enough commonality of being and story lines that empathetic resonance becomes possible.

Some may argue as to whether narrative empathy exists as an inherent aspect of self or whether it must be cultivated. This strikes us as a specious low-context approach. Narrative empathy is not a discrete measurable thing. This is like asking whether a silent piano resonates or not. From a high-context perspective, narrative empathy is situated within a particular cultural context, and it cannot be understood outside of relationships. Although we can accept that people vary in their individual empathetic potential, the greater issue is how to maximize resonance and compassion among people and how to enhance narrative empathy, whatever people’s innate capabilities.
Narrative Empathy in the High and Low Context: So Where Do We Go From Here?

This is where a discussion of high- and low-context communication may be of use for understanding narrative empathy and why stories matter. The clinician understanding and communicating along a low-context story line may care very deeply about the patient. This caring may arise from a real appreciation for the negative consequences of a particular illness and the measured hope that the clinician’s technical skills can make things better. The patient or family member in turn may be so preoccupied with the impact of the illness on their personal story lines that they cannot appreciate what the clinician is trying to say or the caring motivation that is driving the communication. The sad result may be miscommunication, poor decision making, mutual frustration, and a failed empathetic connection.

Narrative empathy is not just something “nice” or some laudable aspect of human goodness. The resonance of empathy is energizing and pushes participants beyond more isolated perspectives into story lines that are mutually constructed and mutually beneficial. Narrative empathy is that mutual understanding in the clinical context of how storied lives overlap, experiences are shared, and life’s events and struggles, including pain, suffering, loss, and illness, “fit” into a larger life narrative. We see this when clinicians, patients, and families meld together common stories of caring. When done well, we recognize that there is no inherent incompatibility between low-context medical science and high-context human caring. Proper use of medical science is just one way to contribute to the greater human drama. Conversely, a lack of empathy cannot be viewed simply as an issue of an individual character flaw. Lack of empathy in relationships is de-energizing and alienating. Just as empathy begets empathy in an iterative fashion, so lack of empathy tends to spiral into mistrust, anger, and hatred, further distancing people from one another at a time when they need each other most.

So the question then becomes, “What can be done about all this?” The above discussion suggests that it is nothing as simple as “making” people more empathetic. The metaphor of piano resonance suggests a general approach. In tuning a piano, one must listen to one’s own instrument, relative to the reference tone. Thus, a first suggested step is cultivating self-awareness in difficult encounters that problems may result less because of fundamentally different beliefs or psychological barriers like denial and more from people being “out of tune,” working along very different story lines. These story lines tend to buffer individuals and mute resonance and compassionate interactions. Having recognized this, the next two critical steps are self-reflection and deeper listening to the other. Self-reflection may help the individual rephrase or repackage one’s message in a manner that the other person may better understand. Self-reflection and awareness also may allow one to engage story lines within oneself more in sync with another and bring these to bear in the conversation. For example, if a discussion about medical aspects of a disease does not seem to be “working,” one might switch to a more “relational” approach, working more explicitly to build trust and respect, before coming to some decision. Consideration of the other person’s story requires suspension of purpose—trying to get one’s way in the conversation—and requires an honest search for the “sense” within the other’s narrative, even if on the surface it appears to be nonsense. One does not have to agree with this “sense,” but far too often, we cut ourselves off from even trying to understand that there is an internal logic to others with whom we disagree.

We believe that such an approach can foster narrative empathy, which may in turn enable participants to move toward better and mutually constructed stories, which in turn will result in better decision making and improved health care outcomes.

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