

Tamara K. Liller

In Search Of Empathy

As a society, we are very fond of *empathy*. It is a trait that we value in ourselves, and we don't mind taking credit for having it. Even as a country, we are proud to send aid to victims of famines, earthquakes, or other natural disasters. Empathy is also a quality we are grateful for in family members, friends, teachers, employers, and doctors. Not quite wanting others to actually feel sorry for us, we are nevertheless relieved and comforted when they show compassion for us during difficult times.

What most of us don't realize is that empathy is not entirely a voluntary or learned quality. Scientists have recently discovered that a significant part of it is *involuntary*. The first step to becoming empathic is having the capacity to automatically tune into and share another's emotions. Medical science has discovered that this capacity is already hard-wired into our brains.¹ Common examples are a baby who begins crying when he hears another baby cry or a person of any age who subconsciously imitates the facial expressions of other people that she encounters.²

Still, there is an aspect of empathy that is learned. It is not enough to share another's emotions. One must also learn to put oneself in another's shoes,³ distinguish who "deserves" empathy and who doesn't, and find out the costs and benefits of being either sensitive or ambivalent to others.⁴ Such a learning process requires mental flexibility and imagination. Books and movies and other media are great avenues of social education in this regard. Of course, it is also crucial to know the difference between reality and imagination and the boundaries between one's own mind and others'.

University of Chicago neuroscientist Jean Decety, an expert in the field of empathy, points out that: "empathy requires emotional control—the capacity to distinguish Self from Other. People who lose themselves in other people's pain experience personal distress."⁵ When this happens, they are then likely to recoil from them (a natural aversion to painful stimuli) rather than assist them. The trick is to keep enough of an emotional distance from

"Every good physician has empathy. Irrespective of the disease, when you find someone who will feel for you, you feel better. That is the mystery of empathy." —Dr. Jean Decety, University of Chicago

those in pain to be able to lend support or give assistance.

Functional MRI (fMRI) technology has been extremely helpful in illustrating the regions of the brain which are activated when one experiences or imagines personal pain, or alternatively, when one witnesses and thus indirectly experiences the pain of another person. More and more studies are being conducted in this area. What they show is that while there is an overlap in the neural areas that process personal pain and the pain of others, the overlap is not complete.⁶

A study conducted by Philip L. Jackson et al., offers an interesting example.⁷ Study volunteers were shown pictures of people with their hands or feet in painful or non-painful situations (i.e., fingers pinched in a door, a heavy object dropped on a foot, etc.) and were instructed to rate the level of pain that *they* might feel if they were in a given situation. They were also told to rate what they imagined *another person's* pain level might be if (s)he experienced the same situation.⁸

What the researchers found was that both Self pain and Other pain activated the neural network in the brain which is involved in pain processing (i.e., the parietal operculum, anterior cingulate cortex or ACC, and the anterior insula). However, they also discovered that pain experienced by Self involved the pain matrix more completely (i.e., in the secondary somatosensory cortex, the ACC, and the insula proper).⁹ In other words, the brain could distinguish between personal pain and the pain of another and give the self priority—an important distinction when the individual's survival is at stake.

Decety and French scientist Julie Grèzes make the following observation: ". . . first-person experience and third-person experience of pain share common circuitry, but . . . indirect pain representations (as elicited by the observation of pain in others) are qualitatively different from the actual experiences of pain. It may be what allows us to distinguish emphatic responses to others versus our own personal distress."¹⁰

Why is a discussion of empathy relevant to those of us who suffer from chronic illness, and more specifically, from fibromyalgia? As persons who can be physically and emotionally incapacitated by pain and other symptoms, receiving solace from others simply makes us feel better, and it can also bring us the critical help we need with daily tasks we can no longer accomplish on our own. Because of physical limitations imposed by illness, we may have to seek accommodations at home, at school, or at work so that we may continue to function and fulfill our responsibilities, albeit at a different level or in a different fashion. Without the empathic support of others, we would be likely to find ourselves very much alone.

Those who figure prominently in our lives have a different challenge. Typically, their goal is to help and support us without completely identifying with our pain (i.e., emphatic over-arousal¹¹) and thereby exhausting or destroying themselves in the process. For their own emotional survival, they must learn to do so. If our symptoms are severe, and they are very close to us, this may be extremely difficult for them to do. Alternatively, they may need to learn the lesson (as we have) that a certain level of pain or stiffness is sometimes inevitable in fibromyalgia—or in some cases even beneficial, such as that incurred after a session of physical therapy or other bodywork therapies.

For many fibromyalgia patients, the biggest challenges to be faced are from those who do not yet “believe in” fibromyalgia. These may include

aloof medical professionals, “well-meaning” friends and neighbors, or simply uninformed members of the public-at-large. If fibromyalgia can be written off as an unproven or fictional illness, a lack of empathy can be rationalized and is thus guilt- and obligation-free.

When there are physicians who DO want to help, a patient with fibromyalgia can be a challenge since the illness itself is not only complex and long-lived but also frequently resistant to effective treatment. A doctor may walk a tightrope between the “clinical detachment” he was taught in medical school, the frustration he experiences when treating a particularly difficult case of fibromyalgia, and the empathy a patient seems to need in certain instances.

In a recent article, author Lydialyle Gibson highlights the views of Donald Scott and William Harper, two University of Chicago professors who teach classes on clinical skills to medical students at the University of Chicago’s Pritzker School of Medicine:

“Empathy is more than a nice idea, insist Harper and Scott; it’s a pragmatic skill that stands at the center of the patient-doctor connection, on which so much else depends. ‘If the connection is strong, the patient is more likely to follow a doctor’s recommendations,’ Harper says. ‘You can order the fanciest test in the world, but if the patient does not buy into it, it doesn’t matter.’ Empathy builds trust

Image provided by Dreamstime.com



and encourages openness. It makes sick people feel better. “We’re not teaching [students] to have empathy,” Scott says. “Students become naturally attached to their patients. We’re teaching them to recognize empathic moments when they arise and express the empathy they already have inside. What to say when a patient opens up, how to react, when to lean in closer.” . . . [Harper adds:] “You have to gauge the level of relationship that the patient wants. Some patients just want the facts. But you have to be careful to understand that just because the patient is not outwardly emotional doesn’t mean there are no emotions inside.”¹²

For those of us who are fibromyalgia patients, there is one final and very important concern. If concerns for our own well-being and our own pain monopolize the neural networks of our brain too extensively, we run the risk of shutting off our sensitivity to the concerns of other people close to us, or we may become cynical or ambivalent about the hardships of the healthy people in our lives. Self-absorption may be a survival mechanism when chronic illness occurs, but it can isolate us from the world at large. Unfortunately, to some extent, we are limited by how well we are “hard-wired.”

Jean Decety points out that there are “large individual differences” in people’s capacity for empathy. He cautions that while social science has

perhaps excused the relative lack of empathic capacity in some because of differences in education, past trauma, or childhood experiences, there is more to it than that. The other force to be reckoned with is biology. One of his next studies will be of bullies who not only don’t care about inflicting pain on others--they actually like it.¹³

The bottom line is that we still have a lot more things to learn about empathy.

References

1. Gibson L. “Mirrored Emotion.” *University of Chicago Magazine*. April 2006, p. 35.
2. Ibid, p. 35.
3. Ibid, p. 36.
4. Ibid, p. 39.
5. Ibid, p. 36.
6. Jackson L, Brunet E, Meltzoff AN, Decety, J. “Empathy Examined Through The Neural Mechanisms Involved In Imagining How I Feel Versus How You Feel Pain. *Neuropsychologia*. 2006;(44);752-761.
7. Decety J, Grèzes J. “The Power Of Simulation: Imagining One’s Own And Other’s Behavior.” *Brain Research*. 2006; 1079(1):9.
8. Ibid.
9. Ibid.
10. Ibid, Decety J, Grèzes, J., p. 9.
11. Eisenberg N. “Emotion, Regulation, And Moral Development.” *Annual Review of Psychology*. 2000; 51:665-697.
12. Gibson, p. 36.
13. Ibid, p. 38.