

ARTICLE

Empathy and the work of clinical psychiatrists: narrative review

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SUMMARY

Clinical research suggests that empathy is associated with better clinical outcomes in various areas of medical care, raising the question of whether a similar effect occurs in psychiatry. The aim of this review is to explore philosophical, neuroscientific and psychological perspectives on the concept of empathy in the context of the day-to-day work of clinical psychiatrists. The definition of empathy is outlined and sociodemographic factors, working conditions and psychiatrists' beliefs that can potentially affect empathy in clinical encounters are explored; educational and training aspects are also reviewed. The review concludes suggesting that research on empathy is needed to understand contextual, training and relational factors that could benefit mental healthcare as well as the working conditions of clinical psychiatrists, both inextricably linked.

LEARNING OBJECTIVES

After reading this article you will be able to:

- delineate the differences between empathy, sympathy and compassion
- identify factors that can have an influence on clinicians' empathy
- outline the potential biases associated with empathy.

KEYWORDS

Education and training; ethics; phenomenology; philosophy; clinical governance.

close as possible to the day-to-day work of clinical psychiatrists, outlining philosophical, neuroscientific, psychological and clinical perspectives. The review starts by outlining two ways of defining empathy, in the narrow and in the broad sense, and relating them to concepts of sympathy and compassion.

Empathy, sympathy and compassion

Empathy in the narrow sense

Empathy has been defined as a 'complex imaginative process in which an observer (the 'empathiser') simulates another person's (the 'target') situated psychological states while maintaining a clear self–other differentiation' (Coplan 2011: p. 5). This definition entails three components: first, affective matching, where the empathiser feels a qualitatively similar emotion to the target's emotion, for example matching anger with anger, as opposed to feeling, for example, fear in response to the target's anger; second, by taking the target's perspective, the empathiser imagines being the target and having the target's experience, as opposed to imagining being themselves having the target's experience; third, maintaining always a clear self–other differentiation during the process, i.e. the empathiser maintains a clear awareness of the fact that the emotions and perspective adopted are those of the target and not of themselves (Coplan 2011: pp. 6–15). This definition sets empathy as an effortful skill that requires high-order cognitive resources such as controlled processing, active imagination and the ability to keep psychological boundaries from emotionally charged subjective experiences. Thus, this definition distinguishes it from concepts such as sympathy, compassion, kindness and concern for the other.

Sympathy

The notion of sympathy has changed in its meaning over time. In the 18th century, the Scottish philosopher David Hume defined it as the inclination to sense the feelings of others, whereas his compatriot Adam Smith described it as the tendency to feel compassion for others, to care about their feelings; more recently it has come to be understood as a feeling of sorrow or concern for someone based on that person's negative emotional state or condition from

Empathy has been the subject of intense neurobiological research, and busy clinicians are told about the brain areas mediating empathy and reminded of its importance. Although that knowledge is significant, the ethical and epistemological challenges involved in the deployment of empathy in the clinical work of psychiatrists are no less important. Things get complicated when the conditions in which mental healthcare work occurs are considered, an issue that we will address below. It is likely that the extraordinary circumstances in which mental healthcare has been provided during the COVID-19 pandemic have intensified those issues (Gillard 2021). The aim of this narrative review is to unpack the concept of empathy, in a manner as

the perspective of somebody who cares for the other person's well-being (Gerdes 2011). Stueber (2019) stresses that the relation between empathy and sympathy is a contingent one, as sympathy does not necessarily require feeling any kind of congruent emotions on the part of the observer, so a detached recognition that the other is in need or suffers might be sufficient. Conversely, empathy can lead to empathic distress, compassion fatigue or mere personal distress, which can prevent a sympathetic response (Stueber 2019).

Compassion

Distinguishing compassion from empathy is important for, although conceptually different, in medical parlance they are often used synonymously. As Bloom indicates, compassion is caring for others, wanting them to thrive, a discrete emotional experience characterised by a state of concern for the suffering or the unmet needs of another (Bloom 2016: p. 138). Bloom distinguishes compassion from empathy, emphasising that compassion is always necessary for any supportive human encounter and that it is unlikely to have negative effects on the target of the emotional experience who, in clinical contexts, would be the patient, whereas empathy is not essential for supporting human encounters and it can certainly have negative effects. Compassion is also distinct from empathy in terms of its scope, since, in empathy, people perceive and mirror a variety of emotions (e.g. delight, pride, or anger), whereas in compassion there is an emotional response to suffering that involves wanting to do something to reduce another's suffering. In mental healthcare, it is unlikely that compassion could have negative consequences, whereas empathy can certainly have negative consequences for the patient, as will be discussed below.

Empathy in the broad sense

A broader definition of empathy seeks to have face validity for clinicians, patients and the wider public. Clinical empathy has been defined as 'attempting, as far as possible, to understand another person's situation, feelings and perspective, recognizing the difficulties in putting oneself in another's shoes; communicating that understanding, checking its accuracy; and acting on that understanding in a helpful way' (Mercer 2004). The communicative component is necessary to ascertain whether the empathiser's understanding is correct and to respond appropriately to that new knowledge. Thus, this definition includes communication skills, communication of compassion, optimism and promotion of autonomy, as reflected in the influential Consultation and Relational Empathy (CARE) instrument (Mercer 2004) (Box 1).

BOX 1 Clinical empathy: a broader definition

A broader definition of the concept of clinical empathy that fits the context of clinical work and is closer to how the public and patients understand empathy involves the clinician:

- trying to understand the patient's situation, feelings and perspective, and recognising the difficulty of imagining oneself in their position
- checking the accuracy of that understanding with the patient
- using that understanding to help the patient.

It includes aspects of good communication skills, communication of compassion, optimism and promotion of autonomy.

(Mercer 2004)

The neuroscience of empathy

Research into the neuroscience of empathy usually distinguishes between, on the one hand, affective empathy or experience sharing ('I feel your pain or joy') where the observer shares the emotional state of the target and, on the other hand, cognitive empathy ('I know you are experiencing pain or joy'). Functional neuroimaging research suggests that affective empathy for vicarious pain is associated with the activation of the anterior/mid cingulate cortex and the anterior insula, whereas cognitive empathy is associated with activations in areas associated with mentalising and theory of mind, including the dorsomedial prefrontal cortex, ventromedial prefrontal cortex, the superior temporal sulcus, the temporal pole and the temporoparietal junction (which plays an important role in distinguishing between self and other) (Stevens 2021). Whether the observed networks reflect genetically determined modules or whether they emerge from associative learning since birth remains moot. For example, Heyes (2018) concluded her review of research in animals, infants, adult humans and robots by suggesting that the 'matching mechanism' at the root of empathy is assembled by associative learning and it is not a genetically determined mental module. A corollary of that view is that empathy and its potential biases (i. e. having more empathy towards those like the empathiser) can be modified by learning new associations via exposure to novel stimuli and relationships. It is this plasticity that is likely to enable the effects of interventions to modulate empathy in the field of healthcare described later.

When Rizzolatti and collaborators (di Pellegrino 1992) found, by using single-cell recordings in area F5 of the premotor region in macaques, that some neurons fired both in association with specific

actions performed by the agent as well as with similar actions performed by others, they opened the new field of the mirror neuron system as the biological vehicle of empathy. However, the requirement of single neuron recording has meant that there is very little mirror neuron research in humans. Instead, researchers have utilised indirect methods to measure neuronal activity, such as functional magnetic resonance imaging, electroencephalography and transcranial magnetic stimulation, all of which share the limitation that the neural activation found may reflect the activation not only of mirror neurons but also of other neuronal populations responding to the presented stimulus (Bekkali 2020). Bekkali et al's meta-analysis suggested that conceptual problems regarding the definition of empathy, as well as methodological problems related to the technology utilised, must be addressed (Bekkali 2020). We next discuss how the real-world context can affect how empathy is deployed in medicine and in psychiatry.

Contextual influences on empathy in the clinical encounter

Socioeconomic factors

Empathy is likely to be influenced by the conditions in which the patient–clinician interaction occurs and it is possible that the more unequal the socioeconomic background of clinician and patient, the more difficult it will be for empathy in the broad sense to emerge because, as indicated above, it involves communicating the clinician's understanding of the patient's situation and feelings as well as acting on that understanding in a helpful way. In this regard, a systematic review (Willems 2005) found that patients from lower social background received significantly fewer positive socioemotional utterances, a more directive and less participatory consulting style, more biomedical talk and more physical examinations. Similarly, the communication between patients from a lower social class and doctors is often characterised by less questioning, less opinion-giving, less affective expressiveness and a less involving behaviour from the doctor (Willems 2005). In a qualitative study of 80 American patients, most participants perceived that the treatment provided by their physicians and the relationship they had with their health provider was affected by their socioeconomic status, although they often avoided saying so directly (Arpey 2017).

Organisational factors

The organisational context of clinical encounters is also likely to influence empathy. In low- and middle-income countries, a significant proportion of the population either do not have access to mental healthcare or, if they do, they access a

precarious service where resources and respect for patients' human rights may suffer (Fearon 2014). If access to private mental healthcare is dependent on payment, potential distortions in the deployment of empathy may occur. Moudatsou et al (2020) report that empathy is negatively influenced by, among other factors, a high number of patients that professionals must manage and the lack of adequate time to see them. Empathetic clinicians can have a positive effect on medical care in a range of areas. A meta-analysis found that empathetic consultations reduced patients' pain and anxiety and improved satisfaction by a small amount and were not associated with any harm (Howick 2018). Sadly, patients suffer when organisational problems coincide with poor standards of care, as documented in the public inquiry into the Mid Staffordshire NHS Foundation Trust: 'a culture of habituation and passivity in the face of issues which may indicate real suffering [...] would be unlikely to be persisted in if those adopting it were constantly to place an empathy for the predicament of patients at the forefront of their mind' (Francis 2013: para. 78).

Karl Jaspers, empathy and psychopathology

The German philosopher and psychiatrist Karl Jaspers refers to empathy as a central aspect of the method of psychopathology. When trying to understand a patient's subjective psychopathological phenomena, he writes, 'we sink ourselves into the psychic situation and understand genetically by empathy how one psychic event emerges from another'; this he contrasts with causal explanation in which 'we find by repeated experience that a number of phenomena are regularly linked together' (Jaspers 1963: p 301). Furthermore, he points out that although rational understanding 'always leads to a statement that the psychic content was simply a rational connection, understandable without the help of any psychology', empathic understanding 'always leads directly into the psychic connection itself' (Jaspers 1963: p 304). Hoerl (2013) points out that Jaspers subscribes to a form of epistemic particularism regarding understanding, in that it is achieved by showing how one psychic event emerges from another in a particular case in a manner that appears 'as something self-evident which cannot be broken down any further'. Importantly, Jaspers warns that the immediacy of the psychological connection, its being self-evident, is not a 'proof' that it is the case and it must be contrasted with other sources of information, such as the personal history and third-party information (Hoerl 2013). In this section we consider the conditions that affect clinical psychiatrists' ability to engage in empathic work with their patients.

Clinical empathy in psychiatry

A qualitative study identified that, for psychiatrists, empathy is an important component of the therapeutic alliance (Ross 2017). Another qualitative study, on patients' views on what constitutes good psychiatric care, found that the quality of the therapeutic encounter with staff, as well as the feeling of being understood by staff, were the most important aspects of care; the perception of staff allocating time to the patient was also important (Johansson 2003). An important question is whether patients and psychiatrists agree on which psychiatrists are perceived as empathetic by their respective patients. An important although rather small study addressed this question. Ten out-patient psychiatrists and five of their patients completed a questionnaire rating the psychiatrists' empathetic skills. Crucially, no significant correlation was found between psychiatrists' self-perception of empathy and patients' perception of their psychiatrist's empathy. Furthermore, psychiatrists' self-assessed empathy was significantly higher than the patients' ratings of their psychiatrists' empathy, a difference that reached significance between male psychiatrists and female patients, i.e. female patients rated their male psychiatrists as less empathetic than their male psychiatrists rated themselves (Aggarwal 2007). It is worth noticing that there are no data pertaining to the impact of empathy, in psychiatry, on outcomes such as hospital admissions, relapse, medication adherence and engagement with community services. The factors specifically influencing empathy in psychiatry are rather limited and will be summarised next.

Socioeconomic factors, ethnicity, religion and empathy

Regarding socioeconomic status, very low-income patients reported experiencing poor communication and poor provider satisfaction in a retrospective study of 68 447 patient-reported experiences, which included measures of provider responsiveness, patient-provider communication, shared decision-making and patient satisfaction (Okunrintemi 2019). Regarding ethnicity, a systematic review and meta-analysis is underway exploring whether racial and socioeconomic status influence patient-reported experience of clinicians' empathy (Roberts 2020). Regarding religion, in a study of 100 out-patients with non-affective psychosis, 16 participants had psychotic symptoms reflecting aspects of their religious beliefs and the majority of participants reported that religion was an important aspect of their lives. However, only one-third had raised it with their clinicians and, in half of the cases, the clinicians' perceptions of patients' religious involvement were inaccurate (Huguelet 2006).

Working environment

Some factors related to the work environment have been linked to lower empathy. A survey of 63 physicians (Ahrweiler 2014) found that they reported that stress at work and being overworked had a negative impact on their empathy, with specific comments on time pressure, clinical workload and time away from direct patient care (e.g. because of paperwork and administration). Specific settings can be particularly difficult. For example, mental health professionals working in in-patient environments in Latin America (Santamaría-García 2017) reported lower levels of empathy. A survey of English mental health teams found high emotional exhaustion among acute ward and community mental health team staff and social workers and greater emotional strain related, among other factors, to a highly demanding job, low autonomy, and limited support from managers and colleagues (Johnson 2012). Thus, it is possible to hypothesise that different management styles would affect psychiatrists' empathy; undoubtedly, research is needed in this area.

Medical education

Some of the problems seen among psychiatrist may have started developing at medical school. A systematic review (Neumann 2011) found that self-perceived empathy declines significantly during medical school and medical residency, particularly following the clinical phase of training, which could be the result of two factors: the 'hidden curriculum' (e.g. harassment, belittlement, discrimination, human suffering and death, shifts of focus on to technology and objectivity, high workload) and the 'informal curriculum' (e.g. fragmented patient-physician relationships with no time for learning from and with the patient, few bedside interactions and inadequate role models) (Neumann 2011). Another systematic review of interventions to enhance empathy in medical students (Batt-Rawden 2013), which included patient narrative and creative arts, writing, drama, communication skills training, interprofessional skills training, experiential learning and empathy-focused training, found that 15 out of 18 studies reported significant increases in empathy.

Psychiatric training

The UK's curriculum for specialist core training in psychiatry (Royal College of Psychiatrists 2020) mentions empathy when taking a clinical history: during a consultation, trainees must 'demonstrate interviewing skills, including [...] the establishment of rapport, the appropriate use of open ended and closed questions, [...] the appropriate use of

facilitation, empathy, clarification, confrontation, reassurance, silence and summary statements' (p. 53) as well as 'demonstrate respect, empathy, responsiveness, and concern for patients, their problems and personal characteristics' (p. 55). The RCPsych's 'Silver Guide' to psychiatric training in the UK (Royal College of Psychiatrists 2022) states that 'At core training, trainees are expected to undertake a short and long-case in psychotherapy under the governance of a Medical psychotherapy tutor. Trainees will participate in Balint or case-based discussion groups to reflect on their psychotherapeutic training and are encouraged to continue to participate in these groups in higher psychiatric training' (p. 8). Regular participation in a series of Balint groups can help trainees to develop their empathy skills.

There is little research on whether empathy and compassion should be explicitly assessed at the point of applying for psychiatric training and how training encourages empathy skills. A qualitative in-depth interview with 21 psychiatry trainees in London (Appleton 2012) found that one factor influencing their choice of psychiatry had been positive role models, including being approachable and people centred, and that trainees had been particularly influenced by consultants who took personal interest in them and their development. Furthermore, many respondents valued the opportunity to have more time with patients and the psychosocial aspects of care, as well as having to develop the skill to establish a rapport with psychiatric patients (Appleton 2012). A survey of 359 psychiatry trainees (Barras 2012) found that those considering leaving UK psychiatry training mentioned as reasons spending too much time on paperwork, feeling that clinical priorities took second place to managerial objectives and not having enough time to see their patients.

A research study into understanding career choices in psychiatry, describing the experiences of 159 trainees on the RCPsych's training programme in 2019, indicated that they enjoyed patient interaction: 89.3% said that they met 'fascinating patients with complex and interesting conditions', 82.4% liked having more time to be with and get to know patients than in other specialties, and 74.4% found their clinical work intellectually comprehensive, with a holistic, biopsychosocial, 'whole patient' approach (Medisaukaite 2020: p. 3). On the other hand, reported challenges included under-resourcing (66%), systemic changes and constraints (e.g. reforms, target culture, long waiting lists) (66%), feeling that psychiatrists were held accountable for adverse patient outcomes more than in other specialties (46.5%), verbal or physical abuse from patients (28.3%), high stress and workload and burnout (37.7%) (Medisaukaite 2020:

BOX 2 Factors that potentially affect clinicians' empathy

- Sociodemographic factors
- Medical education
- Psychiatric training
- Work environment: stress, workload, administration workload, micromanagement
- Burnout
- Clinicians' beliefs about the causes of mental disorders
- Empathy-focused interventions

p. 3). Given that a recent systematic review found a negative association between burnout and empathy (Wilkinson 2017), it is reasonable to assume that a significant proportion of psychiatry trainees find it difficult being empathetic clinicians (Box 2).

Clinician's beliefs about the causes of mental disorders

Clinician's beliefs in this area may be related to their level of empathy towards patients. The reactions of psychiatrists, social workers and psychologists to clinical vignettes emphasising either biological or psychosocial explanations indicated that vignettes portraying a stronger biological explanation yielded lower empathy in all professionals, a phenomenon even more significant among psychiatrists (Matthew 2014). A meta-analysis found that people who tend to explain psychiatric conditions as brain diseases or chemical imbalances may be especially likely to see patients as more dangerous and less likely to recover and more likely to distance themselves from patients than those who do not endorse those explanations (Loughman 2018). Given the correlational nature of these studies, it is difficult to establish a causal relationship. However, a causal role of knowledge and training on empathy is supported by the finding that information about treatability, service provision, training and policy went a long way to change attitudes, including empathy, towards people with borderline personality disorder (Day 2018).

Improving clinicians' empathy

A psychiatrist's empathy could potentially be modified through a range of techniques recommended to enhance therapists' empathetic capacity (Box 3) (Watson 2009). Communication skills training can also help clinicians learn how to express empathy (Michaelson 2022). Another way of improving empathy could be ensuring that clinicians' knowledge

BOX 3 Enhancing clinicians' empathetic capacity

Techniques for improving clinicians' empathetic capacity – their empathetic resonance with their patients – include:

- actively imagining the patient's experiences and life events
- paying close attention to their own bodies to distinguish their feelings or sensations, to imagine what it must be like to be in different situations
- listening carefully to the details and context of the patient's experiences to get more detailed and vivid accounts
- learning to identify the patient's emotions from their narratives and non-verbal behaviour

(Watson 2009)

and skill in descriptive psychopathology is robust (Chakraborty 2020), as this 'opens up a world in which we attempt to understand a range of abnormal human experiences, irrespective of whether they are part of symptomatology of an illness or disorder'; the same author suggests promoting phenomenological psychopathology in training, including standards for the RCPsych's membership (MRCPsych) courses, trainees' portfolios and reading lists for curricula/syllabuses (Chakraborty 2020). Some recent research has utilised virtual reality (VR) experiences of psychotic symptoms (Zare-Bidaki 2022), finding that, compared with observing a clinical interaction, one session of VR increased medical students' empathy towards patients with psychotic experiences, increased knowledge about psychotic symptoms and reduced stigma.

Burnout

Burnout is characterised by overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment (Maslach 2016). A systematic review and meta-analysis found that the average mental health professional has high levels of emotional exhaustion and moderate levels of depersonalisation (or 'dehumanisation', where the professional blocks the empathy they can show to their colleagues) but retains reasonable levels of personal accomplishment (O'Connor 2018). A study of 241 mental health professionals, including psychiatrists and mental health nurses, found that empathy scores were positively correlated with personal accomplishment but negatively correlated with depersonalisation; of concern, they found the highest depersonalisation and lowest compassionate care among staff on mental health secure units (Sturzu 2019).

The negative side of empathy

Empathy also has potentially detrimental effects in clinical work, as it is biased towards 'the near and dear'. Several factors influence this, including a predisposition to in-group biases, i.e. people have more empathy for those that seem like them in terms of, for example, ethnicity and sexual orientation (Prinz 2011). Empathy is also vulnerable to proximity effects, i.e. it increases for those who are nearby geographically and culturally, potentially leading to partiality for kin or in-group members (Prinz 2011). The extent to which empathy's biases affect clinical practice is unknown, but it could potentially be implicit in situations where discrimination occurs. For example, mental health workers with less than 10 years of clinical experience endorsed more severe punishments of individuals portrayed inflicting intentional pain in the Empathy for Pain Task (EPT), a test that taps into cognitive, affective and moral aspects of empathy (Santamaría-García 2017). It is worth considering whether empathy might influence judgements about patients who are perceived by clinical teams as intentionally harming others, leading to decisions about seclusion or discharging them from in-patient wards or from community teams. Exploration of these issues is a matter for further research.

Suggestions for research

Regardless of whether empathy is utilised in the narrow or the broader sense, there are some issues pertaining to its research in psychiatrists' clinical work. Methodologically, this research would benefit from combining clinicians' self-reports, patients' ratings of their clinicians' empathy using the CARE measure and experimental tasks that avoid controlled conscious processing. These three sources of information would improve the validity of the assessments. This review has also highlighted the need to conduct research on the effect of the work environment on psychiatrists' empathy, including management styles, burnout, administrative workload and lack of time to see patients, among other things. Similarly, the effect of training on the use of specific psychotherapeutic techniques could protect clinicians' ability to empathise as well as reduce the risk of burnout. It would be important to establish whether empathy is related to effectiveness, patient experience, patient outcomes and treatment adherence.

Conclusions

From a practical point of view, the promotion of an organisational culture that fosters the competent clinical use of empathy will require collaboration between

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managers, information technology (IT) and estate staff, clinical psychiatrists, as well as patients and their relatives. If all these issues were already challenging before 2020, the COVID-19 pandemic (Gillard 2021) has intensified their urgency. Such collaboration will require, fittingly, a degree of empathy among the different stakeholders.

Author contributions

Both authors contributed to the conception of the work, drafting the work and final approval of the manuscript, and agree to be accountable for all aspects of the work.

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MCQs

Select the single best option for each question stem

1 Which of the following alternatives best describes the components of empathy in the narrow sense?

- a affective matching between the empathiser and the target; the empathiser takes the target's perspective; the empathiser always maintains a clear self–other differentiation
- b affective matching between the empathiser and the target; the empathiser takes their own perspective; the empathiser always maintains a clear self–other differentiation
- c affective matching between the empathiser and the target; the empathiser takes the target's perspective; the empathiser avoids maintaining a self–other differentiation
- d the empathiser feels sympathy for the target; the empathiser remains aware of their own emotions; the empathiser always maintains a clear self–other differentiation
- e none of the above.

2 Which of the following alternatives best describes empathy in the broad sense?

- a attempting to understand another person's situation, feelings and perspective
- b feeling concern for another's pain and trying to help them
- c active listening and good communication skills
- d attempting to understand another person's situation, feelings and perspective, recognising the difficulties in putting oneself in another's shoes, communicating that understanding, checking its accuracy and acting on that understanding in a helpful way
- e a and b and c.

3 For Karl Jaspers, empathetic understanding was crucial because:

- a psychiatrists sink themselves into the psychic situation (of a particular patient) and understand genetically by empathy how one psychic event emerges from another
- b it allows an understanding of the unconscious
- c it establishes scientific causal explanations
- d it is based on an analysis of the strictly rational options available to the person
- e it entails listening to the patient with sympathy.

4 Regarding psychiatrists' self-reported empathy:

- a it appears to be a valid and reliable indicator of how psychiatrists are perceived by their patients
- b there is no need to use an instrument completed by patients, such as CARE
- c patients' perceptions of their psychiatrists' empathy are unlikely to be influenced by differences of socioeconomic status and ethnicity
- d all of the above
- e none of the above.

5 Regarding the effect of clinicians' beliefs on empathy:

- a clinical vignettes emphasising biological explanations of disorders have been associated with lower empathy in all healthcare professionals and even more so among psychiatrists
- b a recent meta-analysis found that people who tend to explain psychiatric conditions as brain diseases or chemical imbalance may be especially likely to see sufferers of those disorders as more dangerous and less likely to recover than people who do not endorse those explanations
- c beliefs fostered by evidence for the treatability, service provision, training and policy for people with borderline personality disorder can help change empathy towards this group of patients
- d all of the above.
- e none of the above.