Psychiatria Danubina, 2012; Vol. 24, No. 3, pp 287–291 *Original paper*

PSYCHIATRISTS' EMPATHY, BELIEFS AND ATTITUDES TOWARDS VETERANS SUFFERING FROM COMBAT-RELATED POSTTRAUMATIC STRESS DISORDER

Marijana Braš[1], Lovorka Brajković[1], Vibor Milunović[1], Ivana Bičanić[2], Franko Haller[2], Veljko Đorđević[1] & Davor Miličić[2]

[1]Centre for Palliative Medicine, Medical Ethics and Communication Skills, School of Medicine, University of Zagreb, Clinical Hospital Center Zagreb, Croatia
[2]University of Zagreb, School of Medicine, Clinical Hospital Center Zagreb, Croatia

received: 27.1.2012; revised: 7.4.2012; accepted: 2.6.2012

SUMMARY

Background: *Empathy is a powerful and necessary skill for understanding another person's subjective experience. In this study we wanted to explore psychiatrists' attitudes towards PTSD, general empathy, possible differences related to age, sex and regional location in Croatia.*

Subjects and methods: *205 psychiatrists from different Croatian regions participated in this study. To define psychiatrists' attitudes towards PTSD patients a questionnaire was devised. It contained 14 items related to psychiatrists' ability to live through emotional and social conditions of PTSD patients. BarOn Emotional Quotient-Inventory Empathy Subscale was used to measure the empathy among the subjects.*

Results: *This study has found statistically significant differences regarding gender in measured variables of the designed questionnaire. Male participants believed they were able to understand war veterans' feeling's and relate to traumatic experience while female participants stated that they had the ability to understand the trivial triggers for suicidal intentions. Regional differences were found in the understanding of war traumatic experience and social deviations occurring in PTSD. Older psychiatrists stated their incomprehension of the social difficulties the PTSD patients were facing. The years of experience in the psychiatric field were associated with inability to understand the patients' feelings'. Differences in empathy among the subjects were not found.*

Conclusion: *The understanding of the empathic process in the therapeutic approach towards PTSD explored in this study was associated with basic variables such as gender and age but the construct of empathy itself is more complex and related with variables not assessed in this study, so our findings are preliminary and further research is needed.*

Key words: *PTSD - war veterans – physician – empathy - attitude*

* * * * *

INTRODUCTION

Empathy has been described as the process of understanding a person's subjective experience by vicariously sharing that experience while maintaining an observant stance (Zinn 1993). Empathy is a balanced curiosity leading to a deeper understanding of another human being; in other words, empathy is the capacity to understand another person's experience from within that person's frame of reference (Bellet & Maloney 1991). This concept as such cannot be viewed as a soley inner process, but is shaped also by attitudes and beliefs formed by cognitive processes, and, therefore, they must be taken into account while exploring empathy in every day clinical practice (Soto & Levenson 2008). Furthermore, the meaning of empathy is often obscured by various theoretical frameworks while the true clinical utilisation of empathy as a potent aspect of the patient-physician relationship remains unknown (Garden 2009). Although in popular discourse empathy has taken on the somewhat sentimental notion of sympathy, from a scientific perspective it is a crucial ingredient in personal development and is essential for the full range of social interactions. Listening empathically to trauma stories is extremely stressful. To remain sensitive and finely attuned to the internal experience of the individuals' psychological injuries requires more than understanding that an event was traumatic – it requires skill and a capacity to use empathy to access the inner scars of the psyche and the organism itself (Wilson 2003).

Research in recent years has been focused on possible brain processes which are concomitant with empathy (Preston & de Waal 2002). Modern neuro-imaging techniques have recently been employed to investigate the functional anatomy of empathy (Decety & Jackson 2004, Decety & Lamm 2006). These studies have shown that observing another person's emotional state activates parts of the neuronal network involved in processing that same state in oneself, whether it is disgust (Wicker et al. 2003), touch (Keysers et al. 2004), or pain (Morrison et al. 2004, Jackson et al. 2006, Lamm et al. 2007, Singer et al. 2004). The study of empathic neuronal circuitries was inspired by the discovery of mirror neurons in monkeys that fire both when the creature watches another perform an action as

well as when they themselves perform it and presents a possible neural mechanism for mapping others' feelings onto one's own nervous system. However, these findings must be confirmed in human subjects.

In the authors' opinion, in modern psychiatric science the focus remains mainly on the biological nature of psychiatric disorder, shifting the paradigm from the phenomenology of the patients' emotions and the complex nature of psychotherapy towards materialistic reductionism. This study follows the biopsychosocial paradigm which puts in focus the therapeutic relationship, while not diminishing the extraordinary progression of biological psychiatry in last two decades.

The main aim of this study was to assess the psychiatrist' beliefs and understanding of combat related PTSD and the problems these patients go through on a daily basis. The authors hypothesized that differences would be found in empathy and understanding related to age, sex, work experience and regional locations. The first three variables were chosen based on previous studies associated with empathy (Cousin et al. 2009, DiLalla et al. 2004), while possible regional differences as a distinguishing variable were chosen based on different cultural and historical development of Croatian regions and war engagement.

MATERIALS AND METHODS

Subjects

Initially, 259 psychiatrists were contacted to participate in this study. 205 psychiatrists, working in various Croatian hospitals, responded and agreed to take part in this research. The inclusion criterion was continuous work with patients suffering from combat related PTSD with traumatic experience originating from the Croatian War of Independence (1991- 1995). The psychiatrists involved in this study, work in secondary and tertiary health care institutions. They were recruited from: General Hospital (GH) Vukovar, General Hospital Vinkovci, Clinical Hospital (CH) Osijek, General Hospital Nova Gradiška, General Hospital Slavonski Brod, Psychiatric Hospital (PH) Popovača, General Hospital Bjelovar, Clinical Hospital Centre (CHC) Zagreb – Clinic for Psychiatry and Clinic for Psychological Medicine, Clinical Hospital Dubrava (Zagreb), Psychiatric Hospital Vrapče (Zagreb), Psychiatric Hospital "St. Ivan" (Zagreb), General Hospital Karlovac, General Hospital Varaždin, Clinical Hospital Centre Rijeka, Psychiatric Hospital Rab, General Hospital Zadar, General Hospital Dubrovnik and Clinical Hospital Split. For the purpose of this study the subjects were grouped by the regional determination of their institutions. The questionnaires were posted by mail to all participants.

Questionnaire

Following a review of the possible questionnaires which could measure the beliefs and understanding of PTSD patients' need, no specific questionnaire was found. In order to overcome this lack of a proper inventory, the authors were forced to design a scale assessing the psychiatrists' attitude towards their patients i.e. war veterans suffering from combat related PTSD as seen in table 1. The scale consisted of 14 items. Each item was a dichotomous variable consisting of a statement with answer "0" meaning "I do not agree" and answer "1" meaning "I agree". These 14 items are showed in a table 1. Another part of the questionnaire consisted of a subscale measuring empathy taken from the Bar-On Emotional Quotient Inventory (Bar-On, 2004). This subscale originally belongs to the Interpersonal scale of EQI. The items consisted of short form sentences and a response scale ranging from "very seldom or not true of me" (1) to "very often true of me or true of me" (5).

Table 1. Questionnaire items assessing the psychiatrists' personal view of combat-related PTSD

	Questionaire items
1	I'm able to understand PTSD patients' feelings.
2	I care about what is happening to PTSD patients.
3	I'm sensitive to PTSD patients' feelings.
4	I think that PTSD patients overemphasize their difficulties.
5	I'm deeply hurt by PTSD patients' suffering.
6	PTSD patients get too much attention.
7	I'm able to understand traumatic events presented by PTSD patients.
8	I can understand seemingly trivial situations that are brought on by PTSD patients to commit or try to commit suicide.
9	I'm able to live through traumatic events presented by PTSD patients.
10	It happens that I don't give too much significance to the things PTSD patients are talking to me about.
11	I can understand difficulties that PTSD patients face while trying to achieve their legal rights.
12	I sympathize with PTSD patients.
13	I can understand criminal deeds PTSD patients have committed (after the war, as civilians).
14	I can understand problems that PTSD patients face in society.

Statistical analysis

After collecting the data, the descriptive statistics was obtained. To test, age, sex, regional and work experience differences among the subjects χ^2 test was performed for each item of the questionnaire. The possible differences obtained on the Empathy Subscale of EQI were tested with one way analysis of variance (ANOVA). For all tests a statistical significance of $p< 0.05$ was taken. The statistical analysis was performed on the Statistical Package for Social Science 16.00 (SPSS INC. 2007).

RESULTS

Subjects

After the collection of data, psychiatrists from the cities of Sisak, Karlovac and Varaždin were excluded. The reason for their exclusion was primarily the low number of the subjects from hospitals mentioned above. The subjects who had not completely filled in the questionnaire, were also excluded. Basic demographic data concerning the subjects concerning, region, age and sex is shown in table 2.

As can be seen from table 2., after these exclusions 190 psychiatrists participated in this study. They were, primarily, divided into 6 groups based on regional determination. All 6 groups were homogenous and did not vary significantly based on variables of sex, age and work experience. The authors found this regional division justifiable.

The descriptive data concerning the devised questionnaire assessing the psychiatrists' attitude towards the patients suffering from PTSD is shown in table 3.

Gender differences

This study found statistically significant differences regarding gender in measured variables of the designed questionnaire. Differences were found in item "I'm able to understand the PTSD patients' feelings", where male participants stated more often that they had the ability to understand PTSD patients' feelings (χ^2=6.655; p=0.011). Furthermore, differences were found in item "I can understand seemingly trivial situations that provoke PTSD patients to commit or try to commit suicide", where female participants agreed with this statement more often (χ^2=12.578; p=0.002). Male participant stated more often "I'm able to live through the traumatic events presented by PTSD patients" compared to female participants (χ^2=6.276; p=0.043).

Differences regarding gender were not found in other items.

Age

For the purpose of the study the participants were divided into four different age groups: "30-39 years old, "40-49 years old", "and 50-59 years old"and"60 and older". The difference related to age was found only in item 14 stating "I can understand problems that PTSD patients face in society", where older participants (60 years old or more) disagreed more often with this statement (χ^2= 28.554; p= 0.005).

Work experience

The study has found differences related to years of working as a psychiatrist in two items. In item 3 stating "I'm sensitive to PTSD patients' feelings" a difference was found, where psychiatrists who had been working for less than 10 years and those who had been working for more than 20 years disagreed with this item more often contrary to those who have work experience ranging between 10 and 20 years (χ^2=13.657; p=0.003).

Furthermore, a difference were also found in item 14 stating "I can understand problems that PTSD patients face in society", where psychiatrists who had been working for more than 20 years disagreed more often with this statement (χ^2=14.009; p=0.030).

Table 2. The demographic data about the psychiatrists who participated in this study

Institution	N	Male	Female	Age	SD	Work experience (years)	SD
GH Vukovar; GH Vinkovci; CH Osijek; GH Nova Gradiška; GH Slavonski Brod	33	11	22	44.64	9.07	12.53	7.24
PH Popovača; GH Bjelovar	20	10	10	45.50	9.20	15.10	10.71
CHC Zagreb – Clinic for Psychiatry and Clinic for Psychological Medicine; CH Dubrava	34	16	18	44.93	9.76	14.46	10.62
PH Vrapče; PH "Sv. Ivan"	35	16	19	47.70	10.12	17.35	9.45
CHC Rijeka; PH Rab	34	19	24	43.35	6.92	12.76	7.46
GH Zadar; CH Split; GH Dubrovnik	34	20	14	44.94	0.46	13.85	9.47
Total	190	83	107	45.47	8.992	14.40	9.22

Legend: GH- General Hospital, CHC-Clinical Hospital Centre, PH-Psychiatric Hospital

Table 3. "Agree"/ "Disagree" frequencies from psychiatrists' attitude questionnaire

Item	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.
Agree	167	161	153	155	164	162	165	160	160	36	165	157	124	174
Disagree	23	29	37	35	26	28	25	30	30	154	25	33	56	16

Table 4. Regional differences in psychiatrist' attitude toward PTSD

Institutions / Questionnaire items	GH Vukovar; GH Vinkovci; CH Osijek; GH Nova Gradiška; GH Slavonski Brod	GH Popovača; GH Bjelovar	CHC Zagreb; CH Dubrava	PH Vrapče, PH "Sv. Ivan"	CHC Rijeka; PH Rab	GH Zadar; CH Split; GH Dubrovnik	χ^2 value p value
7	33	9	28	33	31	31	35,608 (p=0.001)
13	28	17	13	17	19	30	25,568 (p=0.034)

Legend: GH- General Hospital, CHC-Clinical Hospital Centre, PH-Psychiatric Hospital

Regional differences

The significant difference are shown in regional determination are shown in table 4.

It is shown in Table 4. that the psychiatrists from the observed institutions statistically significantly differ from one another in item 7 stating "I'm able to understand traumatic events presented by PTSD patients", where psychiatrists from PH Popovača and GH Bjelovar stated more often that they could not understand these traumatic events. Differences were also found in item 13 "I can understand criminal deeds PTSD patients have committed". The psychiatrists from CHC Zagreb, CH Dubrava, PH Vrapče, PH "Sv. Ivan", DH Rijeka and PH Rab disagreed more often with this statement than others.

General empathy among psychiatrists

The Study has not found differences in empathy measured with the Empathy Subscale from the EQI questionnaire related to the psychiatrists' regional belonging (F=0.765; p=0.617), age (F=0.256; p=0.613), work experience (F=0.996; p=0.463) and gender (F=0.256; p=0.613).

DISCUSSION

One of the key points of this study is finding the subgroup among our sample of 190 psychiatrists with a somewhat negative attitude towards patients suffering from combat related PTSD. As seen in table 2, up to 20% of psychiatrists were not able to connect with their patients, deliver an emphatic response or understand their everyday problems. A more worrisome finding was that 155 out of 190 subjects agreed that PTSD patients overemphasize their problems. This inability to cope with the patients may be associated with a secondary victimization process occurring in the group of individuals suffering from combat related PTSD. Secondary victimization is defined as a social injury from an individual or social network to an individual suffering from PTSD through not acknowledging the primary stressor leading to the disorder, inadequate social support or stigmatization of the disorder *per se* (Vukusić et al. 2003). This lack of emphatic response may lead to inadequate social support achieved by the psychotherapeutic relationship and, therefore, may enhance this process , already represented in the public and individual view of PTSD veterans (Gregurek & Klein 2000), when "the heroes of the nation" become "the victims of the nation". This phenomenon among psychiatrists has already been registered. In a sample of Israeli mental health professionals, Offri et al. (1995) have demonstrated a more negative stand to a war veteran suffering from PTSD compared to a Holocaust survivor. This study has not found a steady pattern distinguishing this "minority" from the rest of the sample based on gender, age, work experience or regional belonging, although some differences were found as seen in the results. More thorough research is needed based on the cultural, personal and social distinction of mental health professionals is needed to establish this pattern as indicated by Solomon (1996).

The second reason of our finding may be related to a burn-out processes defined as a presence of emotional exhaustion, depersonalization and reduced personal accomplishment (Maslach & Jacksom 1986). Although to our knowledge there is currently no data about burn-out syndrome of mental care professionals in Croatia, it has been widely accepted that due to their idealism and intense patient relationship the psychiatrists are at a higher risk for burnout syndrome than other medical professionals (Bressi et al. 2009). Due to a great number of patients, crude work conditions, slow and, often, minimal therapeutic achievements and the underrated position of psychiatry in Croatian medicine; psychiatrists may be more prone to the burnout process.

However, the authors can state that most psychiatrists show an understanding for their PTSD patients and, therefore, stand as a bastion for the war veterans suffering from PTSD. The minority of the psychiatrists lacking these skills toward the patient must be assessed in further research and quality of care studies need to be carried out to identify the potential causes for this phenomenon, so that it can be reversed in order to give the best possible care to the patients.

Limitations

One of the major limitations of this study was the lack of a standardized questionnaire assessing the problem and the lack of z score on EQI Empathy Subscale for Croatian population possibly yielding false negative results concerning the differences in age, gender and regional variables. A second problem arising while interpreting these results is certainly subject bias where the psychiatrist may have tried to show themselves in a better light while completing the

questionnaires. A third limitation arises from not assessing the psychiatrists' own war experience such as participation in combat or refugee status, therefore possibly not accounting for such bias.

CONCLUSIONS

As expected, we have found the differences based on gender, age, work experience and region in the psychiatrists attitudes, beliefs and empathy towards war veterans suffering from combat related PTSD. We have possibly detected a group of psychiatrists with negative attitudes and low empathy to this group of patients, but due to the study limitations, it is not possible to provide an in-depth insight into this group. Further studies of empathy are necessary, as well as studies on the connection between empathy, countertransference, secondary stress disorder, compassion fatigue, burn-out, and other therapists' affective states, which are postulated for better understanding and implementing the therapeutic process, as well as for better training, education and supervision of therapists.

Acknowledgements: None.

Conflict of interest: None to declare.

REFERENCES

1. *Bar-On R: Bar On emotional quotient inventory. Multi-Health Systems Inc., Canada, 2004.*
2. *Bellet PS, Maloney MJ: The importance of empathy as an interviewing skill in medicine. JAMA 1991; 266:1831-2.*
3. *Bressi C, Porcellana M, Gambini O, Madia L, Muffatti R, Peirone A, Zanini S, Erlicher A, Scarone S, Altamura AC: Burnout among psychiatrists in Milan: a multicenter survey. Psychiatric services 2009; 60:985-8.*
4. *Cousin G, Schmid Mast M: Interactions between patients and physicians: why should we care about gender issues? Rev Med Suisse 2010; 6:1444-7.*
5. *Decety J, Jackson P: The functional architecture of human empathy. Neurosci Biobehav Rev 2004; 3:71-100.*
6. *Decety J, Lamm C: Human empathy through the lens of social neuroscience. Scientific World Journal 2006; 6: 1146–1163.*
7. *DiLalla LF, Hull SK, Dorsey JK: Effect of gender, age, and relevant course work on attitudes toward empathy, patient spirituality, and physician wellness. Teach Learn Med 2004; 1: 165-70.*
8. *Garden R: Expanding clinical empathy: an activist perspective. J Gen Intern Med 2009; 24:122-5.*
9. *Gregurek R, Klein E: Posttraumatic stress disorder - Croatian experience. Medicinska naklada, Zagreb, 2000.*
10. *Jackson PL, Brunet E, Meltzoff AN, Decety J: Empathy examined through the neural mechanisms involved in imagining how I feel versus how you feel pain: An event-related fMRI study. Neuropsychologia 2006; 44: 752-61.*
11. *Keysers C, Wicker B, Gazzola V, Anton JL, Fogassi L, Gallese V: A touching sight: SII/PV activation during the observation and experience of touch1. Neuron 2004; 42: 335-346.*
12. *Lamm C, Batson CD, Decety J: The neural basis of human empathy – Effects of perspective-taking and cognitive appraisal. J Cognitive Neurosci 2007; 19:42-58.*
13. *Maslach C, Jackson SE: Maslach Burnout Inventory Manual (2nd ed.). Consulting Psychologists Press, Palo Alto, 1986.*
14. *Morrison I, Lloyd D, di Pellegrino G, Roberts N: Vicarious responses to pain in anterior cingulate cortex: is empathy a multisensory issue? Soc Cogn Affect Neurosci 2004; 4: 270-278*
15. *Ofri I, Solomon Z, Dasberg H: Attitudes of therapists toward Holocaust survivors. J Trauma Stress 1995: 8:229-42.*
16. *Preston SD, de Waal FBM: Empathy: its ultimate and proximate bases. The Beh Brain Sci 2002; 25: 1–72.*
17. *Singer T, Seymour B, O'Doherty J, Kaube H, Dolan RJ, Frith CD: Empathy for pain involves the affective but not sensory components of pain. Science 2004; 303:1157-1162.*
18. *Singer T: The neuronal basis and ontogeny of empathy and mind reading: Review of literature and implications for future research. Neurosci Biobehav Rev 2006; 30: 855-863.*
19. *Solomon Z: Responses of mental health professionals to man-made trauma: the Israeli experience. Soc Sci Med 1996; 43: 769-74.*
20. *Soto JA, Levenson RW: Emotion recognition across cultures: the influence of ethnicity on empathic accuracy and physiological linkage. Emotion 2009; 9 :874-84.*
21. *SPSS 16.00: SPSS.Inc. 1989-2007.*
22. *Vukušić H, Wilson JP, Gregurek R, Komar Z, Pavić L, Gogić B: Secondary victimization of war veterans with post-traumatic stress disorder: the Croatian experience. Psychiatr Danub 2003; 15:13-23.*
23. *Wicker B, Keysers C, Royet J, Pierre, Gallese V, Rizzolatti G: Both of us disgusted in my insula: The common neural basis of seeing and feeling disgust. Neuron 2003; 40: 655–664.*
24. *Wilson J: Empathic strain and post-traumatic therapy. Guilford Publications, New York, 2003.*
25. *Wilson JP: Empathy in the treatment of trauma and PTSD. Brumer-Routledge Press, New York, 2004.*
26. *Zinn W: The empathic physician. Archives of internal medicine 1993; 153:306-312.*

Correspondence:
Vibor Milunović, MD
Centre for Palliative Medicine, Medical Ethics and Communication Skills,
School of Medicine, University of Zagreb, Šalata 4, 10000 Zagreb, Croatia
E-mail: v_milunov@yahoo.com