

The assessment of therapeutic attitudes in the psychiatric setting

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Although 'attitude change' is included as one of the aims of the 1982 training syllabus for psychiatric nurses, curriculum designers are given little guidance as to what constitute desirable attitudes in the psychiatric nurse, and how those attitudes are to be assessed and evaluated. This study has three aims: to attempt to outline what might count as desirable attitudes, to propose a theoretical framework for the measurement of those attitudes, and to devise a test instrument and pilot it on three groups with differing amounts of counselling skills and experience. The outcome of the pilot study produced surprising results, leading to the tentative hypothesis that counselling training and/or experience may have a detrimental effect on so-called 'therapeutic attitudes' in the nurse.

INTRODUCTION

Psychiatric nursing is often seen as involving two main elements. First and foremost, it is regarded as a practical undertaking, as being something that one person *does* to another (hence the verb *to nurse*). Secondly, psychiatric nursing has also been seen as involving a knowledge component, a body of theory and research on which current practice is based, and from which new practice can evolve. Psychiatric nurse training has supported this dual role, and traditionally comprises a practical, ward-based element supported by a shorter, theoretical part usually taught in a school of nursing. This dual role reflects the content of the 1982 psychiatric nurse training syllabus of the English National Board for Nursing, Midwifery and Health Visiting which is divided into two sections entitled 'Nursing Skills' and 'The Knowledge Base'.

Equally, this division is also acknowledged when it comes to evaluation of students. In the past, the knowledge base has been evaluated by means of tests, essays, multiple choice questionnaires, seminar presentations, and ultimately by a state final examination. Nursing skills, which include clinical performance, the ability to work individually and as part of a team, the ability to teach skills to

others, and a whole host of other skills-based activities, have usually been assessed by ward reports and by ward-based practical tests, normally carried out by clinically practising nurses.

However, as well as knowledge and skills, the English National Board (ENB) also make reference to a third component of educational outcome, albeit rather belatedly in an appendix to the syllabus. They write:

When we speak of educational aims we refer to the variety of outcomes on skills, attitudes and knowledge, which are intended to result from participation in a course of training.

Thus, although the third component of attitude change has been identified as an educational aim, it is not directly addressed as such in the syllabus. Rather, we are informed, 'the development of desirable attitudes in the nurse is subsumed in the total process of the educational experience'. We are not told, however, what exactly count as 'desirable attitudes', and this decision is presumably left to the curriculum designers.

The aims of this paper, then, are threefold. Firstly, it will attempt to define what might constitute 'desirable attitudes', based on extensive research in psychotherapy and the other caring professions, secondly, it will propose a

theoretical framework for constructing an instrument for measuring such attitudes, and thirdly, it will develop one such instrument and initiate a short pilot study

THERAPEUTIC ATTITUDES — A REVIEW OF THE LITERATURE

Clearly, the 'desirable attitudes' referred to by the ENB are attitudes held by the nurse about psychiatric illness, and in particular, towards patients. The attitudes considered desirable will depend to some extent on the therapeutic orientation adopted, but there is extensive research evidence to suggest that certain attitudes are inherently therapeutic, whether the therapist holding them practises behaviour modification, group therapy, psychoanalysis, or any of the many other treatment approaches adopted by nurses. This view is most often associated with the work of Carl Rogers, who points out

In any psychotherapy, the therapist himself is a highly important part of the human equation. What he does, the attitude he holds, his basic concept of his role, all influence therapy to a marked degree (Rogers 1951)

Rogers identified three attitudes which he believed must be present in order for a therapist to perform effectively. These are genuineness, respect and empathy, and each will now be examined in turn.

Genuineness, realness or congruence means being one's self, putting up no professional front or personal façade. The therapist makes him/herself transparent to the client, that is, the client can 'see through' the therapist. There is a close matching, or congruence, between what the therapist is experiencing at gut level and what is expressed to the client.

Respect, acceptance or prizing, otherwise known as 'unconditional positive regard', involves the therapist experiencing a positive, acceptant attitude toward whatever the client is at that moment, be it confusion, resentment, fear, anger, courage, love or pride. Such caring on the part of the therapist is non-possessive, and the client is prized in a total rather than a conditional way.

Empathy is the sensing of the feelings being experienced by the client, and the communication of this understanding back to him/her. As Rogers points out, when the therapist is functioning best, s/he is so much inside the private world of the client that s/he can clarify not only the meanings of which the client is aware, but even those just below the level of awareness.

There is ample evidence that these three attitudes, if held by the therapist, are indeed beneficial to the client. Whitehorn & Betz (1956), for example, looked at a group of physicians who had successfully worked with schizophrenic patients and compared them with a group who were unsuccessful. They found that successful physicians took a client-centred approach that concentrated on the person rather than the illness. Furthermore, they developed relationships in which the patients felt trust and confidence in the physician. In later studies, Barrett-Lennard (1962) and Mullen & Abeles (1972) correlated empathy with therapeutic experience, and Truax & Mitchell (1971) concluded that 'in counselling and psychotherapeutic situations an empathic approach to the patient is a major determinant of successful outcome'.

Heine (1950) asked clients who had undergone successful therapy what had helped them most, and found it to be trust in the therapist, being understood by the therapist, and the feeling of independence they had in making choices and decisions. A similar study by Fielder (1953) indicated that the elements differentiating expert from less expert therapists were an ability to understand the clients' meanings and feelings, a sensitivity to the clients' attitudes, and a warm interest without any emotional over-involvement, findings that were later confirmed by Halkides (1958) and Barrett-Lennard (1959). In the Halkides study, high correlations, all at the 0.001 level of significance, were found between successful outcome of therapy and the three attitudes of empathy, acceptance and genuineness in the therapist, as assessed by independent observers. The Barrett-Lennard study used the clients themselves to judge whether their therapists held the above attitudes, and again, the clients who judged their therapists to be most empathic, genuine and accepting were those who were found to have changed most during therapy.

Meanings and feelings

Quinn (1950) showed that 'understanding' of the clients' meanings and feelings is essentially an attitude of *desiring* to understand, and Seeman (1954) found that success in psychotherapy is closely associated with a strong and growing mutual liking and respect between client and therapist. Furthermore, this 'mutual liking' or empathy was found by Bergin & Jasper (1969) and Bergin & Solomon (1970) to be unrelated to the therapist's academic performance, intellectual competence or diagnostic skill. Truax & Mitchell (1971) carried out an extensive review of the research dealing with genuineness, respect and empathy, and concluded that

Therapists or counselors who are accurately empathic, non-possessively warm in attitude and genuine are indeed effective. Also, these findings seem to hold with a wide variety of therapists and counselors, regardless of their training or theoretic orientation, and with a wide variety of clients or patients. Further, the evidence suggests that these findings hold in a variety of therapeutic contexts and in both individual and group psychotherapy or counseling.

Finally, several writers have attempted to relate the above research findings to the field of nursing. Studies by Altschul (1972) and Cormack (1983) both found the quality of the nurse-patient relationship to be an important component of treatment, and that if the patient believed that the nurse displayed poor interpersonal behaviour such as lack of empathy or genuineness, then the relationship would suffer. Furthermore, Shanley (1984) discovered that, while the majority of psychiatric nurses in his sample had positive relationships with patients, nevertheless over 10% had relationships that were likely to be detrimental to the patients' recovery. Thus, Reynolds & Presly (1988) conclude that 'the process of relationship building is central to everything that the nurse does with her client', especially since, as Shanley (1988) notes, 'the nature and influence of patients' "informal" relationships with mental nurses has been largely neglected and undervalued'. Engledow (1987) goes further to suggest that relationship-building skills are equally important for the general nurse and need to become part of a nurse's 'tools of trade', claiming that 'these skills should form an essential component of both basic and post basic education', and that they are 'both a foundation for improved professional practice and a strength for enhancing the status of nursing as a professional discipline'.

MEASURING ATTITUDES

In order to measure attitudes, it is first necessary to determine just what is understood by the term. Most definitions speak of a 'disposition' or a 'predisposition' to act or respond (Rokeach 1960, Mednick *et al* 1975, Liebert & Neale 1977), although, as Burns & Dobson (1984) point out, the word 'predisposition' merely indicates a *tendency* towards action, not that an action will necessarily follow. 'Indeed', they point out, 'there are occasions when we have attitudes towards persons or objects where actions are not possible or even desirable'. Furthermore, as Altschul & Sinclair (1981) state

the evidence of laboratory research and of people's behaviour in real life shows that behaviour is not always congruent with beliefs and feelings, not even with the verbal expression of intended behaviour

In other words, people may at times act contrary to their beliefs, and even contrary to how they say they intend to act. Clearly, then, attitude measurement is an extremely complex process.

In the past, researchers have adopted three basic methods of measuring therapists' attitudes. They have used the therapists' self-assessment of their own attitudes, they have used assessment by the clients undergoing the therapy, and they have used assessment by independent observers. All of these methods are open to question. In particular, the use of independent observers has been the subject of much criticism on methodological grounds (Carkhuff 1969, Matarazzo 1971, Butler & Hansen 1973, Gormally & Hill 1974, Gormally *et al* 1975, Perry 1975). Gurman (1977), in a review of 26 studies, found only the clients' perception of the attitudes of their therapists to be linked to therapeutic outcome, and that furthermore, there was no correlation between patients' perception of the therapeutic relationship and either therapists' perception or judges' assessments, with therapists rating themselves consistently higher in the possession of therapeutic attitudes than did their patients. Gurman concluded that, despite certain methodological shortcomings

there exists substantial, if not overwhelming, evidence in support of the hypothesised relationship between patient-perceived therapeutic conditions and outcome in individual psychotherapy and counseling

Methodological problems

However, there are both practical and methodological reasons why assessment by patients was thought to be unsuitable for this particular study. From a practical point of view, it is unlikely that student nurses will spend enough time on any one ward or with any one patient for the patient to make an accurate assessment of their therapeutic attitudes, and there are other problems associated with asking patients to make formal assessments of the nurses responsible for their care. Even if those difficulties could be overcome, there are also ethical restrictions on the involvement of patients in research projects.

Equally serious are the methodological problems, which centre around the difficulties of measuring such a complex construct as an attitude. Taking the definition offered by Thrustone (1946) of an attitude as 'the degree of positive or negative *affect* associated with some psychological object' (my italics), and remembering that an attitude is only a *predisposition* to act, then any method which relies on observation by one person of another may not be accurate. Firstly, it could be argued, it is not always possible to

determine the nurse's affect or feelings simply from his or her behaviour. S/he may, for example, have a very negative attitude towards a certain patient but be very successful at hiding it. And secondly, since an attitude is only a predisposition to act in a certain way, the nurse's attitudes may never actually be translated into behaviour. If the intention is to measure attitudes rather than behaviour, then only self-rating by the nurse him/herself is relevant. However, it has also been noted that direct questioning of subjects about their attitudes is also open to criticism as a method (see, for example, Cantril 1944, Payne 1951, Edwards 1957).

There is, though, a third method by which attitudes may be measured, and that is by means of *attitude scales*. These consist of a number of statements to which the subjects are asked to respond in some specified way, usually by either choosing between several statements about the same psychological object, or by rating a statement on a scale depending upon the extent to which it is agreed with. In this way, it is possible to devise a standardized test which is quick and easy to administer and which is less threatening to the respondents than direct questioning.

DEVISING AN ATTITUDE SCALE

What is being attempted here is the construction of an attitude scale, based on theoretical work by Hammond *et al* (1977), together with a short pilot study using the scale. Although the validation and standardization of the scale are beyond the scope of this study, the results of the pilot will be briefly analysed and discussed, bearing in mind the many restrictions on any conclusions which may be drawn.

There are several ways of constructing attitude scales. The Likert Scale (Likert 1932) presents the subjects with a list of statements representing varying attitudes towards some object or situation, to which they are asked to respond by ticking boxes ranging from 'strongly agree' to 'strongly disagree'. Osgood's Semantic Differential Technique (Osgood *et al* 1957) requires the subjects to respond to statements in terms of a set of bipolar adjectives along a seven-point scale, and yet another method instructs the subjects to rank a list of items in order of importance.

Method

The method adopted in this study presents the subjects with short scenarios of therapeutic situations, involving statements made by a client to the therapist, and asks them to select one of five responses which they think would be the most helpful in that situation. The responses are devised

according to a five-level scale for each of the three attitudes being investigated (empathy, respect and genuineness) and consist of one response at each level. The scales are taken from work by Hammond *et al* (1977), who in turn based them on an earlier study by Rogers *et al* (1967). Each scale ranges from level 1.0 (highly subtractive), to level 5.0 (highly additive), with level 3.0 being the minimal level at which the therapist's response is helpful or therapeutic. Thus, on the empathy scale, for example, Hammond *et al* (1977) describe a level 1.0 response as being one in which

The counselor's verbal and behavioural responses are irrelevant, subtract significantly in affect and content, and do not attend appropriately to the other's expressions. The counselor communicates no awareness of even the most obvious, expressed surface feelings of the other person. The responses include premature advice-giving, arguing, changing the subject, criticizing, pontificating, and asking questions that shift the focus from the expressions of the client.

At the other extreme, a level 5.0 empathic response would be one where

The counselor's responses significantly add to the affect and meaning explicitly expressed by the client. Additionally, the counselor's responses accurately communicate the affect, meaning, and intensity of the other person's deeper feelings by word, voice and intensity of expression.

Full description of all the levels from 1.0 to 5.0 for the empathy, respect and genuineness scales can be found in Hammond *et al* (1977).

Test instrument

The actual test instrument used in this study attempts to convert these scales into a questionnaire to measure the therapeutic attitudes of psychiatric nurses, but could be just as easily adapted to suit any counselling situation. The test consists of twelve statements that might be made by patients during counselling sessions with psychiatric nurses, with each statement being followed by five replies. Each reply has been carefully written to reflect a response on a different level from 1.0 to 5.0 for one of the three attitudes being measured. For example, statement number one in the test has a patient saying to a nurse 'I feel strange when I enter a room with other people in it. Everyone looks at me'. This is followed by five replies, designed in this instance to measure the empathic response of the nurse. The level 1.0 response in this case is 'Try in those situations to keep eye contact with people. I'm sure you'll soon find that you're feeling better'. The level 5.0 response,

on the other hand, is 'So if there are already other people in the room when you go in, you feel awkward and embarrassed I also detect a sense of unworthiness, as if you feel you have no right to be there' (A copy of the full test can be obtained from the author)

If the subject chooses the level 10 response, s/he scores one point, the level 20 response scores two points, level 30, three points, and so on. Of the 12 statements, four are designed to measure empathy, four to measure respect, and four to measure genuineness, so that the maximum score possible for each attitude is twenty. If these numbers are then divided by four, the subject will have a score of between 10 and 50 on each of the three attitude measures. One advantage of this test is its flexibility. Any number of statements and responses can be written, as long as they are based on the scales in Hammond *et al* (1977). Thus, tests of any length can be devised, and new tests can be written if the same subjects are to be retested. Writing test items requires a little thought and imagination, especially when attempting to match responses to different levels on the scales, but this task becomes much easier with practice.

USING THE TEST — A PILOT STUDY

Method

Having developed the test, it was decided that it would be piloted on three small samples of nurses representing a wide range of levels of therapeutic training and experience. Sample A was a group of registered general nurse (RGN) students who had just begun their psychiatric secondment, and thus had little or no training or experience as counsellors, sample B was a group of second year registered mental nurse (RMN) students with some training and experience in counselling, and sample C was a group of trained registered mental nurses, including several nurse tutors, who were selected from areas in which counselling took place on a regular daily basis.

The questionnaires included instructions which were designed to be self-explanatory, and were distributed to the subjects without further directions. Wherever possible, the respondents were encouraged to complete the answer sheets while the experimenter waited, and in this way, a 100% response rate was achieved.

RESULTS

The scores for each attitude being measured were totalled and divided by four, and averaged out for each sample group. In this way, three scores were produced for each

Table 1 Average scores on the attitude scale test by sample group

	Empathy	Genuineness	Respect
RGN Students (<i>n</i> = 17)	3.80	3.60	4.11
RMN Students (<i>n</i> = 13)	3.48	3.56	3.91
Trained nurses (<i>n</i> = 12)	3.79	3.46	3.98

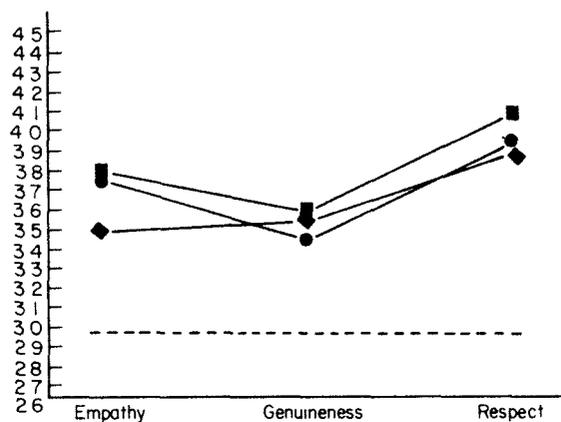


Figure 1 A comparison of attitude-scale scores by sample group. ■ = RGN students, ◆ = RMN students, ● = trained psychiatric nurses, — (4.0) moderately high therapeutic level, - - - (3.0) minimally therapeutic level.

group, for empathy, respect and genuineness, ranging from 10 to 50. The results are shown numerically in Table 1, and graphically in Figure 1.

DISCUSSION

Before discussing the results, it is necessary to restate that, as a newly developed test which has been neither validated nor standardized, any conclusions are, of course, purely speculative. Nevertheless, owing to the unexpected nature of the results, it may be interesting to consider the findings further.

All scores were above the minimally therapeutic level of 3.0, but only one score topped the moderately high therapeutic level of 4.0. Contrary to expectations, the RGN seconded students scored highest on all three attitude scales, whereas, generally, the RMN students scored lowest, although the trained nurses had the lowest score for genuineness. All three groups produced their highest score on the respect scale, and whereas the RGN students and the trained staff scored lowest on the genuineness scale, the RMN students scored lowest on the empathy

scale This finding is rather disturbing, since many studies have indicated that, of the three attitudes, empathy is the most therapeutic However, since the test has not been standardized, it is difficult to make meaningful comparisons between the different scales

Interesting speculations

If the three samples are taken as representative of populations with varying amounts of counselling training and experience, then some interesting speculations can be made about the therapeutic effects of such training and experience, at least for the psychiatric hospital in which this study was carried out Taking the scores for the RGN students as a baseline (little or no counselling training or experience), then the effect of 2 years' psychiatric training (second year RMN students) would seem to have a negative therapeutic effect as far as attitudes are concerned, with even trained and practising counsellors displaying attitudes measured as being less therapeutic than those of the beginners

Of course, the right attitudes are not the only factors that go to make an effective therapist, and experience and technique also play a large part Also, the differences between the scores for the three sample groups are fairly small, and thus no conclusions may be drawn concerning their therapeutic abilities However, in view of the well-documented evidence about the therapeutic benefits of holding certain attitudes, perhaps more emphasis needs to be placed, both during basic training and post-registration, on the acquisition of those attitudes

CONCLUSION

Let us return now to the three aims outlined at the beginning of this project Firstly, it was proposed that this study should attempt to define what are considered to be 'desirable attitudes', as stated by the ENB It was decided, at least in part, that this meant those attitudes which, when held by the nurse, were found to be therapeutic to the patient An extensive review of the literature revealed three such attitudes to be empathy, genuineness and respect, and thus it was on these attitudes that the study was to focus

Secondly, this study attempted to set out a theoretical framework for the measurement of the above attitudes, and proposed the adoption of a scale based on work by Hammond *et al* (1977), who defined five levels of therapeutic effectiveness for each of the three attitudes And thirdly, a test instrument was developed which sought to measure the attitudes of the respondents and score them

according to Hammond's scale This instrument was then piloted with somewhat surprising results, as discussed above

The results, although tentative, indicate a need for further research in the area, and this entails the standardization and refinement of the test instrument There is thus scope for further work, perhaps in standardizing this test against others, or else by employing triangulation techniques to compare test results with assessments by patients or independent observers

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