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# CHANGING STAFF ATTITUDES AND EMPATHY FOR WORKING WITH PEOPLE WITH PSYCHOSIS

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**Abstract.** Seventy-seven mental health professionals completed a 3-day cognitive behavioural training course for managing hallucinations and delusions in schizophrenia. A questionnaire measuring attitudes and empathy towards working with people who have these symptoms was administered before and after the course. Significant increases in feelings of adequacy, legitimacy, employment related self-esteem, and expectations of work satisfaction were observed after the course and participants displayed high levels of motivation for working with this clinical population at both time points. In addition, the participants showed significant increases in perceived empathy for the experience of hallucinations and delusions. This was a predicted outcome as the course included exercises designed to enhance therapists' understanding of the subjective experience of psychotic symptoms. Empathy is recognized in the wider psychotherapy outcome literature as a therapeutically important variable that influences the formation of a therapeutic alliance but it is a relatively unexamined construct in CBT for psychosis. Further investigations in this area will potentially enhance psychological treatment delivery and subsequent outcomes for people who experience hallucinations and delusions. Furthermore, explication of such ''non-specific'' therapeutic factors may help to explain some of the transient but beneficial effects of unstructured ''control'' therapies observed in recent CBT for psychosis outcome trials.

*Keywords:* Empathy, CBT, psychosis, schizophrenia, therapeutic relationship.

## Introduction

In recent years there has been a growing acceptance of the use of psychosocial treatments for schizophrenia although this has not traditionally been the case (Mueser & Bond, 2000). The lack of involvement that American psychologists had demonstrated in the care and treatment of people with schizophrenia was decried by Bellack (1986) and echoed by Birchwood and Preston (1991), who asked why so little had been done to research Cognitive Behavioural Therapy (CBT) for schizophrenia. A search of seven major British journals,

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covering both clinical psychology and psychiatry between the years 1987 to 1991, found only 67 articles or 3.5% of all articles in these journals had the word ''schizophrenia'' in the title, abstract, method, or results sections (Gallagher, Gernez, & Baker, 1991). While more strict inclusion rules would have reduced this number even further, the authors argued that this was sufficient to demonstrate the lack of interest being shown by psychologists in this area.

Since the beginning of the 1990s, there has been a substantial increase in empirical support for the use of CBT in the management of psychotic symptoms (Tarrier et al., 1998; Kuipers et al., 1997; Sensky et al., 2000) but the implementation of such interventions remains erratic (Division of Clinical Psychology, 2000). Although a lack of appropriate training and supervision opportunities will be likely to impede implementation, it is possible that attitudinal factors within professional groups may also hinder uptake. Such attitudes are reflected in McKenna's (2001) assertions that widespread implementation of CBT in the National Health Service is premature, a view he supports by citing Sensky et al.'s finding that CBT and ''befriending'' were equally effective over a 9-month intervention period. An alternative interpretation is that engagement with psychotic individuals, although not sufficient to bring long-term change, does have some positive benefits. Sensky's trial indicates that the difference with CBT treated patients is that they maintained improvement in symptoms post intervention suggesting that some self-management strategies were learned and implemented. Befriending did not produce this effect. It is possible that increasing clinicians' willingness to work psychologically with psychotic individuals is a necessary precursor to the implementation of therapeutic techniques that may facilitate long term change.

There may be a number of explanations for why psychologists and other mental health professionals may be reluctant to work with or carry out research into schizophrenia. Mirabi, Weinman, Magnetti and Keppler (1985) conducted a survey of 436 mental health professionals, including psychiatrists, psychiatric nurses, and psychologists, to ascertain their attitudes and beliefs about working with the chronically mentally ill. Eighty-five percent of respondents agreed that this was not a preferred group to treat, and many believed that most clinicians avoided contact and referred such clients elsewhere. Most of those surveyed thought that there was little satisfaction in treating the chronically mentally ill. They believed there was not much hope for a satisfactory outcome because available treatments were not helpful in controlling long-term psychotic disorders. Consistent with this finding, a survey of psychiatrists found one of the least satisfying aspects of their work involved treating patients who did not improve or frequently relapsed (Schwartz, Krieger, & Sorenson, 1981).

In describing the lack of interest that psychologists displayed in working with people with schizophrenia, Bellack (1986) outlined four beliefs that might account for this state of affairs. These were: 1) That there is doubt over the validity of the schizophrenia construct (that the label schizophrenia is not a useful one); 2) That schizophrenia is biologically based; 3) That the condition is adequately treated with medication and therefore psychological intervention is unnecessary; and 4) That schizophrenia is too serious a complaint for psychological or behavioural intervention to be effective.

Gallagher et al. (1991) surveyed 150 graduate psychologists from Britain and Ireland and asked them, among other things, Bellack's (1986) four questions. No support was found for Bellack's proposition. Instead, 91% of those surveyed rejected the statement ''schizophrenia is too severe a condition for psychologists to work with'', and 81% disagreed with the statement that ''schizophrenia is adequately treated with medication''. Unfortunately, Gal-

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lagher et al. did not report how many of those surveyed actually worked with people with schizophrenia.

Traditionally, medication has been seen as the best and most effective option for managing schizophrenia (McGrath & Emerson, 1999; Fiander & Burns, 1998; Kerwin, 1994; Lehmann, 1975). Thus, it might be expected that psychiatrists would feel more empowered and more willing to treat such patients. However, the existing survey data do not support this (Nielsen et al., 1981; Packer, Prendergast, Wasylenki, Toner, & Ali, 1994).

Packer et al. (1994) asked American trainee psychiatrists about their attitudes towards working with people with chronic mental illnesses. They found that less than a third believed that working in this area would lead to high job satisfaction, and 89% felt that working in such an area would damage long term employment prospects. They also found that nearly two-thirds of the psychiatric residents felt that those with a chronic mental illness seldom changed, and half the respondents felt that treatment options were limited. Only 3 of the 85 respondents intended to work full time with the chronically mentally ill population.

Such findings have led to the suggestion that psychiatric training programs should address negative attitudes towards working with people who have schizophrenia. Part of this training would include the development of realistic treatment expectations, being able to work with other mental health professionals to provide a more complete treatment, and to understand the issues of patient passivity and dependence (Nielsen et al., 1981).

Stigmatizing public attitudes toward people with mental illnesses are not surprising as many disorders are characterized by behaviours that contravene social norms. However, there is sometimes an erroneous assumption that mental health professionals are immune to these stigmatizing or distancing responses (Minkoff, 1987). Such behaviours can cause feelings of hopelessness, frustration or anxiety in professionals as much as in the general population (Cotton & Pruett, 1975; Colson, Allen, Coyne, & Dexter, 1986; Herzog, Wyshak, & Stern, 1984). It should not be assumed that because clinicians are intellectually aware that apathy and lack of motivation are salient features of mental illness they are also capable of automatically moderating their emotional reactions to client's apparent lack of progress (Minkoff, 1987).

The range of attitudinal factors that effect clinicians' willingness to work with patients with schizophrenia (e.g. pessimism about treatment outcomes, Woodside, Landeen, Kirkpatrick, & Byrne, 1994), may also adversely impact on the relationship between the patient and the clinician. Empathy is considered a component essential to the establishment of a positive therapeutic relationship (Reynolds, Scott, & Jessiman, 1999). In any form of psychotherapy the therapeutic relationship is crucial for treatment (Cartwright, Hyams, & Spratley, 1996), and working with schizophrenia is not an exception in this regard (Turkington & Kingdon, 1996). Yet patients with schizophrenia are seen as particularly difficult to engage in a therapeutic alliance (Minkoff & Stern, 1985). Packer et al. (1994) found that 91% of the psychiatric residents surveyed believed that people with schizophrenia are not able to develop a therapeutic alliance. However, it has been argued that the only reason that many people with schizophrenia attend therapy, at least at the beginning, will be directly due to the positive interaction with the therapist (Nelson, 1997). That is, they may be forced to be there by external forces (court ordered treatment or hospital rules), but they are only going to want to attend if they enjoy talking to the clinician.

One of the major threats to the therapeutic alliance is a failure in empathy (Chadwick, Birchwood, & Trower, 1996) and low empathy has been associated with higher burnout rates among workers (Astroem, Nilsson, Norberg, Sandman, & Winblad, 1991), higher hos-

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tility and anxiety in patients (La Monica, Wolf, Madea, & Oberst, 1987), less involvement and increased belittling comments, and an increased sense of isolation and loneliness felt by the patient (Fox, 2000). However, the development of empathy may be difficult when clinicians are faced with symptoms that are outside the scope of our own experiences (Chadwick et al., 1996; Fowler, Garety, & Kuipers, 1995).

Some of the aims of the CBT approach to the treatment of schizophrenia include gaining an understanding of the cognitions experienced by patients and development of an individualized formulation (Nelson, 1997). Formally teaching these principles to clinicians may also serve to enhance their sense of empathy for the patients' experiences.

The present study aimed to evaluate changes in attitudes and empathy shown by experienced staff undertaking a three-day CBT course for the management of hallucinations and delusions. The course included exercises specifically devised to increase the participants' understanding of, and empathy with, people experiencing hallucinations and delusions.

We expected to find that the professionals' attitudes towards working with clients who have delusions and hallucinations would change as a result of their participation in this course. Specifically, we expected to find an increase in empathy and positive changes in the following five attitude sets: 1) motivation or willingness to work with people with delusions and hallucinations; 2) expectations of work satisfaction that is to be gained from working with this population; 3) participants appraisals of their knowledge and skills in working with this population; 4) the extent to which they felt it was legitimate for them to attempt to intervene therapeutically with these clients; and 5) the professionals' self esteem in relation to working with this client group.

## Method

To test whether participating in the training led to the predicted attitude changes, a questionnaire was administered before and after taking part in the course. The course content focused on CBT for hallucinations and delusions and, correspondingly, the focus of the questionnaires was on the changes in attitudes towards working with these symptoms.

### *Participants*

Overall, 77 participants took part in four separate courses. Three of these programmes were held in England, and one in New Zealand. No formal selection process was applied to determine eligibility for attendance except that advertising for the training indicated that participants should have some knowlege of CBT principles and/or some experience of working with psychotic individuals. Thirty-one per cent of the participants ($n$ = 24) came from the New Zealand group, and 69% from the English groups ($n$ = 53). The average age was 36.8 years of age, ranging from 24 years to 56 years. Fifty-three per cent were female and 47% were male. All but two participants reported having worked with patients with hallucinations and delusions. The occupations described by the participants were: nurses (32.5%), psychologists (11.7%), psychiatrists (5.2%), social workers (3.9%), and occupational therapists (3.9%). The remaining participants described their role in less professionally specific terms, such as ''Team Leader'', ''Team Member'' or ''Care Manager'' (42.8%).

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*Training course structure and content*

The size of these courses ranged from 10 to 24 participants. Each course ran for three days, and all were delivered by the same presenter (Hamish McLeod). The course content was primarily based on the work of Nelson (1997) but the techniques covered largely matched those that are described in many of the major texts in this area, such as Chadwick et al. (1996), and Fowler et al. (1995). In addition to this, a number of exercises were included for the purpose of improving the empathy the participants may feel towards schizophrenic patients.

*Empathy exercises*. In the first of these exercises the group is split into two, with one group (the ''patients'') taken out of the room by the presenter. The ''patients'' were told that they were in a psychiatric ward, that the people in the first room were staff and that the presenter is actually a terrorist who has planted a bomb somewhere in the building. The patients are told that when they return to the room they should explain to the ''staff'' that unless the ''terrorist'' is given a large sum of money the bomb will detonate in 30 minutes. They are to explain the situation to the ''staff'' and convince them to help.

The ''staff'' were told that they work in an inpatient psychiatric setting, and that those who had left the room would play the role of a patient with ''chronic paranoid schizophrenia''. They were then given the task of talking to a ''patient'' with explicit instructions to ''distract them from any delusional ideas and [to] keep them calm''.

Typically the ''patients'' would re-enter the room, pair off with the ''staff'' and try to convince them of the dangerous situation that has arisen. Meanwhile, the ''staff'' typically attempted to deflect the conversation to neutral (and supposedly non-delusional) topics resulting in the ''patients'' becoming more desperate.

This exercise potentially provides lessons for both parties, but perhaps more so for the ''patients'' who often reported feelings of frustration, anger, and a sense of being devalued and ignored. They gain a sense of what it may be like for someone who believes what they are saying to be important but is not taken seriously. This provides them with an analogous understanding of the likely effect of such interactions on a delusional individual. The ''staff'' typically gained a sense of how easy it is to make a priori assumptions about what is ''delusional''.

The second exercise was designed to create an understanding of the difficulties faced by someone experiencing persistent auditory hallucinations, a foreign experience for most mental health workers. Therefore, to promote empathy, the exercise aimed to mimic the sensations and associated difficulties of persistent and intrusive auditory hallucination. A personal tape-player and head phones were used to play a tape of ''voices'' the content of which was based on reports from actual voice hearers. Five of the course participants at a time listened to the tape while the seminar was being presented, thus forcing them to concentrate on external stimuli whilst the voices talked back and forth.

This exercise conveys the difficulties in concentration that voices can cause and the frustration experienced when trying to ignore them. The aim was to foster an awareness that attending to external stimuli while presented with competing internal stimuli can be particularly difficult, especially when the content is emotionally salient and uncontrollable.

The third exercise required course participants to discuss in small groups any unusual feelings or perceptions they had experienced. A common example was perceptual disturbances and hallucination following periods of sleep deprivation (a relatively common experi-

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ence in the normal population, Slade & Bentall, 1988). No restrictions were placed on the type of experiences to be discussed but the participants were instructed to react to such revelations in a respectful manner. The aims were: 1) to introduce the notion that disturbances of perception and belief fall on a continuum of intensity and frequency and are not exclusive to people with mental illness, and 2) to draw attention to the automatic thoughts potentially associated with revealing such experiences (e.g. ''they won't believe me''; ''they will think I'm mad'').

*Measures*

*Attitudes and beliefs*. No measure of attitudes and beliefs related to treating people with delusions and hallucinations was available, therefore we modified the Alcohol and Alcohol Problems Perception Questionnaire (AAPPQ; Cartwright, 1980; Gorman & Cartwright, 1991). The AAPPQ was designed to be a reliable measure of therapists' attitudes towards working with clients who abuse alcohol. This questionnaire has been used to investigate the attitudes of a variety of health workers and volunteers (Lightfoot & Orford, 1986; Hunot & Rosenbach, 1998; Cartwright et al., 1996), and has also been used to develop other questionnaires (Grove & Bush, 1998; Anderson & Clement, 1987).

Because we were interested in mental health workers' attitudes toward working with clients who were experiencing hallucinations and delusions, the questions from the AAPPQ were adapted to refer to ''hallucinations and delusions'' rather than ''drinking or alcohol use''. References to ''drinkers'' were replaced with ''people with delusions or hallucinations'', and ''alcohol problems'' or ''drinking problems'' became ''delusions or hallucinations''. For example, the item ''I feel there is little I can do to help drinkers'' became ''I feel there is little I can do to help people with delusions or hallucinations''.

The original questionnaire is grouped into five subscales with 26 items. Two of these subscales are concerned with Role Security and are called, Adequacy and Legitimacy. Adequacy refers to the way workers felt about the adequacy of their knowledge and skills in working with these clients (e.g., ''I feel I know enough about the causes of delusions or hallucinations to carry out my role when working with people who have delusions or hallucinations''). Legitimacy refers to the extent to which they felt that they had the right to work with clients of this nature (e.g., ''I feel that my clients believe I have the right to ask them questions about delusions or hallucinations when necessary''). The remaining three subscales are concerned with the therapist's Therapeutic Commitment, specifically: Motivation and commitment, (e.g., ''I want to work with people who have delusions or hallucinations''); Work satisfaction (e.g., ''In general, one can get satisfaction from working with people who have delusions or hallucinations''), and Self esteem (e.g., ''I feel I do not have much to be proud of when working with people who have delusions or hallucinations'').

A reliability analysis was performed to determine the alpha levels of each scale. Based on the pre-course data the following Cronbach's alpha values were observed: Self esteem, $\alpha = 0.56$; Adequacy, $\alpha = 0.77$; Work satisfaction, $\alpha = 0.60$; Motivation, $\alpha = 0.58$ and Legitimacy, $\alpha = 0.79$.

Four other questions were adapted from Gallagher et al.'s (1991) study on the beliefs that psychologists have regarding schizophrenia. The questions assessed the degree of agreement with the following statements: 1) Hallucinations and delusions are valid constructs; 2) Gen-

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etics probably play only a minimal role in the determination of delusions or hallucinations; 3) Delusions or hallucinations are adequately treated with medication; and 4) Delusions or hallucinations are too severe a condition for cognitive-behavioural therapy to be effective with.

*Empathy*. Empathy refers to the degree to which an individual can mentally identify with another and see the world as they do. However, due to the unusual nature of hallucinations and delusions the therapist may be unable to understand or imagine these experiences. The following four questions were developed to directly assess perceived empathy towards working with patients who present with hallucinations or delusion: ''I find it difficult to have empathy for the experience of delusions or hallucinations''; ''I can not understand what it is like for people who experience delusions and hallucinations''; ''I find it hard to imagine what it might be like to have delusions or hallucinations''; ''I can relate to the experiences of those who have delusions or hallucinations'' (reversed item). Reliability analysis of these four items provided a Cronbach alpha level of $\alpha = .70$.

All of these items had a 7-point Likert-type response scale ranging from (1) Strongly Disagree to (7) Strongly Agree with a midpoint of (4) Neither Agree or Disagree. A number of the questions were reverse scored, in keeping with the wording of the original questions from which they were adapted.

Finally, a single question was adapted from a study on medical students' attitudes towards pain (Wilson, Brokopp, Kryst, Steger, & Witt, 1992). This question asked: ''How difficult do you think it is to work with patients who have delusions or hallucinations'', and was rated from ''not difficult at all'' (0%) to ''as difficult as could be imagined'' (100%).

## Results

Data were collected from each person before and after they participated in the course. There were slight variations in sample size due to missing data for some variables. Six paired *t*-tests were conducted using pre and post-training scores for each of the six variables. To control for Type-I error a Bonferroni corrected alpha level of $p < .008$ was used. The results of the paired *t*-tests are shown in Table 1. Of the six attitudes that were measured, only motivation to work with people who have hallucinations and delusions did not improve significantly. The other five constructs showed significant improvements after participation in the training programme.

**Table 1.** Results of paired *t*-tests performed on averaged pre and post attitudinal scores

| Variable | Pre-course mean | Post-course mean | *n* | Significance (2-tailed) |
|---|---|---|---|---|
| Motivation | 5.56 | 5.68 | 56 | .275 |
| Work satisfaction | 4.85 | 5.39 | 59 | .000* |
| Self esteem | 4.32 | 4.70 | 57 | .000* |
| Adequacy | 4.81 | 6.39 | 54 | .000* |
| Legitimacy | 4.88 | 5.31 | 60 | .003* |
| Empathy | 4.54 | 5.22 | 56 | .000* |

*Note*. * significant at Bonferroni corrected alpha level of $p < .008$

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A single question asked the participants to rate as a percentage how difficult they felt it was to work with patients who have hallucinations or delusions. There was a significant reduction in perceived difficulty, from a mean of 63.0% ($SD$ = 16.5) before participation to a mean of 57.6% ($SD$ = 19.1) after completion, $t(54) = 2.28$, $p < .05$.

In keeping with Gallagher et al.'s (1991) interpretation of their data, a response of 4 (scale range 1 to 7) was considered a neutral response, and all scores on either side of this were grouped as either agreement or disagreement to the statement. Table 2 summarizes the percentage agreement in the present sample and compares this to data from Gallagher et al.'s study.

## Discussion

It was hypothesized that receiving training in the psychological management of psychotic symptoms would lead to improvements in participants' attitudes toward working with people who have delusions and hallucinations. Attitude change was observed across all measured variables except motivation to work with people with delusions and hallucinations (which remained high pre- and post-training). Also, empathy for psychotic experiences showed a significant improvement after the course and the majority of participants anticipated gaining greater satisfaction from working with this patient group. This increase in satisfaction ratings is in contrast to the findings of Packer et al. (1994), who report that the majority of their sample (trainee psychiatrists) who had completed a training rotation with chronically mentally ill patients, did not believe that working in this area would lead to high levels of job satisfaction.

That the people who took part in the course declared a greater sense of legitimacy in treating patients with hallucinations and delusions may be associated with the growing acceptance of psychosocial treatments of schizophrenia as an adjunct to medication (Mueser & Bond, 2000). This may be closely linked to appraisals of skill adequacy as, in order to gain a greater sense of legitimacy, a better understanding of the treatment method

**Table 2.** Percentage agreement for pre-training beliefs about hallucinations and delusions compared with Gallagher et al. (1991)

| | Disagreed % | Neutral % | Agreed % |
|---|---|---|---|
| Valid constructs | | | |
| Hallucinations and delusions | 13 | 34 | 53 |
| Schizophrenia (Gallagher et al., 1991) | 33 | 17 | 50 |
| Genetics play a minimal role | | | |
| Hallucinations and delusions | 20 | 56 | 24 |
| Schizophrenia (Gallagher et al., 1991) | 67 | 10 | 23 |
| Adequately treated with medication | | | |
| Hallucinations and delusions | 52 | 30 | 18 |
| Schizophrenia (Gallagher et al., 1991) | 81 | 7 | 11 |
| Too severe for psychology/CBT | | | |
| Hallucinations and delusions | 63 | 30 | 7 |
| Schizophrenia (Gallagher et al., 1991) | 91 | 5 | 4 |

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is to be expected. The increase in the sense of adequacy reported suggests that taking part in the course produced an improved sense of competence and knowledge in regard to working with this patient group. Job related self-esteem of the participants also increased after the course. Along with increased expectations of work satisfaction, this could lead to an improvement in intrinsic reinforcement from working in this area.

We found no change in the respondents' motivation to work with patients with hallucinations and delusions before and after taking part in the course. Given the respondents were relatively highly motivated it is unsurprising that this dimension did not change significantly. This finding highlights that the participant sample may have been biased in favour of people who were motivated to learn how to psychologically manage psychotic symptoms. Because of this, some caution must be exercised in extrapolating from this study to the provision of such training to less motivated mental health workers.

An important attitude change was that empathy for the experience of hallucinations and delusions increased by the end of the course. Given the role of empathy in the development of the therapeutic alliance, this is encouraging but there is a need for further research to establish whether perceived empathy leads to changes in therapeutic practice. There is some evidence from research into motivational interviewing training that post-course changes in therapeutic attitudes do translate into modest but durable behavioural change in therapy but training recipients tend to overestimate the magnitude of this effect (Miller & Mount, 2001).

There are few investigations of the role of empathy or therapeutic alliance in treatment of schizophrenia and almost none related to empathy, therapeutic alliance and CBT for delusions and hallucinations. This is despite the consistent prominence it receives by authors of various treatment manuals using these approaches, who in most cases view a collaborative therapeutic alliance as a prerequisite to more specific cognitive interventions (Fowler et al., 1995; Chadwick et al., 1996; Nelson, 1997). One exception is the work of Stark, Lewandwski and Buchkremer (1992) who observed that, for people with schizophrenia receiving individual cognitive-behavioural style interventions, difficulties in the dyadic therapist-patient relationship was predictive of a poorer therapeutic outcome at 2-year follow-up.

Our findings were consistent with Gallagher et al.'s (1991) rejection of Bellack's (1986) hypothesis; that is, the majority of participants did not report the beliefs that Bellack proposed would lead to avoidance of working with schizophrenic patients. Although it is not possible to rule out that this is because health professionals who do not consider psychological interventions for schizophrenia to be efficacious are under-represented in the present sample, some cautious comparisons can be made with Gallagher et al.'s findings. In the present study, a much higher proportion of the participants responded neutrally (neither agreed nor disagreed) to the four items. Gallagher et al. did not indicate whether their respondents had contact with schizophrenic patients, but almost all of those in the present study did. Despite this high level of contact there was a greater level of uncertainty about whether, for example, hallucinations and delusions are adequately treated with medication. This may derive from the professional and occupational diversity of participants in the present study but also could reflect the emerging belief that psychological interventions need to be included when providing comprehensive care.

There were several limitations to the present study. The internal reliability of several of the attitude subscales was low, particularly compared to findings with the original AAPPQ (Cartwright, 1980). In the present study the Self esteem, Work satisfaction and Motivation scales had alpha levels of between 0.56 and 0.60, suggesting they may not be capturing a

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single construct. There is a need to improve the reliability and validity of these scales for use in assessing these specific components of attitudes toward people with hallucinations and delusions. Without the use of a control group we cannot say with certainty that the changes in attitudes were a function of the training program rather than being attributable to artefacts such as social desirability demands. Similarly, with the present design we cannot determine which aspects of the training program leads to changes in specific attitudes or perceived empathy. However, we believe these changes are at least in part due to the specific exercises aimed at increasing participants' understanding of hallucinations and delusions and the accompanying emotional responses. An alternative is that these exercises are unnecessary and similar changes occur as a function of the specific CBT interventions in the program. However, past research into professional attitudes does not support this interpretation. Cartwright (1980) pointed out that a number of studies across different professions have found that training courses in the treatment of alcohol modify knowledge of the issues and beliefs about the nature of alcoholism, but do not lead to changes in therapists' attitudes.

While the creation of attitudinal change is an encouraging start, further research is needed to determine whether these attitudes persist and if they lead to improved staff morale and increased treatment provision for this currently under-serviced group. It will also be necessary to demonstrate that the same effect is observable with a less motivated group of mental health workers, especially as past attempts to teach CBT for schizophrenia to multidisciplinary groups have shown low levels of subsequent implementation (Kavanagh et al., 1993). Finally, there may be value in establishing more clearly how the quality of the therapeutic alliance influences outcomes for people who have hallucinations and delusions.

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