Behavioural and Cognitive Psychotherapy, 2000, 28, 369–377
Cambridge University Press. Printed in the United Kingdom

NURSES AS THERAPISTS (1972–2000)

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Abstract. This paper will review the development of nurse therapy in England over a period of 28 years. By examining the data available on the efficacy of nurse therapists and the latest picture of the workforce, derived from a recently conducted survey, consideration will be given to how nurse therapy might develop in the future. In particular, the paper will provide an analysis of dissemination issues.

Keywords: Nurse therapy, survey, training, nursing, policy.

The beginnings of nurse therapy

At the end of the 1960s behaviour therapy was, for the public at large, an unknown treatment. However, at that time psychiatrists and psychologists began to realize that behavioural treatments had great potential as an effective treatment for a wide range of psychiatric conditions. A detailed review of the development of behavioural psychotherapy and cognitive behaviour therapy (CBT) is out of place here; however, it is worth noting that there were two central strands of development. The first was based on operant approaches, exemplified in the token economy system for chronic mental illness and behaviour modification for autism and learning disabilities. The second strand comprised a broad range of approaches for neurotic and habit disorders, and it was clear even then that behavioural treatments were about to produce a major sea change in the approach to hitherto intractable conditions such as obsessive compulsive disorder and agoraphobia. For the first time we saw psychological therapies being subjected to the rigours of randomized controlled trials, and other research methods that had previously only been used in pharmacological research. This early evidence base was used to persuade first the psychiatric community, and then a wider constituency, that behavioural treatments really were a significant advance. Isaac Marks, then a Senior Lecturer at the Institute of Psychiatry, realized that these new therapeutic approaches would not achieve their potential unless there was a workforce suitably trained to deliver them. At the end of the 1960s, clinical psychology was still an embryonic discipline, and although there were some centres that trained psychologists in behavioural approaches, much clinical psychology training in the U.K. still centred on the acquisition of skills in psychoanalytically-based approaches. Furthermore, in 1970, there were only a few hundred psychologists in the country, attempting to cover a wide range of tasks, including a significant amount of psychometric examination. Marks therefore turned to nurses as

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https://doi.org/10.1017/S1352465800004069 Published online by Cambridge University Press

potential recruits to training in behaviour therapy because of their relatively large numbers and because of Marks' experience with barefoot doctors trained to perform basic medical tasks in Third World countries.

The first nurse therapy course

The first course began in 1972 at 99 Denmark Hill (Maudsley Hospital) and accepted five trainees for a 3-year training programme. Isaac Marks directed this first course and over the many years since has devoted a great deal of his time to the training of nurse therapists and to patients attending the Nurse Therapy Unit. He was helped in his endeavours by psychiatrists Joe Connolly and Robin Philpott and the psychologist Dick Hallam. This pilot course, which ran for 3 years, trained five nurses in techniques as diverse as systematic desensitization and electrical aversion therapy. Trainees were swamped with skills training involving both workshop role-play techniques and feedback on assessment and treatment sessions with live patients. During this time, Isaac's unit began to develop the use of videotape as a tool in training and by the end of his first 3-year pilot course, a well equipped TV studio became central to the training and clinical operation, with all trainees expected to carry out their first assessment with patients in this situation.

In 1975 the first 18-month training course was validated by the Joint Board of Clinical Nursing Studies (which eventually became the English National Board for Nursing, Midwifery and Health Visiting (ENB)). Since that time 16 such courses have been run at the Maudsley Hospital, with between 5 and 12 students in each cohort. Similar courses have been set up in other parts of the country, i.e., Chichester, Sheffield, Plymouth, Guildford and Eastbourne, but these programmes have only run for a few years before being discontinued. The reasons for discontinuation have been largely concerned with the financial resourcing of the programmes. The training in itself is very expensive and, in addition, services who second a nurse to training often need to fund a replacement for the individual.

Diagnostic groups targeted by nurse therapists

Training has focused on the treatment of patients who suffer from a range of common mental disorders known to be responsive to behavioural and cognitive behavioural treatments. Initially the core problems included in the training programmes were:

- Specific phobias
- Agoraphobia
- Social phobia and social skills deficit
- Obsessive compulsive disorder
- Sexual problems
- Habit disorders.

By and large, the programme at the Maudsley Hospital has focused on the use of behavioural techniques and in the early course of the 1970s and 1980s, exposure and response prevention were seen as the central intervention for many of the patients who attended. Social skills training was also deemed to be important, although when the early promise of this technique was not realized, its use faded. From the first course, students were provided with a significant amount of training in the use of sex therapy techniques, and the start of the course was

https://doi.org/10.1017/S1352465800004069 Published online by Cambridge University Press

greatly influenced by experts in this field based at the Maudsley Hospital – notably Dr Michael Crowe and Dr Patricia Gillan. The course at the Maudsley has continued to be greatly influenced by Isaac Marks and, perhaps for this reason, training in the use of cognitive therapy procedures was not an important feature of the course until the mid-1990s. However, other programmes training nurse therapists, notably the programmes at Sheffield and Eastbourne, have enthusiastically incorporated cognitive therapy techniques – although it would be fair to say that in all nurse therapy programmes, exposure based treatments have remained the most important element in training.

By and large, training in all nurse therapy courses has required students to bring to completion at least two patients in each of the problem categories outlined above and to use a range of treatment settings, including the patient's home and inpatient areas.

Outcome data

The first major account of the efficacy of nurse therapists was that of Marks, Connolly, Hallam, and Philpott (1977) who reported the outcome data of the first five trainees over the 3-year period. These uncontrolled data showed very significant changes in various measures of symptom and life disruption. This report was followed by an account of the cost benefits of nurse therapy treatment, this being one of the earliest economic analyses of a mental health intervention (Ginsberg & Marks, 1977). Subsequently, Marks (1985) reported a randomized controlled trial of nurse therapy interventions in primary care, comparing nurse therapist intervention with standard care from the GP. Once more, this study included an economic component. The data showed a substantial superiority of the outcomes of patients treated by nurse therapists over that of patients receiving standard GP care. The target populations in this study were patients with phobic and obsessional states. On the basis of this study and the fact that nurse therapists were increasingly taking referrals from primary care, Marks argued that this setting was the optimum placement for nurse therapy services and that approximately 1800 nurse therapists, placed strategically across the country in large health centres, could provide all of the care and treatment needs for patients with disorders known to be responsive (at that time) to behavioural approaches. As will be discussed in more detail below, this expectation has never been realized and it is doubtful, in the foreseeable future, whether the country as a whole will have more than 250 full-time equivalent nurse therapists.

All nurse therapy courses collect outcome data on every patient treated by trainees in the courses. There is a minimum data set comprising scores on problem and target ratings, fear survey schedule (Marks & Matthews, 1978) and, where appropriate, scores on valid and reliable measures of mood, obsessions and compulsions, etc. Generally speaking, trainees are expected to collect data before and after treatment and at midpoint in treatment if the patient receives more than about five sessions. Ratings are also collected at post treatment and at follow-up intervals; of 1 month, 3 months and 6 months. One study (Duggan, Marks, & Richards, 1993) reported an accumulated data set of more than 3000 patients. Although these data were uncontrolled, results were very encouraging, as the patients showed, across the board, a great reduction in ratings of symptoms and social functioning. The diagnostic groups (i.e., the core nurse therapist categories – agoraphobia, specific phobia, OCD etc) are conditions where spontaneous remission is unlikely once the disorder is established (Marks, 1987). Therefore, one can say with a certain amount of confidence

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Table 1. Activities of nurse therapists

$n = 83$	Mean-percentage of working time given to:	
	Gournay et al. (2000)	Newell & Gournay (1994)
Direct patient contact	49.8%	56.0
Management	16.4%	12.0
Supervision of others	9.9%	9.0
Teaching	7.9%	9.0
Research	7.1%	5.0
Other	8.9%	9.0

that the very significant improvements reported amounted to real change, attributable to nurse therapy interventions. The outcome of nurse therapy interventions has been reported across a range of conditions. For example, Deale, Chalder, Marks and Wessley (1997) and Chalder, Power and Wessley (1996), reported positive outcomes for patients with chronic fatigue syndrome who were in receipt of cognitive behaviour therapy. There have been a number of other reports of nurse therapy interventions with a number of conditions, for example, in obsessive compulsive disorder (Marks, Stern, Mawson, Cobb, & McDonald, 1980); agoraphobia (Gournay, 1989, 1991a, b); body dysmorphic disorder (Veale, Gournay, Dryden, & Boocock, 1996); post traumatic stress disorder (Lovell & Liness, 2000) and schizophrenia (Sensky, Turkington, & Kingdon, 2000).

Nurse therapy follow-up

All nurse therapists trained on ENB Course 650 have been followed-up in three surveys (Brooker & Brown, 1986; Newell & Gournay, 1994; Gournay, Parr, Denford, & Newell, in press). These surveys have examined clinical practice, the organization of nurse therapists' work, and career and professional development issues. The last survey was conducted in 1998 (Gournay et al., in press). At that time, the Central Nurse Behavioural Therapy Register, maintained at the Institute of Psychiatry, identified 274 individuals who had been trained as nurse therapists since 1972. Of these, 43 had moved (and not left forwarding addresses), left nursing or retired, and one nurse therapist had died. The questionnaire was sent to the remaining 231 and eventually data were obtained on 132 (57% of the sample). We obtained detailed data regarding the clinical activities of nurse therapists from 85 respondents.

As Table 1 shows, about half of the nurse therapists' time was spent in direct contact with patients, while the next largest activities are management and the supervision of others. When compared with the results of the previous survey, there is a modest reduction in the mean overall time spent in patient contact, while the time given to management seems to have increased. Obviously, the two data sets are from different (albeit greatly overlapping) populations and, therefore, one needs to be cautious about the interpretation of such findings. We then asked nurse therapists about the problem categories treated.

As Table 2 shows, the commonest disorder treated is obsessive compulsive disorder (OCD), followed by depression, agoraphobia and posttraumatic stress disorder. There is a significant increase in the numbers of patients treated with OCD and depression, compared

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Table 2. Problem categories treated by nurse therapists by percentage caseload

	Percentage of caseload	
n = 85	Gournay et al. (2000)	Newell & Gournay (1994)
Obsessive compulsive disorder	18.2	11.9
Depression	15.7	10.1
Agoraphobia (with and without panic disorder)	15.5	14.3
Posttraumatic stress disorder	11.7	—
Panic disorder	9.3	9.7
Social phobias	6.1	7.2
Simple phobias	5.7	7.5
Somatoform disorders	5.6	6.1
Sexual dysfunctions	3.3	5.2
Eating disorders	2.0	5.6

with the Newell and Gournay (1994) survey, and posttraumatic stress disorder accounts for 11.7% of the case load; this category was not reported before. As noted above, data reported come from two overlapping populations and the caveat about the caution of interpretation is repeated.

As Table 3 shows, the commonest interventions used are self-exposure (unsupervised), the use of self-help materials, response prevention and cognitive therapy. Interestingly, therapist-aided exposure was not frequently used. It should be pointed out that therapist-aided

Table 3. Techniques used by nurse therapists (mean frequencies)

	Gournay et al. (2000)	Newell & Gournay (1994)
Self exposure (unsupervised)	3.44	3.43
Self help manuals/books	3.12	(less than 1)
Response prevention	2.85	2.40
Cognitive therapy (Back)	2.85	2.67
Problem solving for neurotic disorders	2.73	2.35
Cue exposure	2.69	2.21
Exposure in imagination	2.26	(less than 1)
Behavioural counselling	2.22	2.24
Breathing retraining	2.15	2.36
Social skills training	1.68	1.68
Therapist aided exposure	1.52	1.65

* Other interventions rated at less than ‘‘sometimes’’: taped exposure, social skills training, sexual skills training, relaxation training, home visits, computer assisted therapy, biofeedback, video feedback, controlled drinking, tranquilliser withdrawal, motivational interviewing, other cognitive therapies, covert sensitization, habit reversal, contingency management, fear scripts, problem-solving for psychoses.

Frequencies rating 0–4 (0 = never, 1 = rarely, 2 = sometimes, 3 = often, 4 = most of the time)

https://doi.org/10.1017/S1352465800004069 Published online by Cambridge University Press

exposure and other techniques rarely used, such as social skills training, sexual skills training, covert sensitization and habit reversal, were central techniques in early nurse therapy programmes. Very few responders reported using interventions for psychosis, although a small number of our respondents reported dedicating very significant amounts of their clinical time to this area.

All nurse therapists are Registered Nurses in Mental Health, although a majority of our respondents also hold qualifications in other branches of nursing or are qualified nurse teachers. Twenty-six of our respondents had undertaken further courses in cognitive therapy since training, attending the Diploma courses at Oxford, Newcastle or the Institute of Psychiatry. Thirty-five nurse therapists had a first degree alone, and another 35 also held a higher degree – 26 Masters and 9 PhDs. Fifty-five of our respondents had undertaken at least one research project, while 38 respondents had published at least one journal article or chapter. All the nurse therapists, apart from two, were employed at H Grade or higher, and 33% of our respondents were employed on management or education grades, which generally paid better salaries than the clinical gradings. Membership of the British Association of Behavioural and Cognitive Psychotherapy was reported by 81% of our respondents. All bar three of our respondents reported receiving supervision. However, the frequency and nature of supervision was variable, with 42% receiving individual supervision, 22% receiving group supervision, and 36% receiving a mixture of individual and group supervision.

Discussion

The survey provides a broad picture of nurse therapy in the U.K. today. Overall, our respondents seem to maintain a strong commitment to clinical practice, while there is also a significant amount of research and teaching carried out. Most nurse therapist's referrals come from primary care, the proportions of referrals from various sources being broadly similar to the previous two surveys.

With regard to clinical practice, there is an interesting shift in the problem categories, with striking rises in the number of patients with OCD and depression. The increase in patients with OCD may be due to an increased public awareness of this condition and, therefore, a more general increase in referrals to psychiatric services. It is interesting to note that nurse therapists seem to use response prevention as the main method of treatment. The increase in numbers of patients suffering from depression is noteworthy, as is the high frequency of use of cognitive therapy. One could argue that the inclusion of depression as a target area for nurse therapists is logical, as the evidence base for the treatment of depression with psychological strategies has become more robust. On the other hand, this shift away from the core categories of phobic anxiety, OCD and habit disorders could be problematic, as one might argue that the training programme (even with the modifications that have been made in recent years) has not been designed to provide a systematic and detailed training in cognitive therapy. Rather, as the training stands, cognitive techniques are added to a range of other strategies such as exposure, response prevention and skills training. It might be argued that the cognitive therapy skills acquired by therapists during their 18 months training are not sufficient to support autonomous practice with this condition. It is true that a substantial number of respondents from our survey have taken further courses in cognitive therapy at the leading cognitive therapy training centres. However, based on the picture gleaned from this survey, one must assume that the cognitive therapy applied by

https://doi.org/10.1017/S1352465800004069 Published online by Cambridge University Press

nurse therapists may be variable in its quality. There is also another argument to be considered, i.e., that of the targeting of a number of core conditions by nurse therapists and the possible consequent dilution of effect by increasing that number of conditions. Even in 1985 Marks argued that it would take approximately 1800 nurse therapists in the country to deliver the necessary treatments to those patients in the core categories (of phobic and obsessional states). At the present time we are still woefully short of that ideal number. It could also be argued that the treatment response of patients with agoraphobic symptoms or OCD to behavioural and cognitive behavioural treatments is of a much greater magnitude than that of patients with depression. One needs to bear in mind that there is clear evidence about the very low rates of spontaneous remission for conditions such as OCD and agoraphobia and the great superiority of behavioural and cognitive behavioural treatments over other psychological approaches. The same cannot be said for depression and its treatment with cognitive therapy. Depression is a notoriously fluctuating condition with high rates of spontaneous remission and, in this area, the superiority of cognitive therapy over other psychological treatments such as interpersonal therapy is far from established.

The National Service Framework for Mental Health sets out some very ambitious targets for the treatment of common mental disorders and for the use of cognitive behavioural approaches. As this author has pointed out before (Goldberg & Gournay, 1997), the work force of clinical psychologists and nurse therapists is woefully inadequate. Clearly, we must consider whether the nurse behaviour therapy model should be continued in its present form or whether the time has come to consider other alternatives. Obviously, the newly emerging computer technologies may deliver a great deal of effective self help (Marks, 1998). However, we have to consider other solutions. One possible answer may be training significant numbers of community psychiatric nurses (CPNs) in cognitive behaviour therapy, perhaps to somewhat lower levels of expertise than that required by nurse therapists or clinical psychologists. However, given that the 6800 CPNs in England are still struggling to provide a decent service for people with serious mental illness, only a considerable expansion in the CPN workforce will make such training initiatives with common mental disorders possible. There are of course other groups of nurses who could (potentially), deliver some cognitive behaviour therapy and, similarly, we might consider providing them with briefer forms of training. For example, we have known for many years that health visitors can be effective in detecting postnatal depression (Holden, Sagovsky, & Cox, 1989), and it might be that there is a role for them in the psychological management of the more straightforward cases of depression. Similarly, there are approximately 30,000 practice nurses n this country who have very wide ranging contact with people with mental health problems (Gray et al., 1999). It might be argued that they could assist in the dissemination of computer assisted self-help programmes, or indeed deliver some of the more straightforward interventions in panic disorder and phobic avoidance. Indeed, along with David Richards, one of the joint editors of this special issue, the author is collaborating on a trial being run from the University of Leeds, which is examining such a role for practice nurses. Perhaps the time has come to be much more radical in our thinking about the application of psychological treatments and to consider providing high quality training programmes to people without professional backgrounds. An obvious target group are counsellors, who number several thousand and who have provided ‘‘treatments’’ for patients in primary care and other settings for many years. A strategic approach to the systematic retraining of these individuals, many of whom may

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have basic human attributes for the role of psychological therapist, seems an obvious solution to be pursued.

In conclusion, it must be said that the model of nurse therapy training developed by Isaac Marks nearly 30 years ago has become firmly established as part of our provision of psychological treatments for people with a range of conditions. The evidence base for nurse therapy is sound and surveys show that, post-training, nurse therapists continue to deliver a substantial range of clinical interventions and the research output of graduates from nurse therapy courses is commendable. Nevertheless, nurse therapy interventions reach a relatively small minority of people with common mental disorders, and the challenge for the future is to examine how this training can be modified to produce significant numbers of competent practitioners. As matters stand, the majority of people with common mental disorders in this country do not have access to decent psychological treatment and, without major reconsideration of this problem and the development of strategic plans across the country, the National Service Framework targets, underpinned by the principle of equity of access to effective treatment, seem doomed to failure. Without doubt, a major development in training needs to be a truly multidisciplinary approach, breaking down the tribal boundaries. Certainly, because the nurse therapy training is currently restricted to Registered Mental Nurses, this approach is characterized as much by the ''tribalism'' as is clinical psychology training. While there is a substantial set of arguments for retaining the unique character of each of the contributing professions to mental health care (these arguments were fully discussed in the Sainsbury Centre Initiative, *Pulling together*, 1997) we should certainly examine our whole approach to the training of therapists in cognitive behaviour therapy. Not only do we need to consider how nurses, psychologists and psychiatrists should be trained together, but we also need to ask whether there are any arguments for excluding people who do not have these background professions from training. Perhaps we need to reflect once more on Isaac Marks' approach to tackling the problem of the dissemination of effective treatment and ask how much we have really advanced in the last 30 years.

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