Contemporary Themes

Psychiatric Nurse as Therapist

I. M. MARKS, J. CONNOLLY, R. S. HALLAM

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Summary

Under supervision five nurse-therapists have treated phobic patients as successfully as have psychiatrists and psychologists using similar psychological treatments in comparable psychiatric populations. Nurses have also had good results in other neurotic disorders. Intensive training is required. Nurse-therapists find their work rewarding, but the present Salmon gradings make no provision for their advancement should they retain their clinical function. Results suggest that the use of selected psychiatric nurses as skilled therapists can ease the current critical shortage of treatment personnel in psychiatry.

Introduction

In the past few years effective new psychological treatments have been evolved for some psychiatric disorders. Qualified personnel to give these treatments are scarce and throughout Great Britain many patients are turned away for lack of therapeutic facilities. Efficient delivery of services is thus a serious problem. To solve this it would be uneconomic to train many psychiatrists and psychologists simply to administer the newer psychological methods, since so much of their training and skill is redundant to the therapeutic tasks involved. People with shorter training might be able to do the job just as well. This paper reports the results of treatment by psychiatric nurses trained as therapists. Under supervision their results have been at least as good as those of psychiatrists and psychologists working with comparable patients and techniques.

There are several classes of personnel who could be considered as potential therapists for hospital patients, but psychiatric nurses are the most obvious. They already play an active part in psychological treatments in many centres and have knowledge of psychiatric syndromes, modes of relating to patients, and problems of hospital administration, and as a profession are searching for a more clinical role. In Britain and in many other countries there is a trend to accord nurses greater clinical responsibility, a move which can help to ease the manpower shortage and increase the status and attractiveness of the nursing profession for future recruits. This idea is not new. Traditional roles of this kind are those of the midwife and district nurse; recently nurses have assumed more responsibility in intensive care units. In other countries there are anaesthetic and dental nurses. These are front-line workers who carry out day-to-day clinical interventions but call for specialist help when complications need to be dealt with. In line with this trend the present study aims to relieve the shortage of treatment personnel by developing a new grade of psychiatric nurse who can act as a therapist under psychiatric and psychological supervision. The present study is operational research funded by the Department of Health and Social Security over three years to train a small number of psychiatric nurses as therapists, to evaluate their results, and to carry out a social cost-benefit analysis of their work. It is hoped that a new therapeutic grade of psychiatric nurse will emerge who can deal with adult neuroses and personality problems. Their patients will be selected by psychiatrists and treated under the supervision of a psychiatrist or a psychologist. Far from replacing psychiatrists and pyschologists, such therapists will, in fact, increase their effectiveness and the number of patients they can treat by proxy while maintaining quality control.

The aim is not to develop mere behaviour therapists or technicians but rather workers familiar with psychological treatments drawn from many sources including psychodrama, abreaction, group therapy, and counselling. The role of such therapists involves wider skills than those required for operant or token economy programmes, though the latter are included in their training. Wider expertise is essential because unless the therapists can exercise good judgement and a variety of skilled interventions in day-to-day treatment they will need such extensive psychiatric or psychological supervision that the whole point of their training will be lost.

The present programme concerns five nurses with the R.M.N. as their minimum qualification. They were selected out of 80 inquirers, most of whom were male. Of the five trainees three are male and three also have the S.R.N. as an additional qualification. All are in their 20s and were either charge nurses or sisters or staff nurses at the time of selection. In this research scheme they have charge nurse or sister status. Training is carried out by a psychiatrist and psychologist, who are both engaged full-time on the project. The bulk of treatment concerns outpatients at the Maudsley Hospital. Inpatient work is carried out in a ward at the Bethlem Royal Hospital. Much treatment is also carried out at home.

Training and Method

Training consists of seminars, case discussions, videotape demonstrations, films, ratings, and treatment under supervision. There are two ward rounds weekly, one concerning outpatients and one concerning inpatients, plus additional supervisory sessions. All patients are first seen diagnostically by a psychiatrist and selected if suitable. The treatment formulation is made by him or by a psychologist and the thera-

Institute of Psychiatry, London S.E.5
I. M. MARKS, M.D., M.R.C.PSYCH., Senior Lecturer and Consultant Psychiatrist
J. CONNOLLY, M.R.C.P., D.P.M., Research Worker and Honorary Senior Registrar
R. S. HALLAM, DIP.PSYCH., PH.D., Research Worker and Lecturer

pist then executes the overall treatment plan, which is reviewed weekly or more often when necessary. This plan is written with a statement of treatment aims, methods to achieve those aims, residual problems to be expected, and arrangements to be made for follow-up. Each treatment session is also recorded in detail on a special sheet. When the patient is discharged the therapist writes the final letter to the general practitioner, and this is subjected to critical comment at a ward round. The treatment of each patient is thus carefully documented at every stage with emphasis on what treatment is trying to achieve for each patient, the success with which the aims are being fulfilled, and the manner in which this is being effected. Steps in treatment are made explicit.

An important aspect of the therapist's work is that the patient sees him as the main person responsible for his treatment. The therapist is responsible for his own patients under supervision. Early in training initial treatment sessions were carried out jointly with the psychiatrist or psychologist, but as competence was acquired the joint sessions were faded out and are currently used only when the treatment technique is new to the therapist or presents special complications or to provide modelling for the therapist or when the therapist requests help. Most treatment sessions are now carried out by the therapists on their own.

Weekly supervisory sessions are concerned with review of aims and progress, discussion of patients' reactions to therapeutic interventions, decisions about treatment tactics when these need to be changed, reward of therapists' efforts, review of possible mistakes, and the handling of transference problems.

Topics covered by the syllabus include detailed aspects of the psychopathology of those conditions which therapists treat. Emphasis is on adult disorders. There are additional weekly seminars on the theory and practice of psychological treatments.

Therapeutic Methods.—Methods of treatment used by the therapists cover a wide range of skills. They carry out exposure (desensitization and flooding), both in fantasy and in reality, modelling and operant methods, response prevention, thought stopping, guided fantasies and self-regulation, and are also acquiring facility in difficult interpersonal skills such as role rehearsal and contract, family, and marital therapy. Quite a few patients need several kinds of therapeutic interventions for enduring success. The therapists have shown themselves capable of administering these with expertise.

Patients Treated.—Therapists are given as wide a range of clinical experience as possible. They began with simpler problems like focal phobias, worked their way through social and agoraphobias, and are now also treating complicated obsessive-compulsive neuroses, abnormal personalities, marital disorders, and many other problems. Details of patients treated so far are given in the table. Most patients can be treated as outpatients, which is economic, but a minority require careful inpatient management. A substantial number of patients also require extensive treatment at home and with their family. This calls for the utmost tact and skill by the trainees, a challenge which they have successfully met.

Patients Treated by Therapists (April 1972-January 1973)

Outpatients (n = 71)	
Agoraphobias	17
Social phobias	13
Other phobias	22
Obsessive-compulsive neuroses	9
Self-mutilation	1
Trichotillomania	1
Stammering	2
Personality disorders	2
Marital disorders	3
Obesity	1
24 now in follow-up phase	
8 Dropouts	
Inpatients (n = 12):	
Obsessive-compulsive neuroses	9
Phobic	1
Personality disorder	1
Hysterical conversion reaction	1
2 Dropouts	

Many patients had mutliple problems requiring family and marital therapy; 13 patients required home treatment given by therapist.

Selection of Patients.—Out of 115 patients screened diagnostically by psychiatrists over a six-month sample period 68% were considered suitable for and taken into psychological treatment, a further 17% were considered suitable but declined the offer of treatment, and 15% were unsuitable as they needed other forms of management. Most patients seen in our special clinics could thus be treated by the methods used by the nurse-therapists. In routine outpatient clinics a conservative estimate is that 10% of all psychiatric outpatients would benefit from the newer psychological techniques as a major aspect of clinical management.

Assessment of results is of prime importance. Fortunately methods of assessment of neurotic patients are now well tried. The measures vary from problem to problem but follow the same basic plan, so that comparable figures will became available for most classes of patient. All patients are assessed before treatment, at the end of treatment, and through follow-up over one year. Together the patient and therapist select the two main target problems for which the patient requires help. These are selected after discussion of which handicaps most prevent the patient from leading a normal life. The two main target problems are rated by the patient and an observer who will not be implicated in treatment; fear and personality questionnaires are completed. Details of work and leisure adjustment are obtained as well as a crude estimate of the economic disturbance caused by their problems.

Two strategies were logically possible to compare the results of nurse-therapists with those of other professions. Ideally one would compare patients assigned at random for treatment by nurse-therapists and by psychiatrists and psychologists, equating diagnosis and treatment method. This would be very expensive and take a decade to accumulate meaningful results. A more practicable strategy, which we have adopted, is to compare results obtained by therapists with those obtained in past studies of comparable patients treated by similar methods by psychiatrists and psychologists. Much data are available on this already, and care was taken to assess patients in this research by means similar to those used with psychiatrists and psychologists as therapists.

Reliability of Measures.—The reliability of our main scales[1] had already been established in eight previous studies with psychiatrists and psychologists but was reviewed again when used here with nurse-therapists. In the present study with phobic patients ratings of the main target problem showed a correlation of 0·95 between one therapist and another seeing the same interview on videotape before treatment and interviewing the patient separately after treatment, and 0·84 on change scores between patients and therapists. The main rating thus shows very satisfactory reliability. Ratings of an independent observer (an uninvolved clinical psychologist) are also being accumulated at one month of follow-up to provide an external check on our own bias; ratings to date yield a picture similar to that provided by measures from the patient and from the therapists.

Results

The nurse-therapists have taken to their new clinical role with verve and aptitude, have carried out demanding clinical treatments with skill, and have shown themselves capable of the tasks originally envisaged for them. Not only have they been enthusiastic, but their energy has led to considerable

therapeutic benefit for their patients. This is the main point of our research.

Of the 31 patients who have completed treatment so far 23 —all outpatients—had phobic disorders. This is because the therapists necessarily began with easier problems like specific phobias and gradually extended their experiences to more complex disorders. The latter results are being accumulated.

The results of therapist treatment of phobic disorders are shown in fig. 1 (23 patients at the end of treatment, 21 at one month of follow-up to date). The first target problem is the main phobia, as rated by the patient and the therapist. Mean treatment time for the patients as a whole is nine weeks with an average of 10 sessions. These patients improved highly significantly ($P < 0.001$) during treatment by exposure methods. A rating of 7 indicates almost complete avoidance and of 2 uneasiness but no avoidance of the phobic situation, so that the change in ratings after treatment indicates substantial improvement in these patients. Most treatment sessions were of true exposure but some patients had desensitization or flooding in fantasy and a few had guided fantasies. Some patients required only one session of treatment for satisfactory gains while others needed several dozen sessions—the scatter is wide. Results have remained stable at follow-up, which so far is six months for 15 patients.

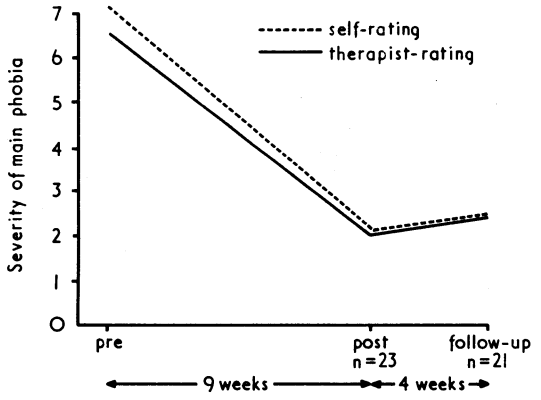

FIG. 1—Improvement in main phobia after treatment by nurse-therapists.

Results by nurse-therapists are superior to those obtained with desensitization in fantasy by psychiatrists and psychologists.[2-5] A fairer comparison, however, is with patients treated by psychiatrists using the more powerful method of flooding in vivo. Here again the results obtained by nurses compare well with those of psychiatrists (fig. 2). The study of Boulougouris *et al.*[6] had a mean of 15 treatment sessions in a group of agoraphobics and other phobics. That of Watson *et al.*[7] was in specific phobics with a mean of three prolonged sessions of treatment. The patients treated by the nurse-therapists have been a mixture of nine agoraphobics, 10 specific phobics, and four social phobics. It is obvious that the results obtained by the therapists so far are at least as good as those obtained by psychiatrists in previous studies. Follow-up will continue for at least a year, as in the study of Boulougouris *et al.*,[6] and longer than the three to six months of Watson *et al.*[7]

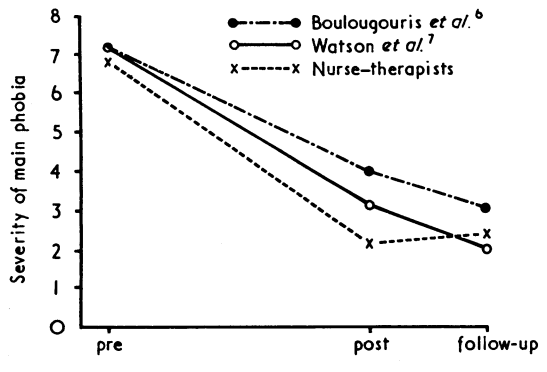

FIG. 2—Outcome of nurse-therapist treatment of main phobia compared with previous results.

Not only did the patients improve significantly with respect to their main phobias but their general fear score also diminished significantly (< 0.01) (fig. 3) on a questionnaire measuring the overall tendency to fear in a wide variety of situations, based on that used by Marks and Herst.[4] Improvement in phobias was accompanied by significant improvement in work or home adjustment in those patients who had impairment of work before treatment ($P < 0.001$ (fig. 4). Where work or home adjustment was satisfactory beforehand this remained so after treatment.

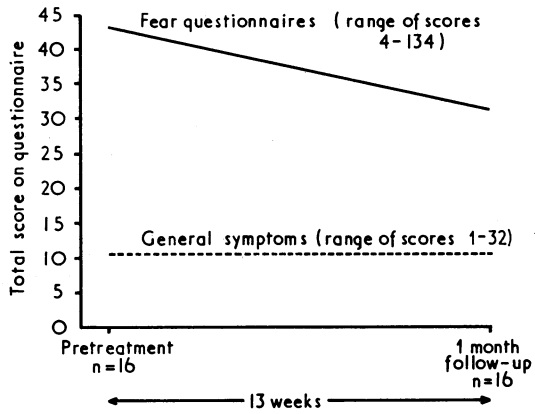

FIG. 3—Improvement in fears and general symptoms in patients treated by nurse-therapists.

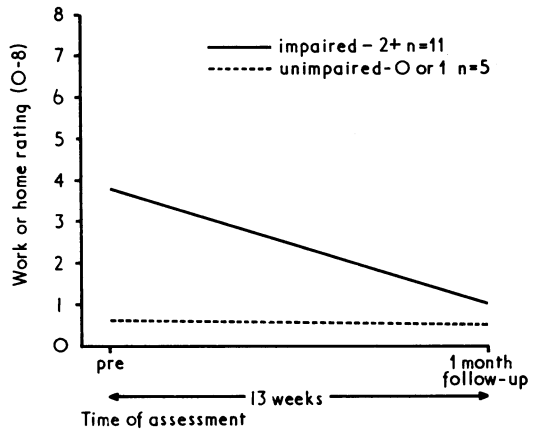

FIG. 4—Improvement in work or domestic efficiency.

These results are thus very encouraging in that nurses have treated phobics as successfully as have psychiatrists in comparable populations. Of course, results may be less good in field conditions in remote areas where supervision might be less intensive, or with therapists who are selected less

carefully, but this is for future study. The following two cases illustrate wider aspects of the work of the therapists, and especially the way they carry out family and other treatments.

CASE 1

The first patient, a 21-year-old girl of borderline intelligence, was referred for treatment of agoraphobia of one year's duration and obsessive-compulsive handwashing for six months. She had a right-sided hemiparesis extensively investigated in our neurology and neurosurgery department and thought to be congenital. She was also prone to temper outbursts two or three times a week during which she would shout, scream, swear, and try to strike her parents. She was unable to walk more than five minutes away from home, though she would travel freely if accompanied. She washed her hands dozens of times a day after touching objects she considered dirty or sticky.

The agoraphobia was treated by exposure in vivo. The patient was treated in a park and on buses and tubes during rush-hour, first accompanied and finally alone. She co-operated and after 17 hours of treatment given over eight sessions became able to travel alone by bus to and from a day centre and to shop alone in crowded supermarkets (fig. 5).

At initial assessment the patient's mother heard the principles of exposure treatment and, unasked and unknown to the therapist, applied these to her daughter's compulsive handwashing, making her dirty and preventing her from washing. This resulted in rapid improvement in the patient's compulsions (fig. 5). The mother then requested treatment for her daughter's temper tantrums.

A family conference was held attended by mother, father, the patient, and the therapist. The patient had had five temper tantrums in the two weeks preceding the conference. During a tantrum the patient might break a glass and cry, upon which the mother might say "come, don't worry—it's all right." The patient would tell her mother to shut up; the mother would say "that's not a nice thing to say." The patient would scream "shut up you silly cow," run to her room, and try to strike someone. She would continue shouting insults from her room for up to half an hour. Both parents rarely praised the patient, and at the conference, pointing

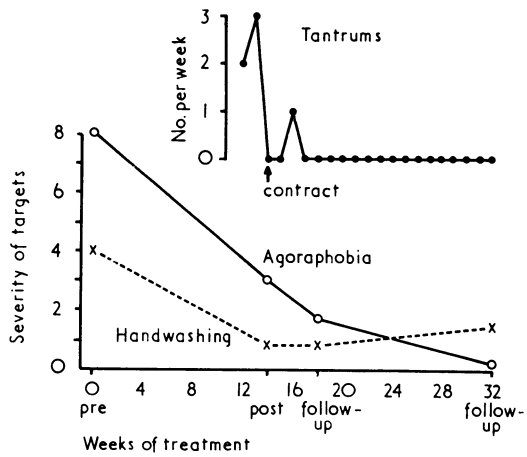

FIG. 5—Case 1. Elimination of phobic, obsessive, and tantrum behaviour.

to a photograph of the patient as a child, the mother said, "look what we had as a child and now look what we've got." The mother then grumbled that her daughter never did anything around the house without being told, and the father complained that she could not even remember how many spoons of sugar her parents took in their tea.

The family agreed to try contract therapy. The parents were instructed to ignore tantrums and when one seemed likely they were to turn and walk away. They were warned that the tantrums might initially increase in frequency before they diminshed. Other contract items were as follows: (1) the patient was to try hard not to have a tantrum, in return for which the family would give her a special reward of her own choice after three days free of tantrums; (2) the patient had to volunteer to do things around the house—help with the cleaning and cooking and make evening tea. For any of these helping behaviours the rest of the family had to praise her a lot, show approval, and give her a kiss and a cuddle. The patient was instructed to allow the parents to do this even if she found it embarrassing.

The contract-building and two family conferences took four and a half hours and progress was monitored by daily and later weekly telephone calls. After contract therapy began the patient had only one minor tantrum when provoked by a child outside her home. She has become much more helpful around the home, makes her own bed, cooks, and makes evening tea. Progress with regard to tantrums, agoraphobia, and compulsions has remained good over six months of follow-up (fig. 5).

CASE 2

This patient a 27-year-old married woman, was referred for compulsive picking of scabs on her 18-month-old son's face and body. This necessitated her son being removed from home for long periods until the scabs or scratches had healed. In addition the patient often beat her children, was frigid, and had marital problems and hypochondriacal ruminations. Her scab-picking also involved lesions on her own face and to a less extent her 4-year-old daughter.

She had had much previous psychiatric treatment before admission to the Bethlem in March 1972. She was first treated by a psychologist using flooding with response prevention and by a psychiatrist with abreaction. Neither approach had any success.

The therapeutic strategy was then changed. In the ward it was noticed that the patient showed no maternal behaviour towards her son. A female therapist then modelled maternal behaviour for the patient in the hope that this would diminish her tension and thus reduce her scab-picking. Treatment sessions consisted of the therapist playing with and cuddling the child with the mother present. The mother was encouraged gradually to participate, and was praised liberally when she did. Subsequently artificial scabs were painted on to the child's face and the patient was instructed to ask for reassurance from the nursing staff if she had the urge to remove these scabs. Improvement in the scab-picking rapidly followed (fig. 6). The therapist then included threatening situations in the treatment sessions—for example, the boy stood on tables and chairs and jumped into the therapist's arms and later into the mother's arms. He was encouraged to run over gravel paths and roll on grass, situations in which he was likely to sustain minor scratches. At home the patient had refused to let either child play inside or outside the home lest they should fall. The patient was then encouraged to undertake everyday tasks in which she would see the artificial scabs—for example, dressing and undressing the child, bathing and washing the hair—activities during which she was most likely to pick scabs and beat the children excessively. Early sessions began with mother as onlooker, and gradually she began to do it under supervision. She was shown how to apply petroleum jelly to the scabs when she got the urge to pick as an alternative response.

Home visits were arranged to allow modelling in other situations and to involve the second child. During journeys by bus and train to home the therapist further modelled maternal behaviour. At home the patient's parents were re-educated regarding their interaction with the children, their interference with her management, and constant reference to the ill appearance of the children. Great tact was needed to handle the family conference involving three generations. The patient was also relaxed and desensitized in fantasy over seven sessions to situations in which her children might injure themselves.

Treatment of the marital and sexual problems then began. Contracts were set up in which the husband agreed to attend to the garden in return for which his wife would cook a meal of his choice. During joint interviews specific items of behaviour were nominated from each partner and matched. These were recorded on daily record sheets and both were given a copy on which was recorded his or her own behaviour as well as the spouse's. The patient spent increasingly long periods home at weekends and was then dis-

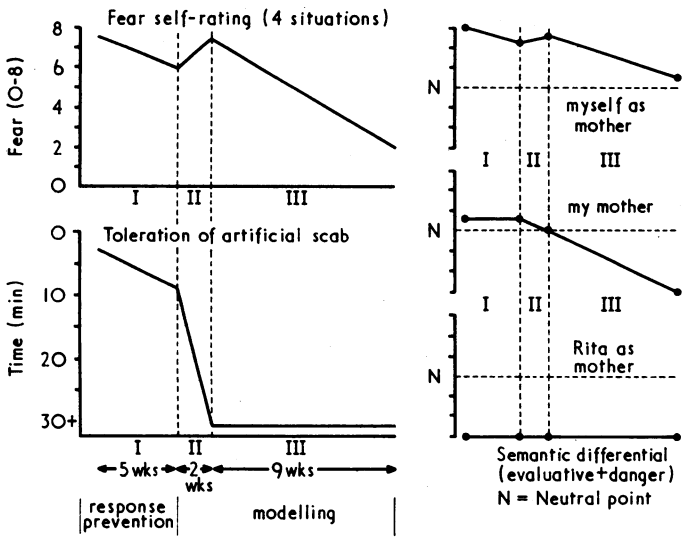

FIG. 6—Case 2, compulsive scab-picking. Change in attitude, fear, and avoidance. Rita is a friend of the patient.

charged. Sexual difficulties were discussed. The patient was desensitized in fantasy for her frigidity and instructed how to use the squeeze technique for her husband's premature ejaculation.

The patient completed 45 sessions of treatment with the therapist. She was then able to tolerate the scabs on her son's face without picking them, the relationship with her husband had improved so that they did not criticize one another, and she also got on better with her own parents. She then for the first time allowed her children to roam and play freely around the home and garden, had no difficulty in bathing the children and only rarely ruminated (fig. 6).

During nine months of follow-up in the outpatient department improvement has been maintained, though booster treatments are still needed intermittently for residual problems.

Social Cost-benefit Analysis

Because phobic and obsessive-compulsive disorders can be defined fairly accurately, measured easily, and treated with reasonable success—a situation not prevailing in many psychiatric conditions—they lend themselves to a social cost-effectiveness study in which the gains to the patient can be weighed against the cost of therapy. An economist will shortly join our team to examine this aspect. There are many problems here in that an economic tag can be placed on items like unemployment and sickness benefit but not on unhappiness. A start, however, can be made in assessing the value obtained for a specifiable expenditure by the N.H.S. This might help the formulation of rational patterns of spending on health care in the future.

General Issues

These are many. The first is placement of present trainees at the end of the present project. Their prospects for employment are excellent and there will probably be many places for future batches of trainees. A more difficult problem is the grade at which they will work. At the moment therapists are grade six on the Salmon scale and by good fortune may manage to reach the seventh (nursing officer) grade while retaining some clinical responsibilities. Present trainees emphasize the rewarding nature of their clinical work and have no desire to be sidetracked into administration. Nevertheless, the current nursing structure and the Briggs report have made no provision for a clinical tree which clinical specialists can climb without abandoning their work with patients. There is no place in the present hierarchy for clinical nurses beyond grade seven at the most. This is a serious issue which will need to be resolved if the role of nurses as clinical specialists is to be furthered.

Our experience suggests certain conclusions about training. In the present research the active phase of training is 18 months, but it may be possible to plan future intensive courses lasting a year. It is doubtful whether more than six nurse-therapists can be adequately trained simultaneously in any one centre, and this requires the full-time efforts of a psychiatrist and a psychologist. The psychiatrist engages in case selection and the psychologist in measurement of results. They share the treatment and supervision. A large outpatient turnover in the parent hospital is needed to supply suitable cases for treatment, and an inpatient facility is also required for a minority of patients. In addition the training centre needs to be able to administer treatment in patients' homes and to run a follow-up service. If and when formal diplomas and syllabuses are agreed a small number of national training centres to produce such therapists might be set up. Therapist services (as opposed to training schemes) might serve an area of a million people rather than the smaller district of a quarter-million, but this is a matter for further study. Qualified therapists need to be linked either to a psychiatrist or to a psychologist depending on the population to be treated and the facilities for case selection and supervision.

The way seems to be opening up for more rational deployment of N.H.S. personnel to allow currently effective treatments to reach more of the patients who need them and can benefit from them. Only in this way will the quality of life of such patients improve and their expensive demands on community resources diminish. Psychological treatments of conditions like phobic and obsessive-compulsive disorders are sufficiently potent to make the old dream of preventive psychiatry a more real possibility. Treatment of patients in the acute phase might prevent chronic disorders of the kind which now place such a strain on facilities for health care. This possibility, however, will become realizable only if the shortage of treatment personnel can be solved. The experience already gained from the present study suggests a practical way of easing this problem.

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