

NURS/MIDW 555

**Cognitive Behaviour Therapy in
Psychosis;**

Relevance to Mental Health Nurses

**By
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2001

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Relevance to Mental Health Nurses**

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**A Research Paper Submitted to the Victoria
University of Wellington**

**In partial fulfilment of the
requirement for the degree of**

Master of Arts (Applied)

In Nursing

Victoria University of Wellington

2001

Abstract

The background to this research report is my personal and professional belief that more can be done in caring for people who experience psychosis.

Psychosis can be a life-threatening illness; about one in ten young men with psychosis will take their own lives. It ravages individuals and robs families and societies of what may have been. Over the last 25 years there has been great progress in the treatment and nursing approach to psychosis, however much of this progress has been predicated on a biological explanation of psychosis. The late 1990s have seen increasing interest in psychological approaches in the treatment of psychosis; notwithstanding that this treatment does not work for all people. This has caused me to examine critically what else might work and why. My intuition is, that Cognitive Behavioural Therapy (CBT) may offer a way forward. It seems that as I have come to a greater understanding of CBT, its theory and its process, it has become increasingly clear that much of what mental health nurses do is, in fact, CBT.

The first aim of this research report is to understand a little about CBT, through

- exploration of the origins of CBT and
- examining the theoretical basis and
- reviewing the evidence that may support its use.

The second aim is to explore the evidence around mental health nurses' training and use of CBT, by critically examining some of the major UK and Australian reports.

I believe that for New Zealand mental health nurses, CBT will be the next major mental health movement in which they are involved. I consider CBT is theoretically and pragmatically compatible with contemporary nursing practice. It seems on the evidence I have found, that potentially, this approach offers the way forward for nurses and a way back for clients.

Acknowledgments

LEO, who represents a number of people I have come to know. In my view Leo epitomises courage in the sense that he suffers alone and deals bravely with his life. He experiences a devastating illness that currently has a poor prognosis.

To my wife, and partner, Clara who has supported me unconditionally through this journey and without whose help this project would not been completed.

To the many colleagues who have encouraged and supported me to identify and complete this thinking and writing.

I am fully grateful to my supervisor, Chris Walsh, and the Graduate School of Nursing and Midwifery (Victoria University of Wellington) for their support and advice in getting to this point in my inquiries.

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2.00 Introduction to Terms Used

For the purpose of this review, I will use the term psychosis to mean a disorder of thought that is characterised by hallucinations and delusions. Delusions occur when people make illogical associations and develop often-bizarre explanations for their feelings that are seen as false beliefs. Hallucinations are false perceptions often associated with visions or voices. For the person experiencing them they are real, they can literally see, taste, feel, or smell the phenomena.

I have chosen not to use the term schizophrenia or schizophrenaform in the body of this paper (unless these terms are used in reports quoted), as these words present difficulties of continuity across studies. There is currently no agreement around a valid and reliable definition of schizophrenia. There is no consistent pattern of symptoms in schizophrenia, no predictable course of the condition, and no particular treatment. It seems unlikely that there is a single cognitive deficit that can explain the disorder of schizophrenia (Bentall, 1996). I have used the term psychosis in a selective sense. I have deliberately excluded organic brain and toxic psychosis from my investigation because they are specific and different subjects worthy of investigation in their own right. To include them in this paper would potentially confuse the subject I am interested in and obscure the clarity I am seeking.

There are a wide variety of symptoms evident in psychosis. Psychosis is a very serious mental disorder; and runs across culture, gender, and race. The severity and extent of the disorder vary among individuals; it affects about 1% of New Zealanders (Jones,

Cormac, Mota, and Campbell, 2000). Psychosis is a life threatening illness, showing increased mortality rates. The disorder often emerges in people who are in their early twenties and can be progressively disabling, affecting every conceivable aspect of human experience (Drake, Cotton, 1986).

Delusions and hallucinations are often associated together in psychosis. Psychosis is a word used to describe hallucinations and delusions and both are frequently found in schizophrenia but not always. A useful way to look at psychosis is to consider positive symptoms and negative symptoms. Positive symptoms of psychosis include hallucinations and delusions. Negative symptoms include a lack of energy, increased social isolation and a lack of motivation.

Other terms used in this paper will be explained as they occur. I have tried as far as possible to use the same terms in all sections of the paper except where specific research reports refer to particular words or terms.

3.00 Introduction

I want to begin this project by telling a story and I will locate the relevance of this research project to contemporary mental health nursing. As the reader finishes the story, I hope that they are able to gain a sense of what it might be like to experience a major mental disorder (psychosis), and what it might be like to work with a person who finds themselves in this situation.

My nursing experience of psychosis is that it often occurs in men at around the age of eighteen. It is a potentially life threatening illness. The likely course of the illness is characterised by a slow deterioration in personal and social functioning. The active symptoms of psychosis are hugely distressing to the individual, their families and friends. Current treatment approaches are problematic with many people failing to respond positively to treatment. It is for these reasons that it is professionally timely and challenging for me to look again at my approach to the nursing management and treatment of psychosis.

The characters in this story are myself, and a person called Leo. Leo is a composite based on people I have come to know and respect and does not actually exist. Leo represents a fictional client who reflects the issues I want to address in this paper.

3.01. Leo's story

Leo is a tall slim man with brown eyes; he is in his late twenties. He lives alone in a small one bedroom flat in a poor suburb of a small city. Although Leo lives alone he is never really alone, for Leo has a psychotic disorder. For Leo this means he is never without 'the voices'. These voices assail him for the entire time of his waking day and he has no control over them. This has the effect of totally preoccupying his mind, to the point where he is unsure about what is real and what is not; he is unable to distinguish reality (the world) from his inner psychotic world.

For Leo the content of the voices is one of criticism. They constantly criticise, abuse, and degrade him. The voices are a manifestation of his psychosis and seem only partly moderated by his current drug therapy.

At a time in Leo's life, before his psychosis, he was part of a large family. Although spread all over the world, the family would keep in touch and celebrate family events, such as the birth of a child or the birthday of their elderly parents. Leo was part of, and connected to, a family of people for whom he gave and received love.

Leo experiences psychosis as an unremitting enduring tirade of abuse and degradation, therefore he is unable to relate to people, his family, or his society. Indeed, he is unable to relate to himself. He has no sense of the context of the real world, as perceived by others. Trapped in a world of psychotic distortions, he is unable to make connections with people. The effect of this experience has left Leo estranged from family and friends. He appears as weird or dangerous, as his face contorts in bizarre grimaces and he responds to people who are not there. He makes comments that do not relate to

reality and are strange and unpredictable. His family have been hurt, upset, and confused by this change in his demeanour. His parents and siblings are no longer able to support him for fear of what may happen. He is no longer receives invitations to family get-togethers. Rather, he receives a card and present at Christmas and on his birthday. He is in a sense alone and is not able to be part of the world of others. He simply does not have the intellectual, moral or social skills available, which would enable him to partake in society.

3.02. Nicks story

I see Leo as a bright man; he was intelligent and outgoing. Before his psychosis, he was a second year student at university studying accounting and statistics. He was considering a career in teaching. Soon after the emergence of his psychosis he became unable to concentrate or organise his study and so dropped out of his courses. Leo came to the attention of the mental health service I work in following an incident when he presented to a local community police station claiming that a child had been interfered with. It was only after some time that it became apparent that he was making a complaint that could not be substantiated and that his belief was based on a delusion, part of a psychotic process. He appeared agitated, he was unable to offer credible evidence for what he described as heinous crimes being committed on many children in the district, and his reasoning was illogical. The idea of a psychotic young man being concerned with the sexual abuse of children caused concern to the police who referred him to the local psychiatric service for further assessment and possible treatment. The situation created both anguish and distress for Leo and his family as the situation unfolded.

To care for Leo as he experiences the ravaging effects of psychosis has been a fearful journey for me. I have seen an ongoing deterioration in his abilities and relationships since his first presentation. I have a sense of an inevitable awfulness about his situation, having seen it many times over the last three decades of my practice. Following the emergence of a psychotic process there is, for an unfortunate few, an inevitable decline into misery and despair. I suspected that this might be the case for Leo.

An active approach to his treatment has seen atypical antipsychotics used in high doses to little effect. As a mental health nurse, I accept that a small proportion of folk will experience a treatment resistant psychosis. I see this as a tragedy. The potential for what might have been had been taken from both Leo and his family. That is, the promise of a full life, of a partner, of family, of participating in society, or of having a valued social role, has been lost.

When I see Leo today he is very thin and has a number of sores on his legs, perhaps due to poor diet and hygiene. He is barely able to let me into his flat for a visit. Leo is unable to receive assistance from community care workers because of the severity of his psychosis, indeed he cannot even accept the meals on wheels delivery.

Leo is an example to me of a group of people for whom conventional bio-medical, nursing and multi disciplinary team approaches fail. What happens in my experience is that the voraciousness of the illness is not modified by the current treatment. Therefore, the treating team is distanced from ongoing contact. Leo is seen as nasty and aggressive with a poor prognosis. This can have the effect of leaving mental health nurses feeling that they are left holding the baby. Often it is the nurse who has the most intense and ongoing contact with the Leos of this world. The mental health nurse is the one who has the expertise in developing and maintaining relationships across time and illness. It is the nurse who monitors mental status, safety issues, and communicates across the family and treatment teams. It is also the nurse who monitors medication supply and compliance issues. As the nurse feels increasingly isolated and unable to

make things, better for the patient they become increasingly despondent. In the context of my history and Leo's story I am compelled to think that there must be a better way.

I think that one good way for me to conceptualise Leo's situation is to reflect on what the novelist James Joyce was told when he was trying to come to an understanding of his daughters experience of psychosis. A psychiatrist explained that life can be seen as a stream of consciousness and that his daughter was drowning in that stream (by personal communication, source unknown).

It was in the context of Leo's story that I started to look at what might work for mental health nurses in these situations. I had been reading some of Phil Barker's work and came across a series of five articles in the Nursing Times published from January to May (Barker, 1998). What the articles were saying about the possible use of cognitive therapy in psychosis sparked a process of inquiry for me. It was the combination of Leo's story and my quest intersecting, which has led to this project.

4.00 Background

I am interested in researching the use of CBT in psychosis and its relevance to mental health nursing. To do this project I have introduced Leo's story and my story to give the reader some sense of my practice issues and the reality of psychosis for Leo.

Psychosis is a serious matter for mental health nurses because of the variability of treatment and outcome for individuals. For young men like Leo there is a one in ten chance of mortality. Psychosis is a life threatening disorder.

Coming to a greater understanding of psychosis and its theoretical explanations will, I believe, assist nurses to do their work and to have a greater insight into the issues and background that support the use of cognitive therapies. The aim of this paper is not to produce the definitive summary of the current state of knowledge regarding psychosis and CBT. Its aim is to survey the ground around CBT, to come to some understanding of what it is, where it comes from, how it is enacted, and to see if it works.

This research is formative in the sense that it seeks to chart the ground, but recognises that development in this area is fast paced with new information becoming available almost monthly.

The methodology I have used for this research paper is that of scholarly inquiry. By scholarly inquiry, I mean a process of research that firstly identifies the area of inquiry, then gathering and sifting information leading me to identify what I see as the relevant literature around the subject. I have tried to structure the literature in terms of what I

see as the dominant themes in Leo's and my stories. The themes that I felt were important were the awfulness of the psychotic disorder and the distress it causes to all involved. The themes of increased isolation and failing function in the context of hallucinations and delusions were clear. Issues around medication and treatment resistance were common to Leos and my experience and the literature reflects these issues. The themes that emerge in Leo's story are treatment resistance and the use of neuroleptic drugs to treat the symptoms of psychosis. Central to the themes is the idea of distress for both Leo and myself.

I spent some time thinking and reflecting on just what was relevant about CBT to mental health nursing and looking at the history and theory of the development of cognitive theory and practice. This is because I believe that it is important to see cognitive therapy in terms of its historical development to understand its relevance to current practice. For example, if I was working with Leo (in a cognitive behavioural style) it would be important for both Leo and myself to have a strong sense of the importance of objectivity, testable evidence of efficacy to embrace the strong learning based values implicit in cognitive therapy. These issues are reflected in the history of CBT. Understanding this would promote confidence and optimism around therapeutic outcomes.

The structure of the paper is firstly to tell two stories. The stories locate the subject in nursing practice and illuminate the themes carried through the paper

The paper is in three parts, with the first part divided into three sections. Section one describes the history of the development of psychology over time. This illuminates the

process of thinking that took place as ideas were developed and tested to reach the current position.

In Section two I discuss the theory of cognition from its roots in behaviourism to the inclusion of learning theory. This process of evolution has led to the formation of a cognitive model of psychosis.

Section three examines recent UK research reports around the use of CBT in psychosis. I have chosen these reports because of the consistency of research style and the direct relevance to this paper. I have looked for consistency around issues of age, gender, length of illness, medication issues and rigour of the reported research projects

In Part two of this paper I have looked for evidence of the use of CBT by United Kingdom nurses. There are a number of relevant studies and reports that I have referred to in this paper. Although there is limited information available, I also found two reports that relate to the Australian context.

In the third part of this paper, I have tried to discuss the relevant issues and come to a view as to the efficacy of CBT and the relevance of this to mental health nurses in New Zealand (N Z).

To come to a greater understanding of psychosis and its theoretical explanations, will, I believe, assist nurses to do their work more proficiently. I believe that as mental health nurses we owe it to ourselves personally and professionally to be able to demonstrate a depth of knowledge around the subject of cognitive therapies. This is because the emerging evidence is becoming increasingly convincing that CBT can work and that it

is the legitimate business of nurses to deliver the therapy. As more information is published there will, I imagine, be ongoing discussion on the development of a cognitive theory of psychosis. An in depth understanding of the history and theory is important for nurses to assist them to contribute to the wider debate from an informed perspective. Given the emerging evidence of efficacy of CBT in psychosis, mental health nurses have a responsibility and a role to lead change in the provision of the therapy in New Zealand. This document concludes with a discussion of what I have found and what this can mean for Leo and nursing.

PART ONE

5.00 History of CBT

The history and growth of cognitive behaviour therapy is interesting as it reflects societies' changing attitudes to peoples problems and the knowledge base from which these problems are viewed. The history of the development of CBT is important to understand because it reveals the layers of meaning that have occurred over time. The theoretical basis of current practice is presented on a cumulative basis paralleling the way society and psychology has viewed human behaviour. It is important for nurses to view the current practice in the context of the historical issues, so nurses have an in-depth understanding that can inform their practice. The importance that I place on a good understanding of the history of CBT is so that nurses can make an informed decision as to their personal and professional views about CBT. The relevance of CBT's history is especially significant because it is a dynamic therapy. It changes over time, and is modified by experience and evidence as practice is researched and tested. For nurses interested in CBT this means that what is seen as the current state of knowledge and practice is a culmination of ideas that have emerged over time and will continue to be tested and modified to guide future practice.

The history of cognitive behavioural therapy is traceable to the ideas espoused by the ancient philosopher Epictetus some 2000 years ago. He noted that people were distressed not by the event but by the view they took of the event. In a sense this could

mean that it was the connection between a persons thinking and responses that would determine their perception of an event, rather than the facts of the event itself.

In the early 1900s, the psychologist John Watson developed the idea that it was the objective study of overt events that was of value. Previous psychologists had worked around the study of subjective internal events (the unconscious mind). Watson showed that it was the use of conditioned stimuli, reinforcement and extinction that would inform psychological developments (Wilson, 1997). This represented a start by psychology to define and measure human behaviour at a time when the dominant paradigm centred on the idea of the unconscious mind.

By the 1920s, the Russian psychologist Ivan Pavlov demonstrated that it was possible to condition dogs to salivate following a programme of pairing food with a light or bell. Pavlov's classical conditioning explained behaviour as being a process mediated by the autonomic nervous system. These early conditioning principals were to form part of the basis of later work around operant methods.

In the late 1940s a South African psychologist, Joseph Wolpe, was working with people experiencing anxiety. He applied the theories of Pavlov and developed a technique called counter conditioning. This involved a systematic desensitization of a person to the stimuli causing the anxiety. This technique was paired with a relaxation technique to inhibit the anxiety, thus forming the early clinical use of a cognitive behavioural therapy, in this case for anxiety (Barker, 1998). The fact that these methods used the imagination of patients to recall their anxiety meant that they were

more than conditioning and were in fact an early form of cognitive therapy. The use of imagination was one way of making a connection between thoughts and feelings.

In the 1950s, a psychologist B F Skinner began work on what was to become operant conditioning. It was Skinner who first named and used the term 'behaviour therapy' (Barker, 1998). The work of Skinner and Pavlov signalled a move away from theories based on consciousness to a behavioural theory based on the objective measurement of behaviour.

It was not until the 1960s that operant conditioning was applied to psychiatry and was used to explain how psychotic behaviour was the result of conditioning. This took place in institutions as individuals responded in predictable ways to reinforcement. As a therapy, operant conditioning came to a brief time of popularity in the 1970s as social skills training (Barker, 1998). In Skinner's work around psychosis, he went on to develop a theory to explain psychosis as a conditioned response to institutional environments.

The formative years of behaviour therapies occurred in the 1950's and 1960's. Seen as a radical movement it challenged the dominant treatment model of psychoanalysis. The 1950s brought the idea that behaviour therapy was superior to psychoanalysis, on the basis that behaviour therapy was testable and could be exposed to scientific experimentation. Behaviour therapy, based on a developing debate around the idea of learning theory and promoted in the 1950s, was a superior alternative to the then dominant psychoanalytic model of treatment.

In the late 1950s, social psychologists were increasingly interested in the field of attribution theory. This theory proposed that people seek to explain things going on around them by attributing them to a cause. These causal attributes then influence the way we feel about others and ourselves (Comer, 1995). Further developed in the 1960s and 1970s, the theory of causal attribution suggested that attributions can influence ideas, decisions, and expectations. If attributions played such a critical role in behaviour and emotion could they also be significant in abnormal behaviours and emotions? Attribution demonstrated a way of connecting thinking, emotion, and behaviour. This was the precursor to the further development of behaviour therapy. The hope was that behaviour therapy was grounded in both scientific principles and learning theory and would supplant psychoanalysis for the treatment of psychological problems (Wilson, 1997).

As this model of social psychology was developing, so was a cognitive model. The convergence of these two models thus set the scene for the development of the cognitive model of abnormal behaviour.

The 1960s saw the development of cognitive and social psychology. Work by the psychologist Bandura saw the theories of social learning expand to include concepts such as modelling. By the late 1960s Bandura had included information processing with modelling in his social learning theories (Barker, 1998). In the 1960s, Aaron Beck and Albert Ellis continued to develop the work of previous psychological theory to the point they were able to name this new model of psychological understanding. It became known as a cognitive model of abnormal psychology (Comer, 1995).

In the 1970s, Lazarus developed the idea of multi modal therapy and based this on separating problems into behaviour, effect, sensation, and cognition. This shift signaled a move from a learning-based theory toward what is currently recognised as behaviour based.

Albert Ellis went on to develop cognitive theory further as a form of therapy known as 'rational emotive therapy'. This therapy involves the therapist in challenging and confronting people's beliefs while at the same time validating them as people, 'humanistic therapy'.

At this same time Aaron Beck, a psychiatrist, was developing cognitive therapy from the roots of Albert Ellis's work of the 1960s (Beck, 1976). Both Beck and Ellis proposed cognitive theories of abnormal psychology. Essentially, they described cognitive processes as being at the centre of behaviour, thoughts, and emotion (Comer, 1995).

Beck took the view that cognitive therapy was a package that included a range of techniques. The idea behind these techniques was to alleviate stress and improve the persons understanding of the relationship between thinking and feelings. The work of Beck initially centred on depression (Beck, 1963).

The growth of behaviour therapy has been extraordinary. The number of publications and journals dealing with behaviour therapy is enormous, as is the burgeoning information on the Internet (Liberman, Bedell, 1989). From 1972 behaviour therapy is the most reported therapy listed in the literature, and awarded more research money than all other modalities combined. The first behaviour therapy journal published in

1963 was *Behaviour Research and Therapy* (Wilson, 1997). There are currently ten journals and one hundred new books a year published on the subject, this is without the plethora of Internet sites available. Cognitively centred behaviour therapy now dominates research in Europe and the United States and now leads understanding of process and outcome of psychological treatment.

The diversity of treatment methods now employed reflects the history of behaviour therapy with techniques now based on empirical scientific research. While desensitisation and aversion were at the beginnings of therapy, it has now moved to include exposure, covert sensitisation, anxiety management, biofeedback, behavioural therapy, and contingency contracting.

The history of behaviour therapy is reflected in terms of critically evaluating clinical outcomes and results. Paramount among these is to replicate clinical findings, assess the durability of therapy, and understand the interaction between biological and behavioural therapies.

The history shows that behaviourists are empirically bound and seek outcomes in scientific terms. This is perhaps significant as it parallels the development of mental health nursing as it seeks to become evidence based and struggles to resolve similar issues. As behaviourism struggles with the significance of therapy, it conducts its experimental work within a scientific reductionist model: mental health nursing seeks to care for the mind and understand and work with the brain and behaviour.

Conceptually it is possible to view the history of behaviour therapy as reflecting a shift from a single model of explanation, to the accepted multi modal explanation.

In the early Middle Ages, a deontological model was used to explain abnormal behaviour terms of a struggle between good and evil reflecting society preoccupation with religion and superstition. Whereas this single model was prevalent in the Middle Ages, we now use a number of models to explain abnormal behaviour. This shift reflects a conceptual view based on experiment and research.

The history of psychological treatment of psychosis is interesting in that it reflects the way our view of major mental health problems has changed over the last forty years. From the 60s and 70s when operant conditioning and classical conditioning of behaviour was undertaken, the early thinking was that Skinners work in the laboratory could be applied to psychosis in an active way. The 70s and 80s saw a shift from direct behaviour management to a model emphasising empowerment in the context of families. This meant modification in the patient and the families' behaviour, while making the tools of self-help available. In the 80s and 90s the emphasis shifted firmly toward the idea of empowerment. This meant the task was not changing behaviour but helping the client change their own behaviour. (Haddock, Slade, 1996.)

The history of the treatment of psychosis using cognitive methods has two significant problems. Firstly, there has been reluctance by a medically dominated theory of treatment to use behavioural methods. This could be because some of the early operant methods were crude in both method and theory. The second problem is that most of the studies thus far have been applied to people experiencing chronic psychosis. In Drury's recent study, he has demonstrated remarkable reduction in hospital time for people

(Drury, Birchwood, Cochran, MacMillan 1996 a: Drury, Birchwood, Cochran, MacMillan, 1996 b, treated actively with CBT and routine psychiatric therapy.

The current conceptualisation of CBT includes the biological, socio-cultural, psychodynamic and behavioural models. Leo is an example of a complex individual with psychosis. This psychosis effects every aspect of his life in interrelated ways Working with Leo it is not possible to separate the physical issues around diet from the distorted cognition about food. It seems that no model is complete in explaining abnormal behaviour. It is in the context of this background that behavioural therapy has developed as a model that stresses the understanding of the processes and thinking that underlies behaviour. Central to the history of the development of behaviour therapy is the scientific reliability of the interventions; it is this reliability that has driven its development (Wilson, 1997). For Leo this means that his delusional ideas and thinking about food have a direct effect on his diet, his eating behaviour and on his nutritional status.

6.00 Theory of the Development of a Cognitive Approach to Human Behaviour

In 1959 Eysenk (Eysenk, 1959) defined behaviour therapy as the application of modern learning theory. This definition was accepted by the mental health practitioners of the day because it represented what was then the scientific approach to the understanding of behaviour.

Defined as a therapeutic approach, cognitive therapy's basis is the principle that people's thought processes could effect their feelings. The goal of therapy is to help the patient to recognise thought patterns that lead to unhappy feelings (Wilson and Kneisl, 1993). In 1986 the social learning theorist Bandura defined cognitive behaviour therapy as an amalgam of behavioural and cognitive strategies based on the assumption that performance based procedures are the best to produce change, mediated by cognitive processes (Bandura, 1986). Behavioral and cognitive techniques are used to reduce stress, but are primarily aimed at assisting the patient to understand the content and function of their thinking (Barker, 1998).

Therapy is a systematic procedure for helping people overcome psychological difficulties. All therapies have three features: a sufferer seeking relief, a trained healer, and a process of contacts between sufferer and healer. A system of therapy has a set of principles and techniques used in accordance with the theory of change.

Cognitive therapists take the view that a person's ability to think is the most important aspect of normal and abnormal human function. They believe that people's behaviours

follow from their interpretations and thoughts. Therefore, the underlying thought process rather than the action needs examination.

The goal of behavioural therapies is to identify the person's problem-causing behaviours and replace them with other ones. Cognitive therapists try to assist people to recognise and change faulty ideas and thinking (Comer, 1995).

The premise that a maladapted process of assumption and thinking causes abnormal function is the basis of the therapy. This is illustrated by looking at some definitions where there are a number of common characteristics. These include the relationship between thinking, feeling and behaving. The aim of behavioural therapy is to relieve distress and promote understanding. Included among these definitions are the two most widely used approaches, Ellise's rational emotive therapy, and the cognitive therapy of Beck.

The theory of cognitive behaviour therapy is rooted in the traditions of applying the principles and procedures of experimental psychology to clinical problems. These principles and procedures rigorously evaluate the effects of therapy and ensure objective evaluation guides clinical practice. In general, cognitive behavioural therapy has tended to reflect the developments in experimental psychology (Wilson, 1997).

A concept central to cognitive theory is that thoughts, emotions and behaviour and physiology are parts of a unified system. To change one part of the system will lead to changes in other parts of the system. The theory of cognitive therapy recognises that each person is a unique individual having a different range of feelings, physiological

responses and behaviours and that these are guided by their thoughts (Curwen, Palmer, Ruddle, 2000).

I think that what Leo's story shows us is, at the time he came to my attention, that his behaviour was driven by his thinking and that the consequences of his behaviour affected his feelings and fed back into his thinking and further behaviour.

Cognitive theory supposes that it is a person's response to events that can be of concern not the event itself (Beck,(1963); Ellis,(1962). Therefore, it is not necessarily the event that causes the concern, but rather the specific individual's response to the event. It recognises that each of us may respond differently to the same event. In Leo's case it was not that he arrived at a police station that was of concern, but his response to his psychosis that caused him to think that children were being abused. A cognitive therapist could be interested in the feelings and thoughts that underlie his behaviour as opposed to his behaviour per se.

6.01. Theoretical Basis of Cognitive Therapy in Practice

Behaviour therapy is an empirically based approach to harness the principles of human learning. Theory looks to target positive goals to strengthen the individual repertoire of possible responses, thereby protecting the individuals from stress related or organically induced symptoms.

Historical factors are of interest to cognitive therapists but emphasis is placed on current personal, social or environmental issues, because these are viewed as central to the problem behaviour. This means that the history is of clinical interest when viewed from a behavioural stance, whereas in some therapies, such as psychoanalysis, a person's history is of prime concern (Curwen, et al, 2000).

Cognitive behaviour theory recognises two components of thinking that form the central focus of CBT. These are conceptualised around ideas called automatic thoughts and underlying beliefs.

Automatic thoughts are those that occur involuntarily in a person's stream of consciousness (Beck, 1974). These thoughts are enduring characteristics, for example a view of the world that it is a dangerous place. An automatic thought like this can colour the way an individuals thoughts are premised, and so can be detrimental to the person by causing anxiety, when in reality objective danger is not a rational view of a given situation. A useful way to look at automatic thoughts is that they are self-statements that are internalised.

Underlying beliefs are what generate the automatic thoughts. These are essentially assumptions. If a person's thinking can be conceived of as a vast filing system within which the world can be fitted, then underlying beliefs are formed in childhood and have an importance based on a hierarchical model. These beliefs guide the way information is processed and eventually the way we behave.

In Leo's case this might mean that due to a psychotic distortion at an underlying belief level he experiences a number of automatic thoughts that interfere in the way his cognitive processes perceive and interpret the world.

Within the drawers of this schematic filing system are core beliefs. These are the specific contents of the drawers. If in the top drawer a person holds that life is essentially dangerous it follows that they may be anxious in a wide range of situations (Beck, 1963).

A theoretical approach that both Beck and Ellis endorse is to symbolise these principals as A, B, C (Beck, 1970; Ellis, 1977).

A is the activating event, this may be an actual, remembered or imagined event

B is the belief that leads to a behaviour, an emotion or physiological response.

C is the consequence such as anxiety. This can be a thought or a belief.

Cognitive therapy encourages the client to recognise and accept their emotions, then to detect their first automatic thoughts and the core beliefs that underlay them. This process that connects thoughts (beliefs) and emotions (consequences) is the essence of cognitive therapy. Once this process has begun it is possible to challenge, with

evidence, unhelpful beliefs. As beliefs are refuted, they are transformed into more adaptive helpful beliefs. The new helpful adaptive beliefs will no longer support the distressing emotions and behaviours the person was experiencing (Curwen et al, 2000).

6.02. Cognitive Theory in Psychosis

Studies on a cognitive approach to the treatment of psychosis have been continuing since the early nineteen seventies. The cognitive theory that underlies the treatment of psychosis is said to be less well developed than theories for the treatment of neurotic disorders such as panic and anxiety (Haddock, Slade, 1996). The cognitive theory of psychosis supports the idea that it is possible to explain the maintenance of psychotic symptoms in behavioural terms, rather than attempt to explain a theory of the schizophrenic syndrome. Cognitive theory goes on to research ways of modifying symptoms of psychosis and the behaviours associated with it. This approach is consistent with cognitive approaches that have always allowed for individual differences to be considered in cognitive theory and therefore optimise outcomes. This view negates the idea that psychosis diminishes a person's ability to understand and make changes in their life. This is an important point especially when considering how you might use CBT in psychosis.

6.03. Enacting Cognitive Behavioural Theory

In CBT, a careful consideration of problems leads to an agreed set of goals for therapy. Because there is an agreed goal, it is now possible to measure outcomes against goals so that any change or progress can be measured. Once goals and problems are operationally identified and measurable, it is possible to examine events that surround and contribute to the behaviour. This can be done by direct observation, self-monitoring and other techniques. Cognitive events that influence clinical problems can be defined, measured and understood so treatment can be planned and implemented. In the treatment of psychosis, once it is observed and measured, external reinforcers may be used to modify observed psychotic behaviour (Haddock, et al. 1996).

6.04. Assumptions Underlying Behaviour Therapy

A number of fundamental assumptions found in the great majority of CBT approaches directly reflect the history and theory of CBT.

These assumptions (adapted from Curwen, et al, 2000) can be summarised as follows

- That abnormal behaviour (even stemming from biological basis) can be favourably influenced using behavioural techniques. For example biofeedback.
- The same principles of learning govern abnormal and normal behaviour. They can therefore be used for therapeutic advantage.
- A behavioural assessment focuses on current issues rather than previous historical antecedents.
- For any given situation, it is better to observe behaviour than rely on what a person says they would do.
- Treatment is individualised to meet the particular needs of the person. Treatment aims to change overt behaviour on the basis that this will result in changes in thinking and mood.
- Cognitive therapy represents an applied science approach therefore treatment is developing and changing as measurable and replaceable treatments emerge.
- Cognitive therapy focuses on a multi-modal phenomenological approach therefore affect, imagery, cognitive and biological processes are all proper targets for intervention.

When a cognitive approach to treatment is used, the underlying assumption is that what caused the problem and maintains the problem, can be mediated by cognitive and environmental processes. This will involve teaching adaptive skills.

6.05. Cognitive Therapy Style

The therapeutic style assumed in cognitive therapy is that the therapist brings a range of knowledge and skills to the relationship. This is not common to all forms of talking therapy. For example, in some talking therapies the therapist may adopt an open or free floating approach to the way that the particular session and the therapy in general will proceed. This is in contrast to CBT, which follows a more structured approach.

In the early stages of CBT therapy the therapist guides and directs therapy actively. This balances with the therapist engaging and being with the client in an empathic sense.

As information is assessed, a cognitive formulation is made. This is revised during the course of therapy as new insights and information emerges. The therapist identifies current thinking that maintains problem behaviour.

The relationship is collaborative, with information shared openly, and the theory of cognitive therapy explained and developed during therapy. It is psycho-educational and co-operative as the client is socialised into treatment and eventually takes over the treatment (Curwen, et al, 2000).

This approach to relationships is in my view consistent with what mental health nurses do. It accords with nursing theory and my understanding of good practice when working with the Leo's of this world.

Each therapy session is structured and based on the cognitive formulation. An agreed agenda is arrived at each session. All sessions follow this basic form ensuring

efficiency of time. The mood is of a business like process of inquiry using a problem solving approach, not a "sick patient role" approach where the therapist gives or does something to a patient. Typically, a session is structured around this pattern (Adapted from Curwen, et al, 2000).

1. Check client's mood, safety issues are agreed and resolved.
2. Review the previous session.
3. Agree on an agenda with criteria to assess progress.
4. Therapist links the current session to previous sessions.
5. Agenda items are progressively addressed.
6. Homework set at the previous session is reviewed and discussed.
7. Set the next lot of homework.
8. Seek and give feed back, arrange the next session.

The therapy is clearly goal-directed as the client brings issues to a session and the therapist helps to understand them in behavioural terms. Goals are jointly set with tasks to meet these goals mutually agreed. As therapy progresses the client will gain confidence and understanding and so be able to take over more and more of the work of therapy. As this is internalised the client will become their own therapist.

A process of Socratic questioning is one of a range of techniques used to challenge the thinking that drives emotion, behaviour, and physiological responses. Socratic questioning is a process of logical deduction based on a series of logically connected questions that will reveal the underlying assumptions and beliefs. This is used to

change unhelpful thinking that will in turn lead to overcoming emotional and behavioural problems.

Cognitive therapy is time limited. This is because it is efficient, highly structured, goal-directed and includes measurement criteria so that both therapist and client will know when therapy is complete.

The development of future cognitive theory rests on improved models of understanding emotions and cognitive processing. It will be this understanding that will lead to treatments that are more effective. To remain true to the original concept of cognitive therapy reflecting advances in scientific understanding, it must remain responsive to experimental research.

Cognitive behaviour therapy is appropriate for people experiencing psychiatric problems as it utilises learning new skills, adaptive-coping and building on existing assets. Behavioural approaches are not exclusive; they readily integrate with other biological approaches to psychiatric problems.

PART TWO

7.00 Review of Evidence

This part of this paper will look at the important issue of medication in the treatment of psychosis. Following this are discussions of a selection of reports and studies, which have involved the use of CBT. The final section looks at reports of the ways CBT has been integrated into the practice of mental health nurses in the U.K and in Australia. I conclude by trying to bring together the threads that have emerged across stories, the history and practice of CBT and to understand its relevance to nursing.

7.01. The Role of Medication

Central to the discussion of the current treatment of psychosis is the use of medication as a treatment. This is an important issue as many of the research reports I will refer to in this section will discuss routine treatment. A significant part of current treatment is medication. This reflects medicines biological view of illness. The medications used in psychosis are commonly one of a group known as the neuroleptics.

For Leo the issues around his treatment using medications are mirrored in this discussion. In Leo's case, he remains on very high doses of atypical anti-psychotic medications that have at best a moderating influence on his illness and the potential to disable him with irreversible side effects.

Neuroleptic medications that have been available since the 1950s are still in use today. They are credited with a transition from institutional care of psychosis to a community-based model common in North America, Europe, and Britain. (Lieberman, 1993). Therefore, it is important to look at issues around the use of neuroleptics in the context of CBT. The term neuroleptic means literally to clasp the neuron. One of the first neuroleptics was chlorpromazine; this was synthesised in France from an anti histamine preparation and is still widely in use today

Arguably, the development and subsequent expansion of neuroleptics has not been on the basis of science, the action of the drug or the pathophysiology of psychosis. Rather the increase in use of neuroleptics in the nineteen fifties was as a pragmatic approach to the management of psychosis when little else was available. It was not until 1963 that a dopamine-receptor-blocking effect was shown, and a relationship between anti-psychotic effect and neuroleptics demonstrated. Studies as to the cause of psychosis are ongoing. For the purpose of this paper, it is not possible to go into the issue any further. Suffice to say that the dopamine hypothesis of psychosis is equivocal (Sunahara, Seeman, Van Tol, Niznik, 1993). The use of neuroleptic medication is problematic in the sense that because these medications affect not only the dopamine receptors but also the cholinergic and alpha-adrenergic receptors, they have side effects. The side effects include extrapyramidal effects such as tremor, drooling, and slowed movements. Endocrine side effects include effects on appetite and body weight.

Opinions are divided into two views on the use of neuroleptics. Firstly, that of continuous treatment. This means regular ongoing intake of medication, and is the

most common form of treatment. The medication is either administered as tablets or as a long-acting oil-based preparation given by deep intramuscular injection. The second emerging view is that it may be better to have long periods of being drug free and only taking drugs at times of stress or if prodromal signs appear (Carpenter, Heinrichs, Hanlon, 1987). These prodromal signs could include subtle disturbance of sleep, early signs of social, emotional withdrawal (including isolation) and a loosening of what would be considered the normal connections between thoughts. Studies in Britain and North America have shown that intermittent use of neuroleptics over the longer term have been associated with higher relapse rates (Hisz, Glazer, Mostern, Heard, Szymanski, Hafez, Mirza, Varna, 1991). Hisz also observed that there was no significant difference in range or severity of side effects in patients treated in the two different ways.

Sometimes in clinical practice high doses of neuroleptic are used in an attempt to manage the distressing symptoms of psychosis. The British National Formulary recommends normal ranges and dose and the use of higher doses of neuroleptic medication is not associated with clinical benefits. There is no therapeutic basis to justify doses more than the recommended rates in the formulary. (Bollini, Pampallona, Orza, Adams, Charmers, 1994.)

The efficacy of neuroleptics is a matter of some conjecture: not all people experiencing psychosis benefit from this drug treatment. In a study (Johnston, Crow, Owens, Done, Baldwin, Charlette, 1992) the scale of relapse amongst people taking neuroleptics was examined. It seems that about forty percent of patients receiving this medication will

relapse over a one-year period. Non treated patients relapse at about sixty five percent over one year. Hisz et al (1991) reviewed the literature and found that treatment resistance was a stable trait. This meant that if a person was a non-responder to neuroleptic medications initially then they were likely not to respond to similar treatment in the future.

New Zealand has seen the recent introduction of new neuroleptics or, in the case of clozapine, reintroduction. These newer agents are expensive to purchase and have ongoing costs in monitoring blood tests. This is because one of the potential side effects can involve serious blood reactions. In clinical practice, these novel neuroleptics have had significant beneficial effects for some people who have been thought of as treatment resistant. I have personally seen some remarkable responses by some individuals to the new neuroleptic drugs.

When it comes to the use of neuroleptics in the treatment of psychosis there are few firm rules. It seems the selection and monitoring of medication is a subjective matter. (Day, Bentall, 1996)

Neuroleptic drugs are not always effective in the treatment of psychosis; therefore, people continue to seek alternative and complementary approaches as a way of dealing with their psychosis.

7.02. Review of Studies

To review the current thinking on the relationship between the current treatment of psychosis and the use of CBT, I will look at four recent studies and discuss the Cochrane Data base of Systematic reviews. (Jones, Cormac, Mota, Campbell, Cochrane, 2000). I have selected these particular studies as they represent contemporary research in this area. The four studies use rigorous methodologies and are presented and discussed in reputable publications. I am aware that there are a large number of other related studies in this area. I have chosen to be very selective for the purpose of this report in order to compare like with like. I have selected studies on the basis that they include people with psychosis, that they exclude primary organic brain damage, and primary alcohol and drug abuse. Each of the studies has used similar assessment scales such as Diagnostic and Statistical Manual (DSM) and Brief Psychiatric Rating Scale (BPRS) scales, thus promoting some consistency in the selection of people for research purposes.

The Diagnostic and Statistical Manual is prepared by the American Psychiatric Association and covers psychiatric and psychological conditions in a systematic and consistent way. It is perhaps the most widely accepted and referred to table of mental illness. For each class and sub class of illness there is an agreed set of symptoms. If enough of the symptoms are present in a person then a diagnosis may be made that is consistent with the DSM. The manual is updated and modified periodically and is referred to as DSM IV Revised, depending on the currency of the manual used. Using this manual approach promoted consistency across diagnoses and in this case provides high levels of consistency among patient groups discussed in various studies.

The Brief Psychiatric Rating Scale is a popular general-purpose scale used since the nineteen sixties for objectively measuring the current mental status of an individual. It is widely referred to in many journal articles and reports because it is reliable and has the advantage of being able to measure small changes in mental state. The assessment takes about thirty to forty minutes to administer and uses an interview and a process of observation. A rating scale compares individual assessment results, giving each individual a score in different domains of mental state. Subsequent re assessment will note any changes, however small, in the person's mental state. These changes can then be used to compare differences across treatment groups.

Each of the studies I have cited in this paper has included detailed information of history, course and duration of illness. The studies all use similar target outcome measures, of reduction of frequency, of severity of psychotic symptoms ie. delusions and hallucinations. The studies were all from the UK, which helps ensure that standard routine care across different sites is similar. The study settings all use similar medication and prescribing style, which is consistent with UK medical registration and College of Psychiatrists standards. This consistency helps to promote an integrated use of language and therapeutic style. Across all the studies is a common thread of understanding in terms of the use of the word CBT. It is consistent with the earlier part of this paper in its application, history, and theoretical underpinning. In this part of my report I am comparing studies with the aim of understanding the effectiveness of CBT in the treatment of psychosis, the effectiveness of treatment when combined with routine psychiatric care and then comparing other supportive therapy with CBT.

7.03. Study One

In 1996, Val Drury and others (Drury, Birchwood, Cochran, MacMillan, 1996) commenced a study in the UK to look at reducing positive symptoms of psychosis and reducing residual symptoms. The study method identified two groups of people. The first group acted as a control group receiving routine treatment and recreational and support therapy (RC group). The second group received routine treatment and cognitive therapy (CT group) at a rate matched by the recreational therapy group. Weekly clinical assessments were made of subjects for a period of nine months.

To identify subjects for the study, an assessment tool was developed to screen out affective disorders (disorders of mood), alcohol and drug abuse, confusional states, and organic syndromes. Subjects were drawn from one psychiatric hospital in West Birmingham. Selection of subjects was designed to include people presenting with hallucinations, delusions and abnormal behaviours that indicated a functional psychosis (as opposed to an organic psychosis, for example toxicity or brain injury). An approved process of informed consent was completed.

Following selection from one hundred and seventeen people, forty were allocated among the two groups. Allocation was based on age of onset, gender, ethnicity, and previous episodes, living circumstances before admission and duration of untreated illness. Sophisticated tools were used to ensure that allocation to one of the two groups was evenly balanced on the criteria offered. Of the total selected 65% were experiencing the first or second episode of psychosis and 70% were within five years of their first presentation.

Assessment of mental state was carried out on a weekly basis using psychological tools that were shown to have good reliability. Neither consultants nor clients were aware of which group they had been assigned. The treating psychiatrist alone prescribed medication and made decisions about discharge timing. All subjects in this study received neuroleptic medication.

To ensure consistency, treatment was delivered using a system of protocols, and routine psychiatric care continued as usual for both groups. Treatment took the form of informal support and recreational activity for the RC group, and of cognitive therapy for the CT group. Recreation and support (RC group) consisted of social activities both on and off the ward. Peoples concerns about psychosis and their current situation were listened to in a sympathetic way, and any particular requests or concerns were referred to the psychiatrist. Sessions of CBT (CT group) lasted for an average of eight hours per week, per patient and took the form of individual therapy, group cognitive therapy, and family engagement and structured activity off the ward. There was a quiet room and music available for both groups.

Data from the study was analysed and revealed both groups showed a marked reduction in positive symptoms of psychosis in the first 12 weeks. The decline in positive symptoms was greater in the cognitive therapy group. Analysis of symptoms at week 1, 7 and 12 showed no difference between the groups at week one but highly significant differences by week 7. The cognitive therapy group showed a significantly faster rate of decline in positive symptoms at week 7 and week 12 compared to the recreation group.

Delusional beliefs were self reported and showed that there was a significant reduction in preoccupation and delusional beliefs among both groups. The cognitive therapy group showed a significant improvement in delusional conviction. Both groups showed reduction in negative symptoms and the improvement was maintained over the 12 weeks at a rate that did not significantly vary between groups.

At the nine-month follow up, positive symptoms were much lower in the cognitive therapy group compared to the recreation and support group (99% for the CT group against 44% for the RC group). At nine months, there was no significant difference between the groups for disorganisation.

On a measure of delusional belief the cognitive therapy group scored lower, reporting fewer and less severe delusional beliefs.

To allow for differences in type and dose of neuroleptic amongst individuals a standardised approach was used. Stelazine is a commonly used neuroleptic drug of the phenothiazine group and it is usual in research to convert neuroleptics to an equivalency of Stelazine according to drug potency. This means that doses of different neuroleptics are ascribed a measure of potency as if they were Stelazine. For example, 5mg of Stelazine is equivalent to 100mg Chlorpromazine. This is known to as Stelazine equivalence. Both groups showed an increasing use of medication over the first 12 weeks.

7. 04. Discussion Study One

This is the first UK study of a cognitive therapy combined with routine treatment for the acute phase of psychosis. In this study cognitive therapy focused on the beliefs, the consequent distress, and the evidence for the belief. It then invited the client to consider alternative constructions for those beliefs. This study has demonstrated CBT has the potential to speed up recovery from positive symptoms and lowers residual symptoms and that these improvements are maintained nine months later. The use of standard routine treatment when combined with cognitive therapy and neuroleptic medication is a promising alternative to current approaches. The study found that there was no significant difference in time to recovery, between first episode and multiple episode people.

7.05. Study Two

Drury (1996 a, 1996 b) completed a further study in two parts. The first part concentrated on the impact of CBT on psychosis. The second part of this study looked at the group who had received CBT and how they were able to generalise improvements made in positive symptoms compared to other aspects of their lives. The study also examined the impact of CBT on recovery time.

Over a period of six months, measures of mood, insight and low-level psychotic thinking were made. Three levels of recovery were identified. These ranged from the resolution of positive symptoms of psychosis, to a person's view of recovery or position of stability. Clinical recovery was taken to mean the presence of insight and the absence of low level psychotic thinking. People could move sequentially from one to three over time. The median for time to recovery was twenty weeks; this is significant when planning resources around CT approaches to psychosis.

7.06. Discussion of Study Two

The importance of this study is that it reveals that people treated with CBT have a more rapid resolution of psychotic symptoms within 6 months. The recovery time was reduced by 25% - 50% as measured by time spent in hospital before achieving a degree of wellness that indicated discharge was then appropriate. The fact that the discharge time was halved in the CBT group has implications for the management and administration of mental health services. The potential benefits of shorter in hospital

treatment times for the treatment of psychosis has personal, financial and societal benefits for consumers, families and providers.

7.07. Study Three

In 1998, the British Journal of Psychiatry (Kuipers, Fowler, Garety, Chisholme, Freeman, Dunn, Bebbington, Hadley), reported the London East-Anglia randomised controlled trial (RCT) for CBT in psychosis. This was a study in which sixty people received CBT and standard care or standard cares alone. Selection of clients for this study resulted in sixty people being selected. Each of these people had at least one distressing symptom of psychosis and had a history of medication resistant psychosis.

Characteristics of employment, housing, and Intelligence Quotient (IQ) between the two groups were matched so there were no statistically significant differences. There was a similarity between the groups in respect to psychiatric history. The CBT group has a mean of 124 psychiatric inpatient days over the last five years compared to 110 for the standard treatment group.

The prescription of medication at the start of the study was at the same levels across both groups. There were changes in medication levels across both groups over the time of the trial; these did not account for changes in psychiatric rating scores.

Treatment given to the CBT group was in accordance with an approach, which allowed for greater standardisation of CBT application to all subjects in the treatment group. This went against the idea that CBT is individualised to the particular needs of each individual depending on the cognitive conceptualisation of their problems. Independent assessors at various times throughout the trial reassessed all participants, first at nine months, then again at eighteen months. The assessments were made using sensitive and well-used measures, including Brief Psychiatric Rating Scale (BPRS). Of

the sixty people who were involved in the initial study, 47 (78%) went through to the eighteen month assessment.

Outcome data showed a considerable improvement in the CBT group at nine months compared to very little improvement in the standard treatment group. There was little improvement in either group over the nine months to eighteen-month period. However, there was evidence that the CBT group had maintained its improvement. Clinical outcomes as measured using the BPRS showed that fifteen out of twenty three subjects in the CBT group (65%) showed a reliable clinical improvement compared to four of twenty-four (17%) of the group receiving only standard treatment.

7.08. Discussion Study Three

This study is interesting because it also analysed some of the economic factors that need to be considered when thinking about treatment of psychosis. The decision to look at the economic factors was not part of the original study; the decision to examine the financial issues was made later. The focus of the economic analysis was to look at the additional costs of CBT in the treatment group and see if there was a financial advantage to treatment. The study had already suggested a clinical outcome advantage over an extended period, it then seemed important to know what the financial implications might be.

Formulation of the analysis was around CBT treatment, service use patterns, and cost of care packages between groups. Calculation of the CBT treatment was based on twenty one-hour sessions per month, per person at a median price of £105 sterling per

month per person. Service use patterns showed that the rate of psychiatric inpatient days for the CBT treatment group was 14.5 days. The rate for the standard treatment group was 26.1 days. The care package costs included accommodation, the difference between the groups was that the CBT treatment group was £180 sterling per month per person less than the standard treatment group.

The main findings of this study were that an improvement of symptoms of psychosis was found in the CBT treatment group and that these were maintained over time. There was a 29% reduction in psychotic symptomatology compared to a 2% reduction in the control group. Any implications being drawn from the financial analysis need to be treated with caution mainly due to the small sample size with limited consideration of all the possible fiscal factors. However, prima face it appears that CBT does not increase the overall costs of treatment and may have relative advantages.

This study is relevant to a large university hospital in the UK. It has intriguing implications for contemporary mental health nursing in New Zealand, but is not of itself indicative. This study has concluded that the improvement in mental health for people with psychosis who were treated with CBT extended over a period of 18 months. It also demonstrated that when CBT was combined with conventional treatment then time spent in hospital was reduced by up to 50%.

7.09. Study Four

Haddock, Tarrier, Morrison, Hopkins, Drake, Lewis (1999) reported in the *Social Psychiatry and Epidemiology Journal* a study conducted into the effectiveness of CBT on recent onset psychosis. It is important to note that this is a pilot study.

The method used was to apply short term CBT with standard treatment including medication. A control group was established using supportive counselling and psychoeducation (SC group) as an adjunct to standard treatment, including medication.

People were selected for the study from consecutive admissions to psychiatric wards. Criteria for inclusion included independent psychiatric assessment using DSM IV (American Psychiatric Association, 1994) criteria for schizophrenia. The first treatment for psychosis was within five years. All subjects had been most recently admitted for onset or relapse of psychotic symptoms. The BPRS scale was used to rate psychotic symptoms and used for inclusion in the study. People were then randomly assigned to the two groups, the CBT or SC groups. Ward staff and medical staff knew of the study but did not know which people were assigned to which groups. Over the period of one year thirty six people were accepted, 27 males and 9 females. The treatment was designed to be delivered over a period of five weeks or until discharge. Booster sessions of CBT were offered at 1, 2, 3 and 4 months following the start of treatment. Assessments were made for a period of two years following the start of the study.

The CBT group was treated using standard treatment and a manual based approach developed by the authors and used in the study which was reported in the *British*

Journal of Psychiatry (and quoted in this report as Study Three), by Kuipers et al (1998). Treatment centered on reducing auditory hallucinations and delusional ideas. As treatment progressed, treatment focused on relapse prevention. Specific treatment included cognitive formulation, symptom monitoring, hypothesis/reality testing, coping strategies and relapse prevention.

Supportive counselling and psychoeducation was carried out using a manual and was matched to the CBT group in terms of time allowed. It offered assessment and counselling in a warm, genuine and empathic way. Specific techniques included reflection, summarising, feed back, and providing accurate information.

Of the thirty-six people offered treatment in the study, 21 accepted and 20 completed the trials. Eventually all the subjects in the CBT group were male. The average ages for the CBT group was 28 years and for the SC groups 30 years. Subjects received a mean number of treatments of 10.2 for the CBT group and 9.1 for the SC group. The attendance at booster groups was low, with seven SC people not attending any. Only two people in the CBT group attended all four-booster sessions. Days in hospital varied between groups as the CBT group spent a mean number of 37 days in hospital, compared to a mean of 55 for the SC group.

The two-year data was collected from case notes and showed the mean number of days to relapse of psychosis as 730 for the CBT group and 527 for the SC group. As a percentage of relapse the CBT group was 44% the SC group 73%.

7.10. Discussion Study Four

The results of this pilot study show that applying CBT to recent onset acutely psychotic people is a feasible treatment option. The refusal rate is high at 30% and is a matter that will need further thought. This is a small-scale trial. It is not possible to say with any certainty that the CBT group were advantaged over a longer term. The study had a majority of young male subjects. This has the potential to skew the results. Against this, the majority of psychotic presentations are amongst this group. This study has a low therapy session rate compared to the earlier Drury (Drury, 1996 a; Drury, 1996 b) study of some 23 sessions. It could be that the relative effectiveness of CBT is related to frequency.

This study does show an effect on relapse and time to relapse, favouring the CBT group. It is not possible to make any other reasonable statement about this study other than it would be interesting to replicate the study on a larger scale.

7.11. Study Five

In 1998, the British Medical Journal reported a trial by Tarrier and others (Tarrier, Yusupoff, Kinney, McCarthy, Gledhill, Haddock, Morris, 1998), which divided people with chronic schizophrenia into three groups. The first group received routine care and intensive CBT, the second group received routine care and supportive counselling, and the third group received only routine care. The trial reports on a programme of intensive CBT combined with medication for a group described as experiencing chronic schizophrenia.

People were selected for the trial by examining patient databases across three National Health Service (NHS) hospitals in greater Manchester. A discussion was held with the person's Doctor. If suitable, the person was approached for inclusion in the trial. The criteria for inclusion included diagnosis of schizophrenia by DSM 3 revised, no evidence of organic brain disease, and no primary alcohol and drug issues. Subjects were all aged between 18 and 65 years. People were assigned to the three groups on a random basis. Eighty people entered the trial; seventy-two completed the programme. The mean age was 38 years; the majority (69) were men.

The group having intensive CBT, plus routine care, has three components to therapy. Firstly, to teach coping strategies aimed at their specific symptoms. Secondly, to solve problems in a systematic way therefore improving function and reducing stress. Thirdly, to identify ways of preventing relapse. The format of treatment was to have six one hour sessions followed up with two review sessions for each of the three components. Sessions were conducted twice a week for ten weeks.

Supportive counselling plus routine care consisted of provision of emotional supported unconditional regard for the person. General counseling skills were used to foster the relationship. There were two one-hour sessions for ten weeks. Routine care consisted of medication, psychiatric management and a care programme approach.

7.12. Discussion Study Five

Results of this study showed that 50% of people had an improvement in both the severity and the number of psychotic symptoms. In the 33 person CBT group eleven people improved. In the 26 person supportive counseling group, four improved. In the 28-person routine care group, four improved. These differences are significant, as there is a 50% greater chance of improvement in the CBT, plus routine care, group. This study demonstrated that there was an eight-fold greater chance of reducing psychotic symptoms by 50% in the CBT group compared to the routine care group. Clearly, people receiving CBT and routine care showed the greatest improvement. Those receiving supportive counselling and routine care showed some improvement, with routine care showing virtually no change. Persistent psychotic symptoms are common in chronic schizophrenia; CBT combined with routine care can change people's thoughts, feelings and behaviour.

7.13. Cochrane Review of Studies

It is important to consider what the Cochrane Centre has to say when thinking about what themes and issues run through the various research reports.

CBT is reviewed in the Cochrane Review (Jones, et al, 2000) as a systematic review of the current research on the use of CBT for schizophrenia. It was most recently updated on the 2-11 2000. The Cochrane centre is widely supported by mental health nurses as it forms part of what informs evidence based practice and so is relevant for nurses when considering their approach to the person with a psychosis.

The Cochrane review begins by acknowledging that medication is the mainstay of the current treatment of psychosis. Over all it found that for people willing to take CBT as an adjunct to routine therapy they could expect a substantially reduced risk of relapse.

A summary of important issues identified in the reports quoted would emphasise that: CBT is effective for significant numbers of people who experience psychosis. CBT is a potent adjunct to routine care and neuroleptic medication in the treatment of psychosis and this may be cost effective. CBT can shorten the time to recovery from acute psychosis and can be generalised to many aspects of psychosis. The use of CBT may spread treatment benefits over time, possibly more than one year.

The Cochrane review raised two important issues in the provision of CBT. Firstly, it said that CBT was a scarce resource, applied by psychologists and was therefore restricted to few people. Secondly, it speculates that there is concern as to how effective CBT would be if applied by less experienced practitioners.

It seems that both of these concerns are potentially the business of mental health nurses. Nurses form the largest part of the professional mental health work force and have the greatest potential to enact CBT with the Leo's of this world. The issue as to the effectiveness of mental health nurses delivering CBT is addressed in the next section and I believe answers the concern in the affirmative for nurses.

PART THREE

8.00. CBT Relevance to Mental Health Nursing

8.01. Introduction

One of the most influential contemporary theorists in current mental health nursing is Hildegard Peplau. Among mental health nurses she is acknowledged to be the leading proponent of psychodynamic approaches to treatment (Peplau, 1997). Peplau's theory of the centrality of the interpersonal relationship is entirely consistent with the CBT model, in that the therapeutic relationship is fundamental to successful therapy. Both Peplau's model and CBT are predicated on the notion of a collaborative relationship and both models require as a precondition an ability to conduct that relationship. It is the conducting of the relationship that is the essential work of mental health nurses. Peplau's theory and the theory of CBT are philosophically congruent in that the therapeutic objective for both is directed toward self-knowledge. Both approaches rely on the idea that change in one area of a person's life can be generalised to changes in another area of life. They take a holistic view of an individual and see the person in the context of their lives.

My experience is that many mental health nurses use the principles of CBT in their clinical practice without having a formal understanding of the history and structure of the cognitive model. This sees the nurse as a therapist in bringing together the art of caring and the science of therapy. It is part of a broad range of knowledge and experience that nurses can bring to the restoration and maintenance of health (Peplau,

1988). What is important for nursing is the potential that CBT may have in working with people who experience psychosis. Working with people experiencing psychotic disturbances using Peplau's interpersonal model uses a process of observation, description, analyzing, formulating and testing this process. Using Peplau's approach is clearly consistent with a cognitive view, these views are complementary and have the potential to validate and enhance the work mental health nurses do (Thelander, 1997). The objective evidence is that CBT has a significant role to play in the treatment of people with psychosis. In New Zealand, about 1% of the population (Jones et al, 2001), experiences a psychotic episode, this disorder is cross-cultural. This means that a significant number of people being seen by mental health nurses will experience psychosis and will require a range of skilled interventions of which CBT is one. Most people seen by mental health nurses for psychosis are treated with medication. A part of mental health nursing is to be involved with the prescribing, administration and monitoring of neuroleptic medication. As nurses well know, between 5 and 25 % of people with a psychosis will not respond to medication. Further, as nurses we are aware that medication has the potential to cause side effects, which are often serious and irreversible. It is for these reasons that I believe that it is important as nurses that we look to cognitive therapies to see how these approaches can assist our clients to recover.

The theory of CBT is consistent with nurses wanting to base their practice on an evidence-based model. CBT is deeply rooted in the science of evidence, it is predicated on notions of validity and reliability; it must be replaceable and is subject to close rigor.

The appealing thing to me as a nurse is the application of CBT to people as individuals. This individualisation of therapy is consistent with nurses respecting people as individuals and tailoring a therapy approach that can meet differing needs. The treatment approach is ethically consistent with the idea of autonomy. This means that a nurse can work with a person using CBT to inform the person about what might be happening for them and promote the idea of self-governance. If mental health nursing is about caring with people, then CBT offers a valuable tool to bring to the caring process.

There have been several reports in recent years that record some of the issues around nurses using a CBT model in practice. The first report (in the next section) relates to nurses working with non-psychotic people in the UK.

8.02. Report One – Relevance to Nursing

Gourney and Brooking (1994) reported on a randomised controlled trial (RCT), involving eleven community psychiatric nurses (CPN). This trial showed that when CPNs worked with people who were experiencing non-psychotic mental health problems there was little difference between GP and CPN care. Health issues for patients involved in this trial included relationship problems, depressive symptoms, anxiety, phobic anxiety, alcohol problems, and bereavement issues. The trial was organised allocating 117 people to three groups, with group one allocated to routine general practitioner (GP) care. Group two was allocated to immediate CPN intervention and group three allocated to a 12 week delay at which time they received CPN intervention. This was a large trial involving 177 patients and carried out over three years across six health centres. The quality of the trial was very good and carried out by respected nurses and reported in the British Journal of Psychiatry. While the results showed that all groups improved over time, there was no significant difference between the groups seen by the GP or the CPNs. It seemed that improvement was independent of the amount of contact. The dropout rate from CPN intervention was 50%. Interestingly there is no evidence that a CPNs intervention will save GP treatment time.

Although this report was not dealing with people who have a psychosis, it is never the less significant because it looks at issues of treatment efficacy when the CBT is delivered by CPNs.

What the authors of this study concluded were that CPNs should concentrate their time on people with serious mental health problems such as psychosis. They estimate that about 1800 nurses would need to be in practice as specialised CBT nurses. At present there are about 70 mental health nurses using CBT in active practice in the United Kingdom (UK). Gourney (Gourney, Brooking, 1994) argue for training of CPNs that focuses on skill acquisition of proven effectiveness in the treatment of mental illness.

Gourney argues that CPNs should be behavioural trained to work with the people who have serious and acute mental disorders. He further suggests that to continue to apply CPNs to primary care is '*squandering a precious resource*' (Gourney, et al 1994).

8.03. Report Two – Relevance to Nursing

In 1997 in an article reported in *Rehabilitation Rounds*, Stuart Lancashire (Lancashire, Haddock, Tarrier, Baguley, Butterworth, Brooker, 1997) commented on a 1993 programme that trained CPNs in a case management style. A significant part of the programme focused on a CBT approach to the management of psychosis. This was a nine-month pilot training course based at a university nursing school in Manchester England. The course was designed around formal teaching and integrating field practice.

Evaluation of the programme shows that people receiving the integrated approach reduced the positive symptoms of psychosis by 50%. There was little or no shift in the reporting of negative symptoms. The client group was said to include many people with long term schizophrenia who were socially isolated and had little family support. The report writer concludes that training, which includes CBT has the potential to provide beneficial effects for clients and has implications for nurse training for the treatment of people with serious persistent mental illness.

The column editors have further suggested that CPNs can provide the backbone of a community based mental health service that is rehabilitation oriented. The challenge is to organise resources around these priorities.

8.04. Report three – Relevance to Nursing

In 1996, the International Journal of Psychiatric Nursing Research printed an article by Adrian Childs-Clarke and Heather Wagstaff (Childs-Clarke, Wagstaff, 1996). The article described the practice of a single clinical nurse specialist working in a CBT service. The nurse completed basic nurse training then went on to complete the English Nursing Board programme (ENB 650) and certification as a cognitively trained nurse. The article offers some clinical data to support the contention that CBT is a brief and effective way to treat neurotic conditions (non-psychotic conditions).

The article discussed 827 consecutive referrals to the nurse from 1983 to 1993. Seventy percent of the referrals were female with an average age of thirty-three years. Twenty three percent of all referrals were seen in their own homes or in clinics. Referrals came from psychiatrists (26%), GPs (45%), the Psychology department (6%), individuals (5%), and others (12%). Reasons for treatment included anxiety (55%), obsessive disorders (13%), with the remainder a mixture of relationship and habit issues.

Treatment was approached on the basis that CBT was a brief focused programme of less than 20 sessions. Of concern in this report is that of the 827 referrals only 348 completed therapy. This suggests either a problem with engagement in therapy or inappropriate referrals.

This report is important because it is one of very few that discusses clinical practice by mental health nurses working in CBT. It does not purport to have high levels of

methodological rigour but does offer an impression and insight into one nurse's practice.

8.05. Report Four – Relevance to Nursing

In 1996, Hafner (Hafner, Crago, Christianson, Brioney, Scarborough, 1996) presented a feature article in the Australian and New Zealand Journal of Mental Health Nursing. The article traced the movement of mental health treatment to the community from hospitals (Hafner, et al, 1996). As this change occurred a pattern of case management has emerged often involving the nurse as case manager. This was an opportunity to look at CBT as a tool for case managers. The important point is made that it is not wise to compare case management between Australia and the U K because of the difference in caseloads. This is because in the U K one quarter of case managers have no one with a diagnosis of schizophrenia on their caseload. This is certainly not the case in NZ in my experience.

Estimations are that 40% of a community case load in Australia are people diagnosed as schizophrenic (Hafner, et al, 1996). This is more consistent with the New Zealand experience. Therefore, the aim of this study was to evaluate a training programme, in CBT, for case managers, all of whom had a nursing background.

The programme being evaluated was a six-month one that involved 22 one and a half-hour meetings for case managers. In addition, each of the four participants in this study was to have ten, one-hour, supervision sessions. Each trainee was to treat at least four clients with a maximum of 12 one-hour sessions. The training time for each trainee did not exceed 115 hours, with 43 hours of group and individual supervision, up to 48

hours supervised therapy and 24-hours background reading time. This training programme also involved the trainees continuing with their normal clinical responsibilities in their areas of practice. The training programme emphasised an empirical, as opposed to a theoretical, approach.

The results of the training programme were evaluated after six months. All four trainees were found competent to assess patients with serious mental disorder and their suitability for CBT. They were seen as able to deliver appropriate treatment, but felt that they had only basic CBT skills. Results of treatment suggested that these nurses were doing statistically significant and clinically worthwhile work. Arrangements were made for ongoing work and continued supervision.

This study has shown that case managers can be trained while working to carry out basic but effective CBT programmes. Training at this level can be carried out in a relatively short time. This trial has demonstrated that it could be possible to up-skill significant numbers of mental health nurses for the purpose of effectively treating large numbers of clients with serious mental illness, significant proportions of whom will experience a psychosis.

8.06. Report Five – Relevance to Nursing

Since the Hafner, Crago, Christianson, Brioney, Scarborough report (1996), a further report in the same journal by Allen, Tolchard, Band, & Battersby (2000) reported on a pilot programme to train qualified nurses in behaviour psychotherapy.

The background to the paper is that in South Australia a review (Lewkowicz, 1998) identified a need to treat a largely unrecognised and untreated group of people experiencing anxiety disorders. A pilot programme of training in behavioural psychotherapy was instigated. The programme was in fact a combination of behavioural and cognitive approaches to the treatment of anxiety problems.

The aim of the course was to take nurses and equip them with a theoretical, practical and principal based approach to cognitive behaviour therapy. This was seen as an up-skilling of existing practitioners to allow behavior therapy practice to occur under supervision. Suitably experienced psychologists who had agreed to be part of the research carried out supervision. Although the course was directed at the assessment and treatment of anxiety (not psychosis), it has important lessons for the treatment of psychosis by mental health nurses.

Conducted over 24 weeks, the course involved 4-5 hours work and a further 4-5 hours self-directed learning. Workshops covered the main areas of the programme with observation sessions and supervised clinical practice. Supervision was on a weekly basis and consisted of both group and individual sessions. Each trainee managed a caseload of at least two clients for at least five sessions All four of the trainees completed the course and met the requirements of the course aims.

This brief training programme has demonstrated that it is possible to have experienced mental health nurses complete a course of training, with ongoing supervision that meets the identified need for treatment. That nurses conducted treatment was well accepted with no clients asking to be transferred to other therapists during this programme. Problems identified were around trainees getting to classes and managing the programme in conjunction with their regular workload. Since completing the programme two nurses have gone onto work more specifically with behavioral psychotherapy (BP) and two have continued to work in inpatient and community liaison areas. All of the nurses continue to receive ongoing supervision for their BP work.

8.07. Conclusions

What these published reports on training programmes that involve mental health nurses show is that it is possible to adequately train nurses in specific CBT skills. The reports suggest the treatment offered by CBT trained mental health nurses were clinically effective and objectively measurable.

In Australia, the lack of availability of trained CBT therapists restricts the provision of specialised BP. It seems that an expanded role for experienced mental health nurses will go some way to addressing the problems of accessibility (Allen, et al, 2000).

My intuition is that it is the same in New Zealand. There are few clinically trained CBT nurses in practice in mental health services to my knowledge. My sense is that this will change as more overseas nurses are recruited to work in this country. I think that this has the potential to change the expectation of what a mental health nurse can do.

9.00 Conclusion

9.01. Summary

This paper has sought to make some sense of the apparent contradiction around the understanding of psychosis and its treatment. To begin to come to an understanding I have reviewed the historical roots of what is currently understood as CBT. I have traced the early operant approaches to therapy and noted the emergence of learning theories and their influence on psychology. The ongoing power of the scientific method and its objectification of information about the human experience have and remain, critical to the development of CBT. I have reviewed a small number of published research articles that relate to the efficacy of CBT in psychosis. A number of significant conclusions have been drawn as to the effectiveness of CBT in psychosis.

9.02. Conclusions

This research report has explored psychosis as it relates to mental health nurses and the human experience of psychosis as told through Leo's eyes. I have sought to outline the important threads that run from Leo's story through the history, theory and enactment of what has become known as CBT. In the course of this inquiry I have come to see that CBT is rooted in the principles of science, behaviourism, learning theory and the experimental method. The work of early theorists Wilson, Wolpe, Pavlov, Skinner, Eysenk, and Bandura, were developed into what has become known as CBT. Beck and Ellis, recognised as two of the most significant theorists of our time in this area, have

further developed this theoretical basis. CBT assumes an optimistic view of people in that they can change and that there is a simple effective way for that to happen. CBT is predicated on the notion that thoughts, feelings and behaviour are inter related and that each person is part of an integrated whole. It is the understanding of the relationships between these parts that is the nub of CBT.

The enactment of CBT is a collaborative process that relies on relationships. CBT recognises that the therapist brings some skills to the relationship but the intent is to teach and learn so that the patient becomes their own therapist.

Evidence as to the effectiveness of CBT has been reviewed and a number of observations made. Firstly, there is good evidence that CBT when combined with medication and regular treatment has a greater chance of a positive effect than with out CBT. A variety of studies have demonstrated that CBT is a potent adjunct to routine treatment. Neuroleptic medication is a major factor in the treatment of psychosis but is not always effective alone in the treatment of psychosis. The literature about the role of mental health nurses using CBT in their practice is scarce. However, the five articles discussed suggest that it is possible to train mental health nurses to practice CBT in clinically meaningful ways that can be measured.

I began this paper with Leo's story. In the telling of the story, a number of themes emerged around Leo's experience of psychosis. These themes are expressed as withdrawal and isolation, the distress around voices and bizarre beliefs, the struggle of loneliness and the apparent futility of treatment. Amongst these themes was the sense

that thinking, feeling, believing, and behaving were all inextricably linked in a unified way and that for Leo this was part of his human experience.

The enactment of CBT has emerged as a person centred therapy that accepts, empowers and educates the client in ways that are measurable and understandable. I have found many aspects of CBT to be consistent with the application of contemporary mental health nursing practice. There is significant potential for ongoing research in mental health nursing to further explore this exciting area. Sitting alongside the notion of developing research there is an urgent need for an integrated nurse led programme to teach cognitive therapies for clinical practice in New Zealand. This programme would need to be available to all specialist mental health nurses and would be well suited to a post graduate university based school of nursing.

My initial and intuitive sense is that for some selected mental health nurses CBT may offer a treatment modality that is consistent with their thinking, feelings and beliefs about the treatment of people experiencing psychosis. It offers a way forward for the nurse and a way forward for Leo.

10.00 References

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