POSITVE EXPERIENCE AND CHALLENGES IN LEARNING AND DELIVERING COGNITIVE BEHAVIORAL THERAPY AMONG PSYCHIATRIC NURSES OF HONG KONG

Cecil Pak Shun WONG¹, Daniel Yee Tak FONG², Man Ping WANG², and Janet Yuen Ha WONG²

¹Kwai Chung Hospital, China
²School of Nursing, The University of Hong Kong, China

Most psychiatric nurses do not implement cognitive behavioral therapy (CBT) after training. We examined the experience of psychiatric nurses from Hong Kong (HK) in learning and implementing CBT in clinical practice and elucidated the reasons for discontinuing and continuing CBT using a qualitative interview and evaluation survey. We interviewed 13 Chinese psychiatric nurses trained in CBT and reviewed 35 evaluation forms from nurses not implementing CBT. The survey response rate was 100%. Among eligible participants, >70% were recruited from different psychiatric settings to minimize the bias. The overarching theme was the “challenges of psychiatric nurses in CBT learning and implementation and reasons to continue learning CBT without a clear role in CBT delivery.” The main themes were challenges in learning and implementing CBT and positive CBT experience. The psychiatric nurses’ role in HK needs a clear definition for delivering CBT.

Key words: cognitive behavioral therapy, psychiatric nursing, cognitive therapy training, qualitative method, practitioner survey

INTRODUCTION

Globally, the prevalence of mental disorders has been estimated to be 18.1–36.1% and the prevalence has increased 18% from 1978 to 2015 (Kessler et al., 2009; Richter et al., 2019). Global burden of mental illness accounts for 32.4% of the years lived with disability and 13.0% of the disability-adjusted life years; and an amount of 1.5 billion US dollars has been spent in the development assistance for health between 2000 and 2014 (Vigo et al., 2016). Therefore, it is necessary to expand the psychiatric health services to cater the enormous global burden of mental disorders. In Hong Kong (HK), one in seven persons suffers from a common mental disorder during his/her lifetime (Food and Health

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Correspondence concerning this article should be addressed to Daniel Yee Tak FONG, School of Nursing, The University of Hong Kong, 4/F, William M.W. Mong Block, 21 Sassoon Road, Pokfulam, Hong Kong SAR, China (e-mail: dytfong@hku.hk).
Bureau, 2017). It has been reported that 74% of the patients with mental illness did not consult mental health services (Lam et al., 2015). The waiting period for patients in common mental health disorder clinic was 61 weeks in 2015 (Food and Health Bureau, 2017).

Cognitive behavioral therapy (CBT) is a well-established psychotherapy for patients with mental disorders. It is based on the hypothesis that human emotions and behaviors are predominantly driven by a person’s thinking, assumptions, or beliefs and seeks to change how patients perceive themselves, their problems, and the world (Beck, 2011). CBT, when properly delivered, is efficacious in reducing symptoms in patients with depression, anxiety, and schizophrenia (Hofmann et al., 2012). Hence, CBT has been recommended as a psychological therapy in the National Institute for Health and Care Excellence (NICE) guidelines (NICE, 2009, 2011, 2013, 2015).

CBT can be delivered by any mental healthcare professional who has undergone adequate CBT training, including clinical psychologists, psychiatrists, psychiatric nurses, social workers, and occupational therapists (NICE, 2014). Owing to an increase in the prevalence of people with mental disorders, increase in the number of healthcare professionals conducting CBT would lead to the substantial gain in the accessibility of the services. Among the mental health professionals, psychiatric nurses can deliver CBT interventions at a lower cost (NICE, 2014), thereby improving the accessibility of patients with mental disorders to CBT services (Fields et al., 2013). CBT training among psychiatric nurses has been promoted in some Western countries (Horatio: European Psychiatric Nurses, 2012). The training and practice of CBT among psychiatric nurses vary across countries and they are especially remarkable in England. Psychiatric nurses in the United Kingdom (UK) are trained to be the CBT therapists and work under a program called ‘Improving Access to Psychological Therapies (IAPT)’ since 2006. This program is aimed to shorten the waitlist for psychological services (Gyani et al., 2013). Nowadays, CBT training programs for psychiatric nurses are well established and widely available in the United States (US) and the UK (Beck Institute for Cognitive Behavior Therapy, 2016; British Association for Behavioural & Cognitive Psychotherapies [BABCP], 2018).

In the UK, only 33% of psychiatric nurses have reported using their CBT skills, either occasionally or most of the time (Ryan et al., 2005). These trends indicate that the majority of psychiatric nurses in the UK do not implement CBT after training. Similarly, only 30% of nurse practitioners in Southern Arizona implemented CBT after their training (Story, 2014). The underlying cause for this has been rarely discussed. A similar trend has been observed in HK. Nearly million dollars have been invested in CBT training for psychiatric nurses and more than a hundred psychiatric nurses have undergone diverse CBT training in HK since 2007. The number of psychiatric nurses who have undergone CBT training comprises five percent of the total number of psychiatric nurses in HK. Among the psychiatric nurses who received CBT training, most of them have obtained CBT training from the certified CBT trainers of the Academy of Cognitive Therapy, US. However, based on the records of Kwai Chung Hospital in HK, 30–33% of the trained nurses implemented CBT between 2013 and 2017.
Most of the studies conducted in HK investigated the effect of CBT in Chinese people suffering from mental illnesses including schizophrenia (Ng et al., 2008), depression (Wong, 2008), and posttraumatic stress disorder (Wu et al., 2014). All of the local empirical studies focused on the treatment outcomes rather than CBT training. Only one article (Chan & Leung, 2002) describes about the CBT and psychiatric nursing, but it has reviewed only the foreign articles and recommended the incorporation of CBT in psychiatric nursing practice in HK; however, the authors have also mentioned that CBT in psychiatric nursing is an under-researched area. Thus, local study investigating the CBT training of psychiatric nurses in HK is scarce.

A study conducted in the UK suggested that the nurses felt that CBT was beyond the scope of psychiatric nursing and was, therefore, reluctant to implement CBT (Maguire, 2012). However, the study only examined the concerns of the frontline staff working with homeless people and did not explore the concerns of nurses in other clinical settings. CBT trainees in Norway (n = 562, response rate = 48%) reported barriers to CBT implementation, including an unsupportive workplace, limited supervision, ineffective training, and an insufficient number of patients suitable for CBT (Kjøge et al., 2015). CBT trainees in Ireland (n = 43, response rate = 56%) reported that a lack of resources, funding, and time affected the implementation of CBT (MacLiam, 2015). Both surveys were designed for a single training program, and the data were collected from different healthcare professionals, such as psychiatrists, clinical psychologists, and psychiatric nurses. Therefore, the concerns of psychiatric nurses were not specifically addressed in these studies. Moreover, the evaluation of a single CBT course at a particular time point could not represent all the experiences of psychiatric nurses in an ever-changing and long-term CBT learning and implementation process.

Most of the studies evaluating CBT training have focused on the course effectiveness rather than elucidating the ever-changing and long-term CBT learning and implementation process among psychiatric nurses. Hence, the gap in the literature persists. In addition, cultural consideration for Chinese people is necessary in CBT process. Chinese people prefer a structured therapeutic process and expect the therapists to play an active role in providing suggestions and advice (D. F. K. Wong, 2008; F. K. D. Wong, 2011). It reflects that they prefer order and observe deference for those in power (Lin, 2002; Ng et al., 2017). It also emphasizes emotional restraint and self-control in communication under socialization process (Lin, 2002). Cultural influences among the Chinese are based on the ideologies of Confucianism, Buddhism, and Taoism (Lin, 2002; Ng et al., 2017). Nevertheless, the cultural concerns are targeted to the Chinese people who receive treatment, but not the mental health professionals who deliver the treatment. Furthermore, the Chinese residing in HK have been more westernized due to HK’s colonial background under the British rule (Chen & Mak, 2008). Thus, the fusion of Chinese and Western cultures makes the Chinese residing in HK different from the Chinese residing in the mainland. The elucidation of the potential cultural challenges among Chinese psychiatric nurses during CBT learning journey is necessary.

Based on the aforementioned research gaps, it is important to explore the experience of psychiatric nurses in learning and implementing CBT in HK to identify the underlying
reasons for which the majority of the psychiatric nurses trained for CBT do not deliver CBT in clinical practice, along with simultaneously understanding the driving force for the minority who continue to learn and implement CBT. This would be helpful in improving our understanding of the challenges faced by psychiatric nurses in HK. This information is crucial for CBT trainers and managerial staff to identify methods of improving CBT training and practice in the context of psychiatric nursing. Therefore, the present study aimed to examine the experience of psychiatric nurses from HK in learning and implementing CBT in clinical practice and to elucidate the underlying reasons for discontinuing and continuing CBT implementation using a qualitative interview and an evaluation survey.

**METHODS**

This study comprised a qualitative interview and an evaluation survey. The study was approved by the Hospital Authority Kowloon West Cluster Research Ethics Committee in HK.

To the best of our knowledge, to date, there is no quantitative or qualitative study investigating the experience of psychiatric nurses in learning and implementing CBT in clinical practice, and elucidating the underlying reasons for discontinuing and continuing CBT learning and implementation. Hence, there was no conceptual framework that could be followed to quantitatively investigate the experience of psychiatric nurses. Quantitative survey is a method of collecting data at a single point in time. The ever-changing and long-term experience of psychiatric nurses in learning and implementing CBT requires investigation at multiple time points. Investigating a single CBT course at a single time point is not valid. Conducting quantitative surveys repeatedly is expensive, time-consuming, and impractical. In addition, the fusion of Chinese and Western cultures makes the Chinese residing in HK different from those residing in the mainland; the potential cultural challenges in CBT learning journey faced by the Chinese psychiatric nurses in HK cannot be quantified. Thus, exploring ideas of the psychiatric nurses who have experience in CBT learning is a method to answer the research question.

A qualitative approach allows us to obtain a more realistic view of the real world that cannot be understood in numerical data and statistical analyses. It also acquainted us with the perspective of the psychiatric nurses participated in the study through immersion in a situation and as a result of direct interaction with them to understand the underlying reasons for discontinuing and continuing CBT learning and implementation (Anderson, 2010; Hammarberg et al., 2016). Therefore, a qualitative approach was adopted in this study.

Listening to the story of psychiatric nurses was a way to explore their experience in the journey of CBT learning. Therefore, narrative inquiry approach was used in this study. However, we could not totally depend on the information obtained from qualitative interviews because all participants continued to learn and implement CBT at the time of the interview. They could not directly provide reasons for why the psychiatric nurses discontinued CBT implementation. Therefore, an evaluation survey was used to supplement the missing information.

*Reflexivity and Trustworthiness*

We adopted the recommended strategies to enhance the reflexivity and trustworthiness of qualitative studies (Lincoln & Guba, 1985; Ramani et al., 2018). The Consolidated Criteria for Reporting Qualitative Research checklist was adopted for reporting the results (Tong et al., 2007).

*Qualitative Interview*

*Design.* We adopted a qualitative approach by conducting semi-structured individual interviews among psychiatric nurses from HK to enquire about CBT learning and implementation in clinical practice. The guiding questions were established using the concept of narrative inquiry to probe for compelling stories
(Lieblich et al., 1998). The author (C.W.) and two other psychiatric nurses reviewed and discussed the guiding questions before the interview.

Participants and setting. Purposive sampling was used at Kwai Chung Hospital, a public psychiatric hospital, to recruit HK psychiatric nurses who received CBT training and implemented CBT in clinical practice. The public psychiatric hospital had 600 psychiatric nurses at the time of the study, which constituted 25% of the total number of psychiatric nurses in HK. This was the first psychiatric hospital/unit that introduced CBT training in psychiatric nursing. At the time of the study, 10% of the psychiatric nurses in this hospital had received CBT training since 2007. Psychiatric nurses with experience in implementing CBT following training were included in the study. Psychiatric nurses who had not previously implemented CBT in clinical practice were excluded from the qualitative interview. Eighteen psychiatric nurses identified from CBT training and practice records reported that they had implemented CBT after training. All psychiatric nurses had completed CBT training, which included a 2-day CBT course, a 5-day intensive CBT workshop, and a 10-day CBT supervision course in the hospital. The 2-day CBT course covered topics such as therapeutic relationship in CBT, basic CBT model and use of thought record, common behavioral techniques, distorted thought in Chinese people, socratic questioning, and CBT standard questions. The 5-day intensive CBT workshop involved conceptualizing a CBT case with the client’s participation to produce meaningful treatment plans and guide therapeutic interventions; defining behavioral targets with precision and measuring treatment outcomes; utilizing specific cognitive and behavioral strategies, including psychoeducation, cognitive restructuring, exposure, and response prevention; and using CBT with couples, parents, and children/adolescents. The 10-day CBT supervision course in the hospital involved criteria for choosing a right case for CBT session, initial assessment and case formulation, establishing an effective therapeutic alliance, performing an integrative CBT assessment, developing a CBT case conceptualization and intervention plan, implementing systematic CBT sessions, understanding levels of cognition and behavioral analysis, and reforming case conceptualization and intervention plan. The total training time was approximately 119 hours. We recruited study participants from this pool of nurses. Recruitment was performed until data saturation.

Data collection. The aim and procedures of the study were clearly explained to the eligible participants, who were allowed to ask questions and were invited to read the information sheet thoroughly to ensure that they had fully understood the scope of the study. After at least 24 hours, the participants were invited to sign a consent form before completing a brief questionnaire covering their demographic information and CBT experience.

A psychiatric nurse (C.W.) then conducted a 2-hour semi-structured, face-to-face interview with each participant while referring to the guiding questions. The interview consisted of both open-ended and follow-up questions that assessed the participants’ CBT training and implementation experience in clinical practice as well as ongoing opportunities to further develop CBT skills. After the preliminary analysis, we conducted a second interview with the participants. The second interview was an opportunity for the participants to verify the findings by a discussion with the authors and help authors ask further questions based on the preliminary results.

All interviews were conducted in a quiet room to ensure the privacy of the participants. During the interview, field notes were written for further clarification and the preparation of follow-up questions. All interviews were audio-recorded and downloaded onto a password-protected computer.

Analysis. The audio recordings were transcribed verbatim in Chinese. The transcripts were read repeatedly alongside the audiotapes and field notes to confirm the accuracy of the transcription. Transcript analysis was based on the manual of narrative inquiry (Lieblich et al., 1998).

Two psychiatric nurses and C.W. independently coded the transcripts. Interpretation and coding discrepancies were resolved by discussion. The transcripts were read and re-read several times to decide upon the most appropriate coding (Parse, 2001). In case the new information did not match the predetermined code, a new code was developed, and the transcripts were re-read to ensure the appropriateness of the predetermined codes and to confirm that no information had been overlooked. When no new code emerged from the transcripts of the interview, it was defined as data saturation.

After data saturation, we looked into the open codes and categorized them in a meaningful way. Owing to the narrative approach, the interviewer intended to explore the nurses’ experience in the CBT training journey from the beginning to the time of the interview. Therefore, the open codes from each transcript might not have been associated with each other because the learning journey of each participant
was unique. We categorized the open codes in two dimensions, i.e., in a longitudinal way to present the experience of each participant by time and a cross-sectional way to present the experience by event, to record the response sequence of each participant. Further, we found the common categories from all transcripts, wherein, we included the common experience of all participants and excluded the uncommon ones during analysis.

After the open codes were categorized, we further condensed the categories until the main themes emerged. In between, we noted what the participants said during the interview and analyzed whether their experience was a constant phenomenon by further confirmation with the participants and cross-checking with the field notes. The overarching theme was not known before the process of coding by three persons (two psychiatric nurses and the first author) independently.

In total, 85 predetermined codes were identified. We initially classified the open codes into 26 initial categories and then further merged and condensed them into subcategories and different themes. Finally, the interpretation of and inter-relationship between various themes were verified and compared with quotes until the overarching theme emerged. When the overarching theme emerged, we had gone through all the categories to refine the names of the categories without changing the meaning. NVivo version 11 (QSR International, Doncaster, Australia) was used for analyzing the transcripts.

Evaluation Survey
Design. Training evaluation forms were sent to the participants two weeks after the end of CBT training. We retrieved the CBT training evaluation forms to assess the underlying reasons why psychiatric nurses did not practice CBT after their training.

Participants and setting. All CBT training evaluation forms were identified and retrieved from the central nursing division of the psychiatric hospital.

Data collection. All CBT training evaluation forms were reviewed by C.W. We only selected evaluation forms with the answer ‘No’ to the question “Following CBT training, have you ever tried to practice CBT? Please give a reason for your answer.” All narrative contents were input into an Excel file for further analysis.

Analysis. All data were input and preliminarily coded by a clerical staff who was not involved in handling the qualitative interview data; thus, she was blinded to the final results of the interview. The preliminary codes were further confirmed by C.W. After the confirmation, two psychiatric nurses counted the numbers of each code and further categorized the codes into different themes.

RESULTS

Qualitative Interview

Upon data saturation, 13 Cantonese-speaking psychiatric nurses from HK had been recruited making up 72% of the eligible participants. Participants were categorized according to the psychiatric unit types as follows: in-patient units (two), day-patient units (five), out-patient units (three), and community units (three). None of the participants refused to undergo interviews or dropped out of the study. Participants were experienced in psychiatric nursing, with 3–25 years of work experience. Among 13 Cantonese-speaking psychiatric nurses from HK, 10 (77%) were women. The demographic information of the participants is summarized in Table 1.

We identified “Challenges for psychiatric nurses in CBT learning and implementation, and reasons to continue learning CBT without a clear role in CBT delivery” as the overarching theme. Two themes representing the CBT learning and delivery process included “Challenges in CBT learning and implementation” and “Positive CBT experience” (Table 2). The first theme covered challenges in learning and practice environments, and
the second theme covered the factors that encouraged psychiatric nurses to continue with CBT learning and implementation.

**Challenges in CBT learning and implementation.** Participants revealed that there were challenges in their CBT learning and practice for the following reasons: “Training did not match with the expected duty,” “Lack of supervised practice” and “Unfavorable practice environment.”
All participants perceived a mismatch between the training program and their expected role. They did not need to conduct a structured CBT session in their daily routine, but it was necessary to undergo the training.

*I didn’t get the main points about CBT session. The CBT training did not match our clinical needs because we don’t need to provide a structured CBT session.*

(Mr. A, a senior nurse from the day-patient unit)

Additionally, the concerns were raised by all participants regarding the lack of supervised practice during CBT training and implementation. Participants expected systematic supervision during training under the guidance of a CBT supervisor if they were expected to deliver CBT.

*No one supervised the way we did it. You just don’t know what you were doing. This makes the whole learning process painful. I don’t know how to start with a structure session but actually, I don’t need to do so in daily routine.*

(Mr. H, a junior nurse from community service)

Further, unfavorable practice environments made CBT learning and implementation more challenging for psychiatric nurses. All participants cited a limited number of suitable patients and limited time as underlying reasons for not performing CBT.

*Just like today, I went to the ward and there was only one patient diagnosed with depression. I couldn’t find [enough] cases to implement CBT, and that makes things difficult. I think that I would require spending much more time, or even after work to do that.*

(Ms. D, a junior nurse from the in-patient unit)

*Maybe it takes around 45 minutes to one hour to complete a CBT session, and a psychiatric nurse may not have the chance and the protected time to perform a good structured session. It’s an extra workload for me.*

(Mr. J, a senior nurse from the out-patient unit)

*Positive CBT experiences.* The second theme consisted of positive CBT experiences that motivated psychiatric nurses to continue learning and practicing CBT despite its challenges. The subcategories of this theme were “Satisfaction with CBT skill practice,” “Personal experience of CBT benefit,” and “Supportive nurses who are experienced in CBT.”

“Satisfaction with CBT skill practice” was noted in the comments of all participants. The satisfaction arose from using their CBT skills during their interaction with patients.

*After learning CBT, I have become more sensitive to the patient’s needs. In some cases, the improvement is very obvious after my counseling. To me, I am sure that I used the right treatment. I am confident that I am really helping patients.*

(Mr. J, a senior nurse from the out-patient unit)

Having personally experienced CBT benefit was another positive experience reported by all participants. The benefits focused on personal growth and helping others in daily life.
I have known myself more. It first helps me even before I start helping others. This is because when I was attending the CBT lessons, I thought of why I had those irrational thinking patterns in the past. I have been reviewing my past a lot.

(Ms. F, a senior nurse from the day-patient unit)

A friend asked me about the emotional problems of his girlfriend. I’ve given him some suggestions from the CBT approach. Then, he realized that I’m very professional because I can give him good advice and help him.

(Ms. D, a junior nurse from the in-patient unit)

Also all participants mentioned that it was beneficial to receive support from nurses who were experienced in CBT or from certified CBT therapists who were nurses. This support could be in the form of skill transfer or clinical facilitation. Eleven participants reported engaging in group practice, which was a unique manner in which they received support. Group practice often involves three to four psychiatric nurses, led by a CBT therapist, conducting a group-based CBT intervention for patients with depression. Participants mentioned that they could observe how the CBT therapist used CBT techniques and the effects of CBT in group practice.

CBT therapist sharing their experiences with CBT may help us understand the patients. I think it is useful in skill transfer. Today, I applied what I have learned on the patients.

(Ms. E, a senior nurse from the day-patient unit)

I was curious about the effects of CBT at the beginning and even after training. After joining group practice, I started to understand how to apply CBT techniques, and finally, I knew what the real effects of CBT are. I didn’t have the right persons to ask if I had not been in the group practice.

(Ms. C, a senior nurse from the community)

In the second interview, we verified the transcripts of the first interview and explored methods to overcome the challenges. All 13 participants reported that the challenges would be minimized if a clear role in delivering CBT could be assigned to a nurse.

If CBT is my duty, it means I must do it in a formal guideline. Under the formal guideline, I can be justified to take the case and also be justified to receive a formal CBT supervision.

(Mr. J, a senior nurse from the out-patient unit)

A clear role of the nurse to do CBT is good because the barriers to apply CBT will be fewer. First, I don’t need to beg for a suitable case to practice. Second, I don’t need to do CBT on top of my existing work, time is more sufficient. Finally, I can apply CBT sessions but not only to apply CBT techniques.

(Ms. D, a junior nurse from the in-patient unit)

Evaluation Survey

We retrieved 59 evaluation forms from CBT training sessions, which included a 2-
Table 3. Main Themes and Subcategories Based on the Content of the Evaluation Survey

| Main themes                    | Subcategories (number of respondents) |
|--------------------------------|---------------------------------------|
| Clinical difficulties          | No time to deliver CBT ($n = 10$)     |
|                                | Required to perform routine clinical duties ($n = 8$) |
|                                | Not feasible to deliver CBT sessions ($n = 7$) |
|                                | No suitable patients ($n = 6$)         |
|                                | I am not required to deliver CBT ($n = 3$) |
|                                | I am not authorized to deliver CBT ($n = 2$) |
|                                | Suitable patients are referred to another discipline for psychotherapy ($n = 2$) |
|                                | No supervision ($n = 2$)               |
| Personal limitation            | Do not know how to do CBT ($n = 5$)   |
|                                | I do not want to deliver CBT ($n = 4$) |
|                                | I do not have the confidence to deliver CBT ($n = 4$) |

Note. The respondents were allowed to write down more than one reason for discontinuing the implementation of CBT after undergoing training. CBT = cognitive behavioral therapy.

day CBT course and a 5-day intensive CBT workshop, conducted between 2014 and 2017 at the hospital. The response rate was 100%. Most psychiatric nurses did not practice CBT after both workshops. Thirty-five evaluation forms in which the answer ‘No’ had been selected for the question “Following CBT training, have you ever tried to practice CBT? Please give a reason for your answer” were selected. Respondents were allowed to list more than one reason. The reasons were categorized into two different categories including clinical difficulties and personal limitations (Table 3). Three respondents did not provide a reason.

From the survey, we understood the barriers to CBT practice among psychiatric nurses and elucidated the reasons why they did not practice CBT after training. The results of the evaluation survey were consistent with the challenges reported by psychiatric nurses experienced in learning and implementing CBT during the qualitative interview.

**Discussion**

To the best of our knowledge, this is the first study to explore the experience of CBT learning and implementation in clinical practice, alongside assessing the reasons for not implementing CBT, among Chinese psychiatric nurses. It has been reported that approximately 30% of nurses implemented CBT after training (Ryan et al., 2005; Story, 2014). The major reasons for not applying CBT were related to unsupportive workplaces; limited supervision; ineffective training; insufficient patients eligible for receiving CBT; and lack of resources, funding, and time to deliver CBT (Kjøge et al., 2015; MacLiam,
2015). Also, the nurses took into consideration the scope of practicing psychiatric nursing before applying psychotherapy (Maguire, 2012).

In this study, the clinical difficulties of psychiatric nurses who did not apply CBT were consistent with the previously established knowledge. Nearly all the reasons provided in the survey were associated with the assigned job duties irrespective of the clinical setting. In HK, the nurse-to-patient ratios are as follows: psychiatric intensive care units (1:10), post-admission psychiatric units (1:20), and community service (1:80). Also, severe mental illnesses are prevalent in the adult psychiatric setting. These kinds of patients may have complications that are too challenging for CBT beginners (Carson & Clark, 2017). The patients suitable to receive CBT, such as those with depression and anxiety, from CBT beginners seldom need hospitalization and/or community psychiatric service. The high nurse-to-patient ratio and a limited number of suitable patients make it difficult for psychiatric nurses to implement CBT sessions.

CBT training programs for psychiatric nurses, having been adapted from the US and the UK, are easily accessible in HK (Beck Institute for Cognitive Behavior Therapy, 2016; BABCP, 2018). The training sessions are designed to equip professionals to become CBT therapists, and training to conduct a structured CBT session is indispensable. However, after the psychiatric nurses complete their training or become CBT therapists, their role does not include the implementation of structured CBT sessions. Therefore, the psychiatric nurses perceived that CBT training did not match with their expected duty. Learning CBT is similar to learning a foreign language (Trinidad, 2007), wherein, the time for learning and practice are essential; however, psychiatric nurses do not have the opportunity to continue the practice after the training.

In the absence of a well-defined role for psychiatric nurses in implementing CBT, using theories and concepts of CBT for clinical application is a strategy to practice CBT (Hoeffer & Murphy, 1982). The nurses make use of CBT concepts and techniques in daily nursing care, for example, in communication with patients, which is a more flexible way to implement CBT (Duffy et al., 2013). However, it is an unstructured and inconsistent way of practicing CBT (Trinidad, 2007). CBT learners may not go through the whole process of CBT. On the contrary, CBT is a structured psychotherapy (Beck, 2011), wherein, a series of structured CBT sessions can present a comprehensive process of CBT to people who receive CBT as well as deliver the CBT session. Therefore, learning a structured CBT session is essential for a CBT learner. Thus, a dilemma exists for CBT training and practice among psychiatric nurses.

The lack of supervised practice is another challenge. Psychotherapy supervision is defined as a setting in which one psychotherapist instructs and provides training in psychotherapy theories, methods, and skills to psychotherapists while they are treating patients (Alfonsson et al., 2017). In the clinical view, psychiatric nurses do not require CBT supervision because they do not need to implement CBT. Traditionally, they work under a hierarchical supervision model but there is no requirement for supervisors to receive CBT training. Psychiatric nurses are required to conduct structured CBT sessions among patients during training, but their supervision is inadequate for this purpose.

Although previous studies have reported the clinical difficulties faced by psychiatric
nurses in CBT learning and implementation, none of them has explored the underlying reasons for these difficulties. Psychiatric nurses in the present study reported that the challenges would be minimized if a clear role in delivering CBT was assigned to psychiatric nurses. The choice of applying CBT depends on the role assigned to a psychiatric nurse (Barker, 1980). Considering that due to time constraints, we may not be interested in learning something we are not required to do, the majority of psychiatric nurses do not practice CBT after completing their training.

Despite the aforementioned challenges experienced by psychiatric nurses in CBT learning and implementation, often due to an unclear role in delivering CBT, positive CBT experiences foster the motivation to continue delivering CBT. Participants were found to be satisfied with CBT skill practice on applying their CBT skills in their daily communication with patients. The positive feedback from the patients, including appreciation and positive outcome of CBT, acts as a momentum for the participants. Although satisfaction is difficult to measure, verbal feedback from patients seems to encourage psychiatric nurses. Also, the use of CBT techniques helps CBT providers understand themselves and others. We could not find any report in the literature regarding the effects and benefits of CBT on CBT providers; however, CBT learning and practice among psychiatric nurses appears to help in understanding themselves as is indicated by the feedback from the participants of the present study.

Self-motivation among participants is crucial for the continued development of CBT skills. Further positive support for psychiatric nurses is gained from nurses who are experienced in CBT or from CBT therapists. Their support for psychiatric nurses involves skill transfer and clinical facilitation during training. Sharing of technical knowledge by training experts and sharing experience with peers are recognized learning resources (Bunger et al., 2016). However, the structure of clinical practice is such that the nurses who are experienced in CBT or CBT therapists only support CBT learners working in the same unit. Therefore, not every person learning CBT receives adequate support. Psychiatric nurses participating in group practice comparatively receive more support under the supervision of CBT therapists. Group practice allows psychiatric nurses to gain more positive experiences in CBT learning and implementation. Additionally, participating in group practice allows the nurses to observe the application of CBT techniques by the therapist and experience the impact of CBT.

In the UK, the IAPT project has ensured that the clinical role of nurses changes after CBT training to include specific responsibilities for the delivery of CBT; as a result, over 90% of the nurses implement CBT (Liness et al., 2017). CBT therapists involved in the IAPT project provide CBT intervention according to a stepped care model, in which the delivery of adequate CBT is ensured by engaging persons with an appropriate level of training (Bennett-Levy et al., 2010). Psychiatric nurses in the IAPT project are allowed to provide CBT according to their level of training. However, considering the current mental health policies and nursing traditions, the development of IAPT has yet to take place in HK.

We recommend group practice as a routine for psychiatric nurses to implement CBT in the clinical setting. Also, being a CBT therapist can be one of the career options for
psychiatric nurses such that CBT training and supervision are reformed to fulfill the requirements of the role of CBT therapist. With the new role of psychiatric nurses as CBT therapists, the clinical barriers of implementing CBT by psychiatric nurses can be minimized.

We used qualitative interviews and an evaluation survey to examine the experience of psychiatric nurses from HK regarding CBT learning and implementation and the reasons for discontinuing CBT in clinical practice despite undergoing training. This study involved the first public psychiatric hospital to develop CBT training for nurses and allow psychiatric nurses to implement CBT, thereby providing access to the highest proportion of eligible psychiatric nurses in HK for our study. The response rate of the evaluation survey was 100%. The reasons underlying the choice of not implementing CBT after training were clear. Over 70% of eligible participants from different psychiatric settings were recruited for a qualitative interview, which minimized the bias. The interview and analysis were sufficiently rigorous to generate objective themes from the experiences of the nurses. However, all information obtained was based on recall; therefore, recall bias could not be excluded. This limitation was minimized by including psychiatric nurses working in different settings and by conducting multiple interviews with the participants in order to have ample opportunity to obtain clarifications.

Interestingly, none of the participants reported cultural issues in CBT implementation. It has been suggested that the Chinese people are reserved in communicating individual opinions and expect the therapist to address their all concerns and give advice (Wong, 2013). In addition, Chinese people also have their own form of cognitive distortion. Questioning Chinese people about their personal matters may be perceived as being disrespectful and should be avoided at the initial stage of CBT (Lin, 2002). They also tend to hide their underlying problems and only prefer to discuss the superficial issues with the therapist (Lin, 2002). Hence, the participants might have had difficulty in guiding patients to find the solution. In the present study, the participants did not experience such difficulties during CBT implementation, which might be due to their limited knowledge of the unique Chinese culture. Moreover, the present study was not designed to address the cultural differences while imparting CBT due to the insufficient opportunities for psychiatric nurses to deliver CBT. Further studies comprising participants with different cultural backgrounds who receive CBT intervention are warranted to elucidate the cultural differences.

The present study successfully yielded a rich and deep understanding of the views of Chinese psychiatric nurses regarding CBT learning and implementation in HK. The results of the present study can be used as a reference for CBT training and implementation among psychiatric nurses in all psychiatric hospitals/units in HK as well as in other modalities of psychotherapy training, including family therapy, psychodynamic therapy, and emotional focus therapy, in psychiatric nursing. Since group practice allows psychiatric nurses to gain positive experiences in CBT learning and implementation, future studies are warranted to elucidate whether group-based CBT interventions are feasible for administration by the psychiatric nurses. Additionally, we should explore the concerns of the managerial staff, medical staff, clinical psychologists, and patients
regarding the role of psychiatric nurses in providing CBT in HK.

AUTHOR’S CONTRIBUTION

All authors contributed to research design. The first and second author conducted the analysis and wrote the preliminary version of the manuscript. The first author revised the manuscript and confirmed the final version.

CONFLICT OF INTEREST

All authors have no conflicts of interest to disclose.

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