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Abstract

Objectives: The acute inpatient setting poses potential challenges to delivering one-to-one psychological therapy; however, there is little research on the experiences of both receiving and delivering therapy in this environment. This qualitative study aimed to explore service users' and psychologists' experiences of undertaking individual therapy in acute inpatient units. It focused on the relationship between service users and psychologists, what service users found helpful or unhelpful, and how psychologists attempted to overcome any challenges in delivering therapy.

Design: The study used a qualitative, interview-based design.

Methods: Eight service users and the six psychologists they worked with were recruited from four acute inpatient wards. They participated in individual semi-structured interviews eliciting their perspectives on the therapy. Service users' and psychologists' transcripts were analysed together using Braun and Clarke's (2006) method of thematic analysis.

Results: The accounts highlighted the importance of forming a 'human' relationship – particularly within the context of the inpatient environment – as a basis for therapeutic work. Psychological therapy provided valued opportunities for meaning-making. To overcome the challenges of acute mental health crisis and environmental constraints, psychologists needed to work flexibly and creatively; the therapeutic work also extended to the wider context of the inpatient unit, in efforts to promote a shared understanding of service users' difficulties.

Conclusions: Therapeutic relationships between service users and clinicians need to be promoted more broadly within acute inpatient care. Psychological formulation can help both service users and ward staff in understanding crisis and working collaboratively. Practice-based evidence is needed to demonstrate the effectiveness of

adapted psychological therapy models.

Practitioner Points

- Developing 'human' relationships at all levels of acute inpatient care continues to be an important challenge for clinical practice.
- Due to the distress of individuals and the constraints of the acute inpatient environment, psychologists need to be flexible and adaptable in delivering individual therapy.
- Making meaning and psychological formulation can give service users a sense of hope and empowerment, and can contribute to a shared understanding within the ward team of service users' difficulties.

Introduction

The acute inpatient unit is regarded in the UK as a key component of managing mental health crisis (Bowers, Chaplin, Quirk, & Lelliott, 2009). Over the past decade, there has been a decrease in the number of beds in acute inpatient units and a greater emphasis on discharging service users quickly, partly due to the introduction of crisis resolution and home treatment teams, as well as financial pressures (The Commission on Acute Adult Psychiatric Care, 2015). Consequently, the threshold of mental health crisis required to warrant an acute ward admission has increased. Service users tend to present with high levels of risk, more severe and comorbid mental health problems, and concurrent social issues (McCrone, Dhanasiri, Patel, Knapp, & Lawton-Smith, 2008).

The quality of care in acute inpatient wards has been heavily criticised by both service users and staff (Wood & Alsawy, 2016). For example, service users have reported that custodial rather than therapeutic values prevail in acute wards, which are often characterised by rapid staff turnover and impoverished environments (MIND, 2011). In addition, overcrowding and a lack of therapeutic activities have been highlighted (Joint Commissioning Panel for Mental Health, 2013). Recent years have seen calls for improvements in acute mental health care, including increased access to psychological therapies (Department of Health and Concordat Signatories, 2014) and the recommendation that “a wide range of effective psychological therapies” be available to all service users in acute and crisis mental health settings (MIND, 2011, p.45). In practice, however, the definition and delivery of psychological therapy provision has varied widely across acute inpatient settings (British Psychological Society, 2012).

Psychological therapy in the acute inpatient setting

There are several potential challenges to implementing psychological therapy in acute inpatient wards. Individuals often are in a state of crisis, and receive high levels of medication and multiple treatment interventions alongside any psychological input (McGowan & Hall, 2009). Stays in UK acute inpatient units tend to be short (in 2015, an average of 32 days; NHS Benchmarking Network, 2015), thereby limiting the opportunity to plan and deliver structured psychological therapy. A substantial proportion of service users in acute inpatient settings are also detained involuntarily under the Mental Health Act (in 2015, nearly one-third; NHS Benchmarking Network, 2015); they are therefore more likely to perceive professionals as coercive and non-therapeutic (Seed, Fox, & Berry, 2016). The constraints of this setting, and the particular needs of individuals, may therefore necessitate adaptations to be made to established psychological therapies (Clarke & Wilson, 2009).

A small body of evidence indicates that individual psychological therapy in inpatient settings can be effective. For example, Kohler et al. (2013) found reductions in symptoms for service users with unipolar depression, who had received twice-weekly CBT for an average of 13 sessions. Similarly, Schramm et al. (2007) found improvements in service users with major depression, who had received interpersonal therapy for 15 sessions, three times a week. However, these findings may have limited generalisability: the regularity of sessions may not be possible in a typical acute inpatient unit, and the findings are based on discrete diagnostic groups.

How individual psychological therapy is implemented in contemporary inpatient settings therefore needs further attention. We know little about psychologists' experiences of undertaking therapy in this context, and service users' experiences of engaging with it. Qualitative research is well suited to exploring such

experiences, and has the potential to provide useful information for planning and shaping effective psychological services.

One recent qualitative study examined the experiences of psychological input – including individual, group and family therapy – in the acute inpatient setting, from the perspectives of four service users and six staff members involved in their care (Donaghay-Spire, McGowan, Griffiths, & Barazzone, 2015). The participants' accounts suggested that psychological input helped service users make sense of a crisis, improved relationships, and contributed to recovery; empathy and understanding from psychologists was particularly valued. Some challenges and barriers to providing psychological input were also noted, including service users' high distress levels and some individuals feeling not 'ready' to talk. However, the study did not focus specifically on individual therapy, nor did it explore the experiences of those delivering the psychological intervention.

Aims of the study

In summary, the acute inpatient environment poses potential challenges to delivering one-to-one psychological therapy; however, there is a lack of research on the experiences of both receiving and delivering psychological therapy in this environment. The present, qualitative study aimed to explore the experiences of service users and their respective psychologists undertaking individual psychological therapy in inpatient acute wards. It focused on the relationship between the service users and psychologists, what service users found helpful and unhelpful, and what (if anything) psychologists found challenging and how they attempted to overcome those challenges.

Method

Setting

The study took place on four adult acute inpatient units (two female, two male) at a large psychiatric hospital in London. Each ward had two days of dedicated input from a qualified psychologist, which included one-to-one psychological therapy as well as assessment, formulation, consultation, family work and groups. Several assistant and trainee psychologists also worked across the wards providing low-intensity individual and group interventions.

Ethical approval

Ethical approval was obtained from an NHS Research Ethics Committee. All participants gave written consent to take part.

Participants

Inclusion criteria. Service users were eligible for the study if they: (1) had received at least three individual therapy sessions provided by a qualified or assistant psychologist (the three-session minimum was to ensure sufficient experience to reflect on); (2) had sufficient English to give consent and participate in an interview; (3) had no significant learning disability or developmental disorder that would impede participating in an interview; and (4) had capacity to consent to participate in the research.

Recruitment. The psychologists working on the wards were asked to identify eligible service users. Fourteen met the inclusion criteria and eight consented to take part. Of the six who declined, two stated that they found it difficult to trust professionals and feared what might be done with their data, three gave no reason, and one had significant symptoms that made it too difficult to engage with the interview.

The psychologists and assistant psychologists who had worked, or were currently working, with the service user participants were also invited to participate. All consented and took part.

Participant characteristics. The eight service users (five men, three women) ranged in age from 21-55 years (mean: 39); six described themselves as White British, and two as Asian British. Their primary diagnoses were personality disorder (N=3), psychosis (N=2), and anxiety, depression and autism spectrum disorder (one each); across the wards, the most common primary diagnoses were psychosis spectrum disorders (70-80%). Four participants were detained under the Mental Health Act at the time of interview; six had been detained at admission. Length of stay on the ward at the point of study recruitment ranged from four to 48 weeks (mean: 21); this was much higher than the hospital's average length of stay (25 days). The duration of therapy ranged from three to 31 sessions (median: 11.5); this was much higher than the service's typical therapy duration of 3-8 sessions. At the time of interview, the therapy had come to an end for five of the eight participants.

Six psychologists participated (two had worked with two service user participants each). Three were clinical psychologists, one was a counselling psychologist and two were assistant psychologists. The qualified psychologists had one to six years' post-qualification experience; the assistant psychologists had one to two years' experience. All six psychologists reported integrating more than one therapeutic approach in their work; the most common were CBT, psychodynamic therapy, acceptance and commitment therapy, and compassion-focussed therapy.

Semi-structured interviews

Semi-structured interview schedules were developed specifically for the study. For service users, the questions explored the experience of the therapy sessions

and the relationship between service user and psychologist, what was helpful and unhelpful about the sessions, and perceived outcomes. The psychologist interview asked similar questions, and also explored any challenges to delivering therapy in the inpatient setting and possible adaptations made to overcome these.

The interviews were conducted flexibly, with attention to exploring individuals' meanings and personal experience. They began with broad, open questions (e.g. "What was your overall experience of working with the psychologist?"), followed by more focussed questions addressing the topics of the study (e.g. "In what ways were the meetings with the psychologist helpful or unhelpful for you?"). Follow-up questions were used to elicit detailed descriptions and clarify meanings (e.g. "What changes did you notice?", "How important was that to you?"). If participants described predominantly positive accounts, they were encouraged to discuss unhelpful or contradictory experiences in order to broaden and confirm the patterns presented (Creswell, 2012).

The interview with each psychologist was conducted as soon as possible after the respective service user interview, in order to minimise any time differences since the last therapy session or discrepancies in memory of the intervention. Service user interviews lasted between 25 and 121 minutes; psychologist interviews lasted between 53 and 81 minutes. All interviews were audio-recorded and transcribed verbatim.

Data analysis

Braun and Clarke's (2006) method of thematic analysis was used to identify patterns of ideas across the data set. The analysis followed the recommended six phases. First, the researcher (CS) familiarised herself with the transcripts by reading them several times. Second, tentative codes were developed to label all data relevant

to the research aims. Third, the codes were grouped to produce initial themes for each interview. Fourth, the themes were combined across interviews to produce a tentative thematic map. Fifth, the themes were refined and further synthesised by comparing them across the data set; themes not supported by rich evidence were removed. Sixth, quotations were selected from the transcripts to support each theme. The process of developing the final set of themes was informed by the frequency of material across the data set, as well as how central the ideas were to an individual's account.

The service user and psychologist transcripts were first analysed separately, and then examined for commonalities and differences. In the final stages of analysis, the themes from their respective accounts were combined into an integrated set of themes representing both perspectives.

Credibility checks were undertaken to ensure the rigour of the analysis (Barker & Pistrang, 2005). These included a consensus approach (discussions between CS and NP about different ways of labelling, clustering and synthesising the data, eventually reaching a consensus on how to best represent participants' accounts) and analytic auditing (VH checking the results against the data).

Researchers' background

At the time of the research, CS was a trainee clinical psychologist. Having previously worked in a forensic mental health inpatient unit, she perceived that service users detained involuntarily were often distrustful of professionals' motives in providing 'therapeutic' interventions; she therefore assumed that there might be considerable barriers to individual therapy on inpatient units. NP is an experienced qualitative researcher with an interest in therapeutic processes; she had no experience of delivering therapy in inpatient settings. VH is a clinical psychologist working in inpatient care with an interest in the patient perspective on psychological

interventions in secure settings. CW is a consultant clinical psychologist and professional lead for the inpatient and acute psychology service in which the study took place; she has a long-standing interest in psychological involvement and therapy in such settings

All authors engaged in a process of self-reflexivity (Willig, 2008) to address how their own background and beliefs might play a role in the research. This included ‘bracketing’ their assumptions (Fischer, 2009), which was facilitated through discussions with other members of the research team. Because of CW’s role in the psychology service, she did not take part in any aspect of data collection or analysis.

Results

The analysis of the service user and psychologist accounts generated eight themes, grouped into three overarching categories (Table 1). Each theme is summarised with illustrative quotations. (Service users and the psychologists they worked with have corresponding identification numbers, e.g. SU1 and P1; for psychologists who worked with more than one service user, both identification numbers are given, e.g. P2/3 to indicate the psychologist who worked with SU2 and SU3.)

[Insert Table 1 here]

Category 1. Connecting

The themes in this category reflect service users’ and psychologists’ experiences of building an open and trusting therapeutic relationship.

Theme 1.1: Being seen as an individual

Service users and psychologists both emphasised the importance of their relationship, in which service users felt listened to and understood as an individual. This contrasted to service users’ experiences of relationships with many ward staff,

whom they perceived as too busy to listen or as following protocol at the expense of listening.

“There’s some people, who like just literally listen to you while they’re writing, and I realised that they are not listening...they are just note taking and I don’t tend to open up to people like that.” (SU4)

“...[I] see so many people but they always ask me the same questions. But [the psychologist] didn’t, she asked me different ones.” (SU6)

All service users described how their psychologist allowed them time to open up about important issues and listened carefully to what they said. They valued the psychologist being “*there just for me*” (SU2), and being accepting and non-judgmental.

“...you are opening yourself up, you are emotionally naked. And how the person reacts ... You know, look at me warts and all... And they don’t turn away.” (SU3)

A priority for psychologists was to offer service users the opportunity to tell their story and feel listened to and understood as a person, rather than as a diagnostic category. In an environment dominated by a medical view of ‘mental illness’, they felt it was particularly important to provide a humanising experience.

“I can share that humanity with them that they’re not a label, or an illness, or a bad thing that’s happened, or any of those things, they are just a person, and I’m a person too.” (P1)

“...be compassionate and listening attentively... just trying to, I suppose, sit with them in terms of when they are very distressed.” (P2/3)

However, psychologists were also concerned that the relationships they formed with service users could have negative consequences, both during service users’ stay on the ward and after discharge. Service users often relied on them for support, seeking them out outside of therapy sessions, rather than talking to ward staff. The advantages of developing a sound therapeutic relationship also had to be considered against the possibility of ending therapy without further input in the community.

“...you go to the ward and all the patients you're seeing every session are there... they come up and want to have a chat with you and you've already met with them for an hour.” (P2/3)

“...it's almost unethical, I think, to see them lots and lots... and then they suddenly fall off a cliff. So we're quite careful about stuff like that, how we manage the issue of dependence.” (P6/7)

Theme 1.2: Responding to my needs

Responsiveness to service users' needs was highlighted as a central feature of the therapeutic relationship, both at a macro-level (e.g. therapy goals) and at a micro-level (e.g. moments in therapy sessions). For service users, the process of psychologists explaining treatment information and collaboratively deciding on therapy goals led to a sense of trust and contrasted to a sense of coercion sometimes experienced with other professionals.

“...[the psychologist] seemed sort of different from the psychiatrists, who seemed to have these grand schemes and treatment plans and were bamboozling me with kind of little charts, and saying we have got to get through this stage.” (SU4)

In therapy sessions, service users felt able to choose what they were comfortable to disclose. When they chose not to share personal experiences, they appreciated the psychologist respecting their boundaries and remaining focused on helping them.

“...she knew it was a delicate issue...so she wasn't harassing me about it or wanting to know what happened, she just said 'you don't have to tell me what happened but here are some skills to use'.” (SU7)

Similarly, psychologists described their efforts to be attuned to each service user's needs, frequently adjusting their interpersonal style and way of working in order to achieve this.

“...it was easier for him to have an activity rather than having, kind of sitting across from me in a room...I think it was just a decrease of intensity of that interaction with him and maybe made it a bit more tolerable and a bit easier.” (P8)

Category 2. Addressing the problem

The themes in this category reflect service users' experiences of how therapy helped them understand and manage their difficulties, and psychologists' experiences of doing this, e.g. how they implemented therapeutic models.

Theme 2.1: Understanding the "Sudoku of the mind"

All service users valued the opportunity to discuss and make sense of their difficulties. For most, it was a novel experience to have someone explain the development of their crises in a normalising and understandable way. This seemed to reduce a sense of shame and stigma, and made problems seem more manageable.

"...[the psychologist] said, 'Okay, the reason it's happening with you is, this, then this thing led to that.' You see, so maybe if this didn't happen, this would not have happened. Which means that maybe I am not so messed up, I'm not such a jinx."(SU3)

"...[other professionals] just kind of kept pushing papers around the table and just, you know, why don't we try this drug and we will try this anti-depressant or we will try that. Really, they are just missing the whole Sudoku of the mind." (SU4)

Service users valued how psychologists identified important areas to discuss, steering the conversation in a way that facilitated personal exploration related to their individual difficulties.

"...her guidance, her rudder of the boat... she steers the conversation. And it ends up being about me and it brings stuff out." (SU2)

"...she has this knack, the way that she asks something...or whether it's just that I'm ready to talk, I don't know. But that she has this way of making me say things I didn't realise." (SU4)

For psychologists, a key aspect of individual therapy was developing a personalised formulation of service users' current and longstanding difficulties. They described this as a unique aspect of the therapeutic work which was not available elsewhere on the ward.

"I think the only thing that transcends it all is the importance of a highly individualised formulation, and a longitudinal view of the patient and not just a cross-sectional – this is what they're experiencing today, how do we get rid of it – which is the temptation." (P6/7)

“So often with inpatient work, it’s those little moments formulating with clients and just helping them to join the dots and talk about how they’ve ended up here and why...So I think he found that really helpful, just to sit and go through it all, and you don’t get that anywhere else.” P(2/3)

Theme 2.2: Hope as a “rare commodity”

Service users felt empowered by gaining a new understanding of their current crisis and longstanding difficulties; they felt more confident and more positive about the future. This was especially profound for some service users, who felt that hope had been a “rare commodity” (SU3) in their lives.

“The last little pieces just slotted in and...I’m kind of better now, I feel much stronger emotionally now than I have maybe for 30 years.” (SU4)

Service users also valued learning techniques and strategies to manage their difficulties. This offered a new hope that they could be more in control of their reactions.

“I’m hoping within time, it will get me in my brain to think ‘hey up, I’m not right now, perhaps I should be doing this, should be doing that.’” (SU5)

Most service users balanced this new hope alongside the uncertainty of the future and a real possibility of relapse when they moved beyond the support of regular individual therapy and the structures of the ward.

“To be able to say ‘this is what is working for me’ is an improvement. That does not necessarily mean that two days later I may not try and hang myself, because things come and go in waves. But it’s the frequency of the waves, the intensity of the waves, you know, the progress has to be measured carefully.” (SU3)

Theme 2.3: Traditional models “don’t fit”

All the psychologists felt they needed to adapt the therapeutic models they had been trained in. The level of insight, memory and general functioning assumed by traditional therapeutic models was perceived as unrealistic for most service users experiencing acute distress and side effects of medication. In some instances they felt that recommended approaches could even increase service users’ distress.

“Most of the time on the ward it’s pointless asking people to do much analysis of their thoughts, ordering their thoughts, thinking about what other people think, because they are too distressed. It might look like they’re doing it, but they won’t.” (P6/7)

“I find the type of anxiety you’re dealing with when people have become an inpatient for anxiety is so, so severe that that kind of doing some breathing or mindfulness is really, really hard for people, and actually it tends, I find it makes them more anxious.” (P8)

Restrictions of the ward environment also meant that some therapeutic approaches were either not possible or needed to be adapted. For example, it was difficult to implement behavioural activation or graded exposure when service users were restricted to the ward.

“...you can’t go out, you can’t encounter necessarily the things, the scenarios... that you’re discussing in therapy. You can’t directly challenge that.” (P1)

Psychologists described the importance of continually assessing service users’ capacity for an intervention, making changes to recommended models and drawing on multiple models and techniques. In doing so, they sometimes felt uncertain about the best evidence to draw on for their interventions, and the impact their adaptations might have on the effectiveness of the work.

“...all the NICE guidelines say that CBT works for psychosis and was developed for outpatient trials anyway, so I always have that in the back of my mind: What am I doing, is that evidence-based practice?” (P2/3)

Theme 2.4: “Recalibrating”

The unpredictable nature of staffing levels, space availability, and discharge plans on the ward made it difficult for psychologists to plan and consistently provide therapy sessions. They needed to be flexible, seeing service users at unplanned times and in unpredictable settings.

“You start seeing, assessing a patient, see them once, then they’re discharged because they are well enough to go home in the community, because they are pushed for beds. That’s it. You don’t get to say goodbye, hello.” (P5)

“The ward setting, just a total lack of space and privacy, and sometimes not only that but...but he quite liked when he met with me sitting in front of the toilet door playing cards on the ground.” (P8)

The focus of sessions also needed to be “recalibrated” (P6/7) according to changes in service users’ mental state or symptoms. This made it difficult to plan a coherent treatment intervention or to consistently work towards agreed goals. Some psychologists therefore attempted to deliver ‘stand-alone’ treatment sessions.

“...it’s like being a car engineer, like test running a car because you’re constantly having to recalibrate things and think, well, when she’s feeling like that I can’t really do that.” (P6/7)

“There’s a lot of people for whom every single session has to function as the last session, because they might just be discharged.” (P8)

Rapidly changing situations or crises on the ward also meant that the focus of the therapeutic work had to change. Managing the most risky behaviours or prominent symptoms sometimes had to take precedence.

“...sometimes that [focus of the session] completely goes to pot when there has been a crisis in the ward and you have to spend time trying to contain that.” (P2/3)

“...it’s fire-fighting... it’s not getting to that core of what I should be [doing].” (P5)

This set of challenges required flexibility, but at the same time remaining person-centred and attuned to the needs of each service user as much as possible.

“It’s like being an octopus, a juggling octopus. That’s one of the reasons why it’s so intense, you know.” (P6/7)

Category 3. The broader system

The themes in this category reflect the challenges and complexities of delivering and receiving therapy within the broader system of inpatient care, and how psychologists attempted to navigate (and help service users navigate) these challenges.

Theme 3.1: Finding a shared view of the problem

Both service users and psychologists highlighted instances in which the ward team held a view of service users' difficulties that seemed to lack an understanding of the service user's perspective. Service users emphasised the importance of the psychologist advocating on their behalf with the ward team; they felt this was invaluable in providing a consistent understanding of their needs and ensuring their voice was heard when the team made treatment decisions.

"She always used to meet up with me in the ward round and took my side." (SU1)

"So she fought for me, for example, they wanted to give me ECT. And for a variety of reasons from the past, I was not going to take it." (SU3)

Similarly, psychologists described taking an advocacy role and fostering supportive relationships between service users and other members of the team.

"I would champion him at ward rounds, or we'd prep for ward round. We'd go over what he was going to say, and we would debrief after." (P1)

Psychologists described a sense of balancing dual responsibilities: on the one hand, helping service users to understand and articulate their difficulties; and on the other hand, helping the ward team to understand service users' perspectives and develop ways of working together.

"I felt that I was wondering is the client my client or is the ward my client, you know, is it the ward...the problem that needs to be resolved, or is my client the one that has some issue that they want to talk about?" (P8)

"... 'cause he did split the team a bit because of his past and the team isn't very comfortable working with him. So a bigger part of my role is managing that relationship with staff." (P2/3)

Theme 3.2: Consistency in an inconsistent environment

Psychologists described how service users sometimes received inconsistent care on the ward, due to differences in shift patterns, training discipline and attentiveness of individual staff members. This environment made it difficult for

service users to develop trust and a sense of safety, which were important to their recovery.

“I think it can be really hard in this environment to trust what the staff are telling you when often it’s so inconsistent just by the way it works...The smallest thing, you know, not getting a one-to-one when you’re supposed to have a one-to-one from a nurse, different people being on shift from who you were expecting. (P6/7)

Psychologists recognised that therapy was only “one small component” (P1) of service users’ experience on the ward. Therefore, although the therapeutic work might be consistent, the context of an inconsistent ward environment was perceived as inevitably influencing service users’ experiences, threatening to undermine the effectiveness of the therapeutic work.

“When you’re [the psychologist] saying [to the service user] ‘you’re worth exactly the same’...and then they get dismissed accidentally because someone has to do whatever else...it just goes straight down.” (P1)

Inconsistencies between the goals of the therapeutic work and the treatment goals of the wider multidisciplinary team also posed challenges. Psychologists sometimes felt they were “walking a tightrope” (P6/7), keeping in mind multiple perspectives in planning and delivering therapy. They were acutely aware that the therapeutic work took place within a larger system.

“It’s all a system isn’t it. You can’t just do CBT and learn about the person because you’re not the only person within that person system even if it’s just a healthcare system or within a ward... There’s all these different dynamics you have to manage and that impacts on your ability to have a good relationship with the client.” (P2/3)

Discussion

This study explored the experiences of engaging in individual psychological therapy in the acute inpatient setting, from the perspectives of eight service users and their respective psychologists. Their accounts highlighted the importance of: (1) forming a ‘human’ relationship, particularly in an environment dominated by a medical view of ‘mental illness’; (2) the meaning-making process, which gave service

users a sense of hope and empowerment; and (3) promoting a shared understanding of service users' difficulties within the ward team. Psychologists described challenges in their work, requiring creativity and flexibility in implementing therapeutic models in order to be responsive to service users' needs.

A human relationship

It is a truism to state that a positive therapeutic relationship is a sine qua non of psychological therapy. Encouragingly, we found that such relationships could be established in an inpatient setting in the context of crisis, high levels of risk and forced detention. Service users and psychologists emphasised the importance of their relationship – in which service users felt listened to, and responded to, as individuals – which formed the basis for productive therapeutic work. Perhaps more importantly, and somewhat concerningly, service users highlighted the rarity and significance of such 'human' relationships in what they felt to be a dehumanising environment. In line with previous research, they reported that other ward staff were often too busy to listen (Stenhouse, 2011) and that treatment decisions were not made collaboratively (Baguley, Alexander, Middleton, & Hope, 2007).

The need for improved therapeutic relationships in inpatient settings has been recognised in the recent 'compassionate care' agenda developed for modern nursing (Department of Health, 2012; Francis, 2013). The drive for compassionate care involves facilitating recovery through basic human qualities and relationships in healthcare settings (Cole-King & Gilbert, 2011). Service users have reported that interactions that allowed them to feel cared for and listened to, helped them retain a sense of independence and dignity and contributed to recovery (Bramley & Matiti, 2014). Such interactions are not – and should not be – the sole prerogative of psychologists, nor should they occur only within psychological therapy. Indeed,

psychologists in the current study were concerned that service users' reliance on them could foster dependency. However, systemic challenges to promoting therapeutic relationships more broadly within inpatient settings are also apparent (Cole-King & Gilbert, 2011). Nurses are often inadvertently encouraged to focus on risk and ward management tasks, at the expense of one-to-one time with service users, making them appear inaccessible (Stenhouse, 2011) and less compassionate (Bramley & Matiti, 2014). Similarly, psychiatrists have reported that the immense time pressure they face undermines their ability to meet the individual needs of service users alongside managing major risk and clinical decision making (Green & Bloch, 2001). The present study indicates that developing compassionate care at all levels of acute inpatient care continues to be an important challenge for clinical practice.

Making meaning

Service users valued the opportunity to make sense of their difficulties: they emphasised how their psychologist helped to identify important areas to discuss, facilitated exploration, and explained their difficulties in an understandable and meaningful way. Similarly, psychologists highlighted meaning-making – in the form of sharing psychological formulations with service users – as a key element of their work. This meaning-making process was described by service users as a novel experience, leading to less self-blame and a sense of hope and empowerment, which are important aspects of recovery (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). These accounts are consistent with the argument that psychological formulation offers a valuable addition to psychiatric diagnosis in understanding risk and crisis (Logan & Johnstone, 2010). Given that contemporary acute inpatient settings aim to reduce risk and promote stability (Bowers, 2014), psychological formulation may be a key strategy for helping to achieve this.

Promoting a shared understanding

Service users and psychologists described how the therapeutic work extended to (and was also affected by) the wider context of the inpatient unit. Psychologists endeavoured to promote a shared understanding of service users' difficulties amongst the ward team; in this way, the meaning-making process – and psychological formulation – was not confined to the therapy room. For service users, advocacy from a trusted professional led to feeling more prepared and supported in ward rounds. This is consistent with recovery principles in inpatient care: providing information about treatment and allowing service users to exercise choice in clinical decision-making is important in mental health recovery (Johansson & Lundman, 2002). However, as has been acknowledged elsewhere, ward round procedures would benefit from changes that make the patient experience a priority (Cappleman, Bamford, Dixon, & Thomas, 2015).

Implementing therapeutic models: creativity and flexibility

Due to the distress of individuals and the constraints of the environment, psychologists reported needing to be highly flexible and adaptable. They continually assessed service users' capacity for intervention and drew on a variety of therapeutic approaches to 'recalibrate' their approach and meet the needs of the individual. Consequently, they were sometimes uncertain about whether their practice was evidence-based. There is some evidence that therapists' flexibility to respond to both the context and needs of the client leads to improved outcomes in outpatient therapy (Owen & Hilsenroth, 2014). This highlights the need for the development of practice-based evidence in acute inpatient settings to demonstrate the effectiveness of adapted psychological therapy (Clarke & Wilson, 2009). Such evidence would provide valuable guidance for psychologists undertaking individual therapy in these settings.

Limitations

The service user participants in this study were not representative of individuals in the local setting, nor are they likely to be representative of the broader UK acute inpatient population. Black and minority ethnic individuals, as well as service users with a diagnosis of psychosis, were under-represented, and the length of hospital stay and of therapy was higher than average. All participants had engaged in some way with psychological therapy, having attended a minimum of three sessions and in some cases many more. Furthermore, the recruitment procedure involved psychologists identifying potential participants: they may have been inclined to approach service users who stayed in therapy, developed a therapeutic alliance, and had more positive experiences. However, it can be argued that the findings demonstrate what can occur under optimal circumstances – i.e. when service users engage with psychological therapy – rather than what is typical. As with much qualitative research, the study thus offers insights into the particular rather than the general (Barker, Pistrang, & Elliott, 2016).

The service users' highly positive accounts of psychological therapy also may have been influenced by their knowledge that the interviewer was a clinical psychologist. However, the interviewer made clear that she was not involved in the service and she encouraged participants to express any negative views. Finally, the sample of psychologist participants (with varied training backgrounds and levels of experience) and the heterogeneous therapeutic approaches used may not generalise to other settings.

Research implications

Further research should focus on evaluating psychological therapies specifically adapted for acute inpatient settings. There are a number of ongoing trials

(e.g. Haddock et al., 2016; Jacobsen, Peters, & Chadwick, 2016) but it is also important to accumulate practice-based evidence to complement the evidence from RCTs (Barkham, Hardy, & Mellor-Clark, 2010). Given the high levels of risk seen in contemporary inpatient environments, psychological therapies targeting risk reduction require particular attention. The findings from the current study also underline the need for including recovery-oriented measures of outcome (Leamy et al., 2011), such as hope and empowerment.

Clinical implications

Psychological formulation offers a valuable addition to psychiatric diagnosis in making meaning of individual experiences and promoting a shared understanding within staff teams. If done sensitively and collaboratively, formulation has the potential to support individual recovery and improve relationships within inpatient care (Berry et al., 2016). However, the challenge is to integrate formulation-based practices within the current structures of inpatient settings, in order to promote compassionate understanding within staff teams and to consistently implement personalised care and treatment planning (Macneil, Hasty, Conus, & Berk, 2012).

A further challenge is to promote the development of therapeutic relationships on inpatient wards beyond the therapy room. Psychologists may be able to assist in this task by offering interpersonal skills training for clinical staff (Awa, Plaumann, & Walter, 2010) as well as regular reflective practice and supervision time (McCabe & Priebe, 2004). However, it will also be necessary to consider organisational-level factors which impact on the emotional demands felt by clinical staff in inpatient settings (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). Increasing support for staff, e.g. by providing mentors, is imperative (Morse et al., 2012). Work to address these issues has begun in the compassionate nursing field and other

developments such as Safe Wards (Bowers, 2014). It will necessitate committed action from government, research and management sectors, but if successful, the positive impact on service users' experience and recovery would be significant.

References

- Awa, W. L., Plaumann, M., & Walter, U. (2010). Burnout prevention: A review of intervention programs. *Patient Education and Counseling*, 78(2), 184–190. <http://doi.org/10.1016/j.pec.2009.04.008>
- Baguley, I., Alexander, J., Middleton, H., & Hope, R. (2007). New Ways of Working in Acute Care: A Case for Change. *Journal of Mental Health Training, Education and Practice*, 2, 43–52.
- Barker, C., & Pistrang, N. (2005). Quality criteria under methodological pluralism: implications for conducting and evaluating research. *American Journal of Community Psychology*, 35(3–4), 201–212. <http://doi.org/10.1007/s10464-005-3398-y>
- Barker, C., Pistrang, N., & Elliott, R. (2016). *Research Methods in Clinical Psychology: An Introduction for Students and Practitioners* (Third edit). Chichester, UK: John Wiley & Sons, Ltd. <http://doi.org/10.1002/9781119154082>
- Barkham, M., Hardy, G. E., & Mellor-Clark, J. (2010). *Developing and delivering practice-based evidence : a guide for the psychological therapies*. Wiley-Blackwell.
- Berry, K., Haddock, G., Kellett, S., Roberts, C., Drake, R., & Barrowclough, C. (2016). Feasibility of a ward-based psychological intervention to improve staff and patient relationships in psychiatric rehabilitation settings. *British Journal of Clinical Psychology*, 55(3), 236–252. <http://doi.org/10.1111/bjc.12082>
- Bowers, L. (2014). Safewards: a new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing*, 21(6), 499–508. <http://doi.org/10.1111/jpm.12129>
- Bowers, L., Chaplin, R., Quirk, A., & Lelliott, P. (2009). A conceptual model of the

- aims and functions of acute inpatient psychiatry. *Journal of Mental Health*, 18(4), 316–325. <http://doi.org/10.1080/09638230802053359>
- Bramley, L., & Matiti, M. (2014). How does it really feel to be in my shoes? Patients' experiences of compassion within nursing care and their perceptions of developing compassionate nurses. *Journal of Clinical Nursing*, 23(19–20), 2790–2799. <http://doi.org/10.1111/jocn.12537>
- Braun, V., & Clarke, V. (2006). *Using thematic analysis in psychology*. Qualitative Research in Psychology. Taylor & Francis.
- British Psychological Society. (2012). *Commissioning and Delivering Clinical Psychology in Acute Adult Mental Health Care*. London.
- Cappleman, R., Bamford, Z., Dixon, C., & Thomas, H. (2015). Experiences of ward rounds among in-patients on an acute mental health ward: a qualitative exploration. *The Psychiatrist*, 39(5). <http://doi.org/10.1192/pb.bp.113.046409>
- Clarke, I., & Wilson, H. (2009). *Cognitive Behaviour Therapy for Acute Inpatient Mental Health Units: Working with Clients, Staff and the Milieu*. London: Taylor & Francis.
- Cole-King, A., & Gilbert, P. (2011). Compassionate care: the theory and the reality. *Journal of Holistic Healthcare*, 8(3), 29–36.
- Creswell, J. W. (2012). *Qualitative Inquiry and Research Design: Choosing Among Five Approaches*. SAGE Publications.
- Department of Health. (2012). *Compassion in Practice – Nursing Midwifery and Care Staff Our Vision and Strategy*. London.
- Department of Health and Concordat Signatories. (2014). *Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis*. London.

- Donaghay-Spire, E. G., McGowan, J., Griffiths, K., & Barazzone, N. (2015). Exploring narratives of psychological input in the acute inpatient setting. *Psychology and Psychotherapy: Theory, Research and Practice*, Nov 4(online publication ahead of print). <http://doi.org/10.1111/papt.12081>
- Fischer, C. T. (2009). Bracketing in qualitative research: conceptual and practical matters. *Psychotherapy Research: Journal of the Society for Psychotherapy Research*, 19(4–5), 583–590. <http://doi.org/10.1080/10503300902798375>
- Francis, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London.
- Green, S. A., & Bloch, S. (2001). Working in a flawed mental health care system: an ethical challenge. *The American Journal of Psychiatry*, 158(9), 1378–1383. <http://doi.org/10.1176/appi.ajp.158.9.1378>
- Haddock, G., Davies, L., Evans, E., Emsley, R., Gooding, P., Heaney, L., ... Awenat, Y. (2016). Investigating the feasibility and acceptability of a cognitive behavioural suicide prevention therapy for people in acute psychiatric wards (the “INSITE” trial): study protocol for a randomised controlled trial. *Trials*, 17(1), 79. <http://doi.org/10.1186/s13063-016-1192-9>
- Jacobsen, P., Peters, E., & Chadwick, P. (2016). Mindfulness-Based Crisis Interventions for patients with psychotic symptoms on acute psychiatric wards (amBITION study): protocol for a feasibility randomised controlled trial. *Pilot and Feasibility Studies*, 2(1), 43. <http://doi.org/10.1186/s40814-016-0082-y>
- Johansson, I. M., & Lundman, B. (2002). Patients’ experience of involuntary psychiatric care: good opportunities and great losses. *Journal of Psychiatric and Mental Health Nursing*, 9(6), 639–647.
- Joint Commissioning Panel for Mental Health. (2013). Guidance for commissioners

of acute care – inpatient and crisis home treatment. London.

Kohler, S., Hoffmann, S., Unger, T., Steinacher, B., Dierstein, N., & Fydrich, T.

(2013). Effectiveness of Cognitive-Behavioural Therapy Plus Pharmacotherapy in Inpatient Treatment of Depressive Disorders. *Clinical Psychology & Psychotherapy*, 20(2), 97–106. <http://doi.org/10.1002/cpp.795>

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry: The Journal of Mental Science*, 199(6), 445–452. <http://doi.org/10.1192/bjp.bp.110.083733>

Logan, C., & Johnstone, L. (2010). Personality Disorder and Violence: Making the Link Through Risk Formulation. *Journal of Personality Disorders*, 24(5), 610–633. <http://doi.org/10.1521/pedi.2010.24.5.610>

Macneil, C. A., Hasty, M. K., Conus, P., & Berk, M. (2012). Is diagnosis enough to guide interventions in mental health? Using case formulation in clinical practice. *BMC Medicine*, 10, 111. <http://doi.org/10.1186/1741-7015-10-111>

McCabe, R., & Priebe, S. (2004). The therapeutic relationship in the treatment of severe mental illness: A review of methods and findings. *International Journal of Social Psychiatry*, 50(2), 115–128. <http://doi.org/10.1177/002076400404040959>

McCrone, P., Dhanasiri, S., Patel, A., Knapp, M., & Lawton-Smith S. (2008). *Paying the price: the cost of mental health care in England to 2026*. London.

McGowan, J. F., & Hall, R. (2009). The role of psychological therapies in acute psychiatric care. *Clinical Psychology Forum*, April, 14–18.

MIND. (2011). *Listening to experience: an independent inquiry into acute and crisis mental healthcare*. London.

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012).

Burnout in mental health services: a review of the problem and its remediation.

Administration and Policy in Mental Health, 39(5), 341–352.

<http://doi.org/10.1007/s10488-011-0352-1>

NHS Benchmarking Network. (2015). *Mental health benchmarking report*. UK.

Owen, J., & Hilsenroth, M. J. (2014). Treatment adherence: The importance of therapist flexibility in relation to therapy outcomes. *Journal of Counseling Psychology*, 61(2), 280–288.

<http://doi.org/10.1037/a0035753>

Schramm, E., van Calker, D., Dykieriek, P., Lieb, K., Kech, S., Zobel, I., ... Berger, M. (2007). An intensive treatment program of interpersonal psychotherapy plus pharmacotherapy for depressed inpatients: acute and long-term results. *The American Journal of Psychiatry*, 164(5), 768–777.

<http://doi.org/10.1176/appi.ajp.164.5.768>

Seed, T., Fox, J. R. E., & Berry, K. (2016). The experience of involuntary detention in acute psychiatric care. A review and synthesis of qualitative studies.

International Journal of Nursing Studies, 61, 82–94.

<http://doi.org/10.1016/j.ijnurstu.2016.05.014>

Stenhouse, R. C. (2011). “They all said you could come and speak to us”: Patients’ expectations and experiences of help on an acute psychiatric inpatient ward.

Journal of Psychiatric and Mental Health Nursing, 18, 74–80.

<http://doi.org/10.1111/j.1365-2850.2010.01645.x>

The Commission on Acute Adult Psychiatric Care. (2015). *Improving acute inpatient psychiatric care for adults in England. Interim report*. London.

Willig, C. (2008). *Introducing qualitative research in psychology: Adventures in theory and method* (second edi). Open University Press.

Wood, L., & Alsawy, S. (2016). Patient experiences of psychiatric inpatient care: a

systematic review of qualitative evidence. *Journal of Psychiatric Intensive Care*,
12(1), 35–43. <http://doi.org/10.20299/jpi.2016.001>

Table 1. Summary of themes

Category	Theme
1. Connecting	1.1 Being seen as an individual
	1.2 Responding to my needs
2. Addressing the problem	2.1 Understanding the “Sudoku of the mind”
	2.2 Hope as a “rare commodity”
	2.3 Traditional models “don’t fit”
	2.4 “Recalibrating”
3. The broader system	3.1 Finding a shared view of the problem
	3.2 Consistency in an inconsistent environment