Therapy beyond Walls;

The clinical psychologist's

Multi-level work within an open psychiatric ward.

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**Introduction**

Twenty-five years earlier, Michael's key nurse Dawn meets me at the entrance of the Acute Psychiatric unit known as "Derwent Ward". The river Derwent in the north of England is unusual in that it flows upstream (rather than Nature's design of downstream) into the tidal river Ouse; those successful Roman invaders went on to manufacture a short cut to York.

I notice Dawn seems reluctant to facilitate my use of the ward's consulting room to meet with Michael for our seventh therapy session. "How has Michael been since our therapy appointment last week?" I ask. "He's cut his face again; it was the day after your session". I think privately that my nursing colleague just doesn't understand the importance of this crucial therapeutic work on Michael's experiences of childhood sexual abuse. Dawn privately thinks this young Clinical Psychologist is misguided, causing Michael to become more disturbed and unnecessarily extending his admission to Derwent Ward.

Having had a quarter of a century to consider this view (it is important to take a little time to reflect) I now consider Dawn to have been correct. There were key things I had yet to learn, including that any individual therapy on inpatient units needs to be fully integrated with the service, and not undertaken by clinicians having little communication and shared formulation with the core in-patient team. I had yet to learn that clients who have histories of childhood abuse who self-harm must develop alternative ways of safely managing distress before addressing their traumatic memories in therapy. If not, the flow of the intrinsic emotional distress is inevitably against the self in a direction congruent with the invasion of their childhood.

Later in my career I had the opportunity to work with, and learn from, a number of group analyst colleagues. I already had experience in facilitating therapeutic groups for clients and of training groups for staff, however I was not aware of the therapeutic potential of the group within the inpatient setting by developing the sense of community, belonging, involvement and agency (Kennard & Haigh 2009, Pearce & Haigh 2017).

Over the next two decades I had the privilege of being a staff member of the Acorn programme, a DBT-informed Therapeutic Community at the Retreat York, UK. Opening in 1796, the Retreat "mental health project" and its founders rejected the inhumane treatments of the day (purging, burning, bleeding) and applied their Quaker values and practice to a new institution for the treatment of the insane that was to prove remarkably effective (Tuke 1813). Samuel Tuke wrote of the importance of "exciting the capability of the patient", implicitly acknowledging that the ward environment could have a powerfully enabling effect. The relevance of the Quakers original approach to contemporary mental healthcare is still apparent (Borthwick, Holman, Kennard et al. 2001).

Too often we presume that the problem is solely located within the patient, and the correct therapy will remedy this pathology. Comprehensive formulation of our patients clinical presentation might still usefully take account of social, environmental, occupational and spiritual factors, as did the Quakers. There was a reason this pioneering institution was built on an eminence, with beautiful grounds of sufficient size for animal husbandry (Tuke 1813).

The importance (if not primacy) of attachment experiences and learning has been acknowledged as important for us all (Bowlby 2005). Perhaps the nature of the anticipated interaction and the actual relationships between the patient and others might exceed the effect of any simple intervention? Wampold (2013) found 87% of outcome variance was due to client related factors and other factors outside therapy. Only 13% could be attributed to the treatment itself, and of this, the therapeutic alliance had by far the greatest contribution to outcome, far greater than the therapeutic model (Green & Latchford 2012). If this is correct, our therapeutic interventions need to extend beyond the walls of our therapy office in order to maximize effectiveness.

Whilst the complexity of client presentation may be particularly challenging, the clinical psychologist is perfectly placed to make a valuable contribution to the care and treatment received during their psychiatric admission. The integration of theory, research and practice is what differentiates clinical psychologists from other professions. Skillful, collaborative formulation of the individual's mental health difficulties and strengths, in the context of their past/ present relationships and life experiences, will effectively inform the inpatient team's considered interventions and care plans.

Lucy was a fifty year old high former school teacher. She was admitted to the ward following a life threatening overdose and now presented with depressed mood and marked intrusive thoughts about dangers befalling her family members. Lucy reported she was happily married to Rick, a train driver and they had three adult sons together. When her youngest son Sam left the family home, as his brothers, Lucy soon became unable to work as her mood deteriorated and her compulsive counting and touching of objects markedly increased. She began to self-harm by ligaturing with shoe laces and electrical wires, and subsequently took a lethal overdose of prescribed and over the counter medications at a time and a place she was unlikely to have been discovered.

With Lucy, Michael and Derwent ward in mind, let us consider a number of potential roles and contributions for the clinical psychologist within the complex system of an open psychiatric ward.

**The Individual therapist**

Whilst this will be familiar role to all clinical psychologists, the system in which this takes place requires additional attention. The level of possible direct clinical involvement with a client will clearly be influenced by the anticipated duration of admission to the open psychiatric ward. If brief, a shared written formulation may be all that is possible, however the potential benefit of this to the individual patient and to future treating clinicians should not be underestimated. The client has too often not encountered a clinician who is so actively and collaboratively curious about their difficulties and how these might "make sense" through the lens of past experiences, developmental learning and current life context.

Following a series of assessment sessions with Lucy the following written formulation was shared with her;

You were born a normal healthy baby to your parents Bill and Brenda; their first child. Brenda and Bill had planned to have a baby soon after Brenda's recent depression as they thought, and were advised by family, that it would help them through what had been a difficult time for everybody. You were a healthy and attentive baby girl and you were welcomed into the world but with heavy expectations immediately placed on your little shoulders. What you could not be expected to understand as an infant was that your mother found being responsible for a child to be more difficult than she had expected particularly as Bill was away from home, apparently working, for much of your childhood. She suspected he was seeing other women and felt frustrated at being unable to keep his attention as she had previously strived to do. As you made sense of how others related to you, and what you could come to expect from them, you learned to feel the source of difficulty for them and that your role was to make others feel better. Brenda very soon became pregnant again and lost this baby at birth; your mother became depressed and withdrawn and received medical care from community services.

You recall that by the time you started school you had difficulty making and keeping friends as you felt different to others; there was nobody at home able to help dress you like the other children in your class. You were teased by the other children and you learned to avoid playtime by staying with the teacher after lessons had finished. You remember thinking it would be better if you died because people said nice things about dead people. You began thinking about things that might kill you, like your mother's tablets in the bathroom. You noticed that thinking about and visualizing this made you feel better.

This initial part of Lucy's formulation is not written in the language of a particular therapeutic model, but you may detect it draws from attachment, systemic and cognitive-behavioural frameworks of understanding. It is more important to incorporate Lucy's own words and reported memories as closely as possible. Lucy found this a deeply validating, emotionally attuned and supportive intervention which further facilitated collaborative work on the second stage of Lucy's formulation explicitly linking childhood experiential learning to her presenting problems and life context.

The clinician should however be cautious that we cannot be certain of the degree of accuracy of childhood memories; the British Psychological Society concluded that memories are records of people’s experiences of events and are not a record of the events themselves. (BPS, 2010).

The longer admission permits a more comprehensive formulation and more active therapeutic engagement with the formulated issues. If a short admission, the client might take the formulation into their future therapy as an outpatient.

The space may be facilitated by the possibility that the Clinical Psychologist, unlike their Psychiatrist colleague, may not be subject to the same degree of immediate transference. This has been my experience as a male clinician working closely with a male psychiatric colleague, however in your own setting a gender differences in either of you may well influence this. From within a Psychodynamic model this may be welcomed.

Alternatively, the more complex client may present and relate differently to members of the team due to a disorganized pattern of attachment (Liotti & Farini 2016). The pattern of multiple relating should be understood as a whole so the individual can experience being held in mind by a benevolent, reliable team. To facilitate this, the clinical psychologist needs to be attuned to the involvement and responses of colleagues, and share details of their own work in the service of the client’s therapy. To permit this, the boundary of confidentiality might be discussed with the client as existing around the therapy team rather than the individual clinicians. There may, however, be details of the client’s history they may request the clinical psychologist to maintain on a "need to know" basis. In most services this would not include information about risk-related behaviour of the patient, or information about imminent risk to others. This exception, whilst important in the careful management of information the patient may feel deeply ashamed of, needs to be used judiciously or risks perpetuating the clients disorganized and fragmented presentation. Many inpatients will have a previously reported history of traumatic events evident in their case notes (McFetridge, Milner, Gavin & Levita 2015) which may (but may not) manifest as a Complex PTSD presentation. In my experience such clients have found this a validating framework of understanding; several guidelines are available to assist you in how to appropriately assess and safely undertake phase-based therapeutic interventions (UKPTS 2017, ISTSS; Cloitre, Courtois, Ford, Green et al. 2012).

Having worked in several inpatient and outpatient settings, my personal view is that when working within a skillful and well-managed inpatient team it is easier to sustain and contain the work than when carrying a caseload of complex clients as an independent clinician; risk is shared and potentially managed more therapeutically, and successes can be shared and acknowledged more effectively.

**The group therapist/ facilitator**

The novice clinical psychologist may have relatively less experience as a group facilitator, but their appreciation of relational and systemic factors assist in the assimilation of these skills. Many individuals with the difficulties conceptualized as a diagnosable Personality Disorder, or as Complex PTSD have been found to benefit from participation in a therapy group. There is evidence for the effectiveness of group therapy for adults with histories of childhood sexual abuse, regardless of whether these are trauma-focused or present-focused groups (Classen Palesh, Cavanaugh, Koopman et al., 2011). More structured groups including a safety and stabilization phase have been found effective with adult survivors of childhood trauma. One recent variant, a 10 session group intervention called ‘Survive and Thrive’ has been developed with the aims of increasing stabilization, understanding links between past trauma and current symptoms, and preparing for trauma-focused therapy. Preliminary studies, including a controlled investigation, have demonstrated this may be an effective intervention in promoting stabilisation (Karatzias, Ferguson, Chouliara, Gullone et al., 2014). As a time- limited structured group this may also be suitable for inpatients with trauma histories.

Equally, there is evidence that patients without a reported trauma history benefit from participation in a residential DBT- informed therapeutic community (McFetridge et al. 2015). This model incorporates the therapeutic community as a method for delivering and enhancing the structured individual and group interventions. This facilitates therapy beyond the walls of the consulting room and the clinical psychologist has potential to play a valuable role in helping the client and staff colleagues to think about patterns of relating within groups.

Following a period of my leave, a clinical colleague expressed concern about Michael's capacity to regulate his feelings and whether more specific work on this was needed? Michael had self-harmed during this time and the staff team had felt concerned and confused as to why he was disturbed after quite a stable period. When I met with Michael as planned we established he had indeed found it difficult not meeting for individual sessions as he believed he didn't have anywhere to take (his) feelings resulting from difficult conversations with his mother. I acknowledged that it was of course disruptive of his therapy for me to be on leave, however understandable and necessary this is. However there were many other staff and fellow patients present during this time that may have been able and willing to offer support if Michael had been able to approach and seek this. My absence had simultaneously highlighted both the therapeutic benefit of consistent appointments and the unintended negative consequences; Michael had not had to practice seeking support from peers or others as any difficult issues would be "saved" and addressed with me within session. We recognized that as an "only child" he had, through no fault of his own, missed the opportunity to practice this key emotion regulation skill earlier in his life. We discussed the potential value of Michael joining a group on the ward to experience support seeking and giving with peers. Following the group Michael was more able to let others know when he was feeling distressed and at risk of self-harm, and in turn experience the degree of emotional containment that can result from doing so.

**Facilitator of a psychologically minded team with therapeutic curiosity**

If the client is to be helped, the staff team must be able to understand and digest the feelings they experience in their interactions with them. If this is overlooked or avoided there is a danger staff will become the unwitting (re-) enactors of the clients' life scripts. The capacity of the staff team to think will in turn be facilitated by organizational factors which promote this including effective, consistent leadership and appropriate working conditions. If such organizational requirements are compromised or absent the clinical psychologist should address this with higher management in a way that effective alerts senior managers to the clinical and financial consequences of this.

The clinical psychologist, actively carrying their formulation skills and broad knowledge of psychological and clinical theory, can be a key contributor to the "psychological mindedness" or reflective capacity of the team. For this to be realized, I would argue, the Clinical Psychologist needs to be seen as a member of the ward team, even if this is not possible on a full time basis.

Within the ward, a culture of curiosity combined with a shared model of understanding and language are fundamental. A regular "staff supervision" (or alternatively named "reflective care") group with a permissive expectation that all staff will attend regularly facilitates this. This enables the staff team to appreciate each other’s perspectives, their differing experiences of the same client, and diffuse and explore the feelings engendered by the team's shared work. An additional benefit of this arrangement is there is a scheduled in (weekly) meeting to take any serious incidents that would otherwise require a special meeting due to their impact. If services and resources permit, this might be facilitated by a clinical psychologist colleague from another unit, with a reciprocal arrangement. This allows the clinical psychologist to actively and equally participate in the group supervision for their team, and through this to model openness to reflexive thinking.

Let us return to Lucy, who on the ward alternates between being "the perfect patient" in supporting the staff and other clients, and occasions of angry denigration of staff members and self-harming. The staff team is at a loss to understand this rapidly alternating presentation, and feel angry and critical of her in return as they know she can be so different. Lucy is aware others are angry with her at these times and feels troubled, and yet strangely reassured, by this. The supervision group was used to acknowledge the very real emotional demands of the teams shared work, and to reintroduce aspects of the formulated understanding of Lucy's attachment patterns of interacting with others and responding to her own distress.

**Culture carrier**

Staff teams inevitably change over time as colleagues gain experience and career development elsewhere, and new members replace them bringing fresh perspectives and valuable "beginners eyes". This will also apply to the clinical psychologist but it is equally important for there to be stability in the team (and career development within the organization to permit this) to allow the culture and norms of a service to become established. The clinical psychologist may then act in a culture-transmitting role, enabling new colleagues to observe, enquire, and then assimilate new ways of understanding and responding to patients within the inpatient unit. This will be of (at least) equal importance to any formalized training provided due to its timely provision at the moments of relevance and need.

**Researcher and scientist practitioner**

The clinical psychologist is not only a therapist, but also a scientist practitioner. Many years before the advent of evidence-based practice and practice-based evidence clinical psychologists were trained to continually evaluate and explore the effectiveness of their clinical (and other) interventions through appropriate measurement. This was later extended within the U.K. to a greater appreciation of mixed method and qualitative approaches following the development of methodologies such as IPA (Interpretive Phenomenological Analysis; Smith, Flowers & Osborne, 1997) and Grounded Theory (Strauss and Corbin 1997).

The open psychiatric ward team and service needs first to be helped to clarify what it seeks to achieve through its work with clients; what are the aims of the service for its clients? Measures can then be identified to best assess these aims at intake assessment, reviews, pre-discharge, and at subsequent post-discharge follow-up. A mixed method approach of quantitative and qualitative measures can be helpful in evaluating whether a service helps it's clients to improve in specific ways, and also to examine the clients' personal experiences of these changes. Considering the example of “the Acorn programme for self-defeating behaviour" at the Retreat, York (UK), the primary aim was to help clients to reduce their self-harm and impulsivity. The primary measures of this were therefore the Multi Impulsivity Scale (MIS; Evans, Searle & Dolan, 1998) and the patient reported outcomes and reflections of change on longer term follow-up (McFetridge & Coakes, 2010).

The ongoing evaluation of clinical changes can also be useful to inform and influence the clinical process. If multiple time points for all patients yield a data set for the developmental sequence of admission and post-discharge the pattern becomes evident and useful in a range of ways. Within Michael's unit, Derwent ward, it was apparent from a representative sample of 56 previous patients, that measures of psychological distress improved during admission, worsened temporarily pre-discharge, and then improved again after 3 months of leaving. This pattern made sense to the staff team as they recognised the anxieties, uncertainties and loss that often accompanied their patients' discharge. It was also helpful for them to be made aware this (generally) subsequently improved by three months post-discharge. This knowledge in turn facilitated more contained "endings" between key nurses and Michael on his discharge, and improved their acknowledgement of his emotional response to this. Michael was also made aware that the data suggested that the period around discharge was difficult for people in general (not just for him) but that this did change for the better over the following year for his predecessors as they were perhaps able to put into practice what they had learned during their admission.

As a service informed by clinical outcome data, the Derwent ward team were, in addition, able to think about additional support around discharge, introducing a weekly transitional group that clients were invited to attend as they approached discharge and continue for the 3 months after leaving. The service, assisted by the clinical psychologist, also noted that readmission rates within 3 months of discharge significantly reduced following the introduction of this transitional group.

The nature and level of doctoral clinical psychology training also equips the clinical psychologist to design and implement primary research to extend the shared clinical knowledge base. Joint research with colleagues from the range of professions can in addition improve team morale, staff retention and development and further raise clinical standards. The successful dissemination of the research by publication and conference presentation may also serve to raise the internal and external profile of the service. Whilst research is invariably the lowest day to day priority in the open psychiatric ward, if successfully undertaken to completion, it can provide many positive benefits for the service. A nursing colleague and I presented our clinical research to a national conference; we had examined the factors likely contributing to the remarkably positive clinical outcome of a small group of patients (McFetridge, Morton & Berg 2006). "I am now a proper researcher" she said with evident pride on our return journey. She went on to develop a successful leadership role within the inpatient service.

**Teacher, trainer, (skillful team-maker)**

We have already noted the informal training opportunities the clinical psychologist potentially contributes to the inpatient team. It is equally important for us to be open to the opportunity to learn from others outside our profession as this can only complement and broaden our existing knowledge. However, the clinical psychology resource in a team will be utilized effectively if more formal regular training opportunities are provided for colleagues. There is much to be addressed in the development and maintenance of a shared clinical model for the ward, whichever focus this takes. It is however, in my experience, a more effective choice of model if this can enable those interacting most frequently with patients to know what to do in your absence. An overly complicated theoretical model that is experienced by the team as the province of more expert colleagues will have limited impact. To this end, clinical psychologists in Scotland have in recent years, been actively involved in training and supervising nursing colleagues in Mentalisation skills (Williams and Beedie, 2017). This is not the full Metallization based therapy training (MBT; Bateman & Fonagy 2010), but a reduced version of the model focusing on the key skills that inpatient nurses can employ in their interactions with patients. A number of unexpected benefits have been found to follow from this training, commensurate with the teams having greater confidence to manage any difficult situation they may find themselves party to.

I recall my own experience of the unexpected non-specific benefit of undertaking EMDR level II training with Francine Shapiro in 1998. I predictably became more expert in this (then) new form of trauma processing therapy, however the additional benefit was that I now felt able to approach the most appalling of traumatic memories with clients with a new found confidence and sense of containment. Clinical outcomes were impressive, but I continue to suspect this was disproportionately influenced by my new found palpable capacity to contain the clients worst life threatening moments; perhaps my own version of Dumbo's feather facilitating the belief he could fly (Walt Disney productions, 1941). Like the author, inpatient team members need feathers too and the clinical psychologist can engender these.

**Leadership; formal or informal**

The clinical psychologist may have a formalized leadership role within the inpatient ward, but more often this is an informal leadership born of the contribution to the team and service over time. I would advise any new clinical psychologist joining a team to go quietly yet confidently; your clinical knowledge and skills will out. Alternatively, a sales presentation of the many reasons you should be followed is likely to be (appropriately) poorly received and ultimately self-defeating. This is unnecessary and likely driven by anxiety on your part (May I offer a feather for your cap?); talk with your new colleagues about their patients' problems and notice what you bring to the developing shared understanding. The new setting in which you work may be unfamiliar as yet but you will probably "recognize" the clients discussed. Clinical psychologists in the main cannot help but be patient-focused, emotionally attuned, and supportive colleagues and soon become appreciated as such.

**Container**

Remembering the ward is a system within a system, there are important contributions to be made in ensuring others can enable these to function effectively. One important role is the supporting of the ward or clinical team manager. They are subject to all manner of displaced feelings and projections from both patients and staff members, coupled with unconscious (and occasionally conscious) "attack" from the parent organization. Often this will be prompted by fear of or actual criticism of the unit from sources external to the organization. The effective management of anxiety at each level within a psychiatric institution is central to being able to sustain an effective service and is a key "management" function.

Managing a psychiatric unit or hospital however brings inherent challenges and complexity, and this can be overlooked from a more detached managerial perspective and interpreted as evidence of a failing service. The pathological patterns of clients past, of possible exploitation, deprivation and abuse, can be "pushed in" to the organization. The clinical psychologist, as a senior colleague, may often be in a position to offer the service manager personal support and informal systemic supervision "as required". The supported opportunity to appraise the validity of criticism (actual or perceived), hypothesize reasons for this, and interrupt otherwise impulsive responses will probably be both appreciated by your colleague and be of significant benefit to the service. Sometimes a staff member may have gone on to act inappropriately and this needs to be dealt with by the manager and digested by their colleagues. The involvements already discussed can mitigate against this to a degree, but the emotional loads of this work should not be underestimated. This was formerly recognised in the UK with certain enhanced employment conditions for those designated "mental health officers" who spent the majority of time in face to face clinical contact with clients. Interestingly, this was removed for new staff two decades ago; could it be that the real impact of the work could no longer be heard, or had the systemic effects of working in mental health on managers and others perhaps never been equally recognised?

**Conclusions**

The river Ouse in York, UK. still floods with regularity, so much so that many visitors are unable to quench their thirst at "the Kings Arms" public house due to the water climbing the doors and walls. Unlike riverside pubs, psychiatric institutions were purposely built on high ground to permit good drainage and sanitation, and therefore better physical health. Our forefathers realized this could contribute significantly to improving the mental health of patients within asylums, together with a culture of community, kindness, respect and social responsibility (Tuke, 1813). In this way, they were not only addressing immediate distress but working "upstream" from the presenting problems of their patients, and leaving the challenge for us to follow their lead.

I have suggested there are a number of roles and means by which the clinical psychologist might work upstream within the system of the open psychiatric ward. A psychological formulation may not only help the patient, but also be of benefit to the team around them, and beyond the admission. In addition to the individual psychological therapy and facilitation of therapeutic groups, the clinical psychologist should contribute to the capacity of the inpatient team to to reflect on their patients and interactions and a position of therapeutic curiosity. Bringing the formulation beyond the walls of the therapy room into the actively reflecting team will additionally assist with the containment of anxiety of the team during times of incident or uncertainty. As time and tide continue, new staff members need to be helped to understand and assimilate the culture of the service, and it is suggested the clinical psychologist can play a lead role here as a culture carrier. This forms part of a broader informal leadership role within the team which takes shape with the regular clinical discussion and other contributions to the teams' work. There is much informal training offered through his process but the clinical psychologist might also usefully provide formal teaching input to the team. The support of those who manage and serve in formal leadership roles is crucial; the clinical psychologist can in this way be both a good colleague and reduce any anxiety-driven impulsive responses by them. Rather than any implied criticism, this can be understood as an inherent effect of the work within a mental health system that Ballatt & Campling (2011) note may otherwise undermine the *intelligent kindness* within the organization. Last but far from least, the competency of the clinical psychologist as a scientist practitioner and researcher can quality assure and further develop the work of the open psychiatric ward, and contribute to the security of the service through demonstrating clinical and financial effectiveness. This can be difficult to prioritize, but open to regret at your leisure. The good news is that as a clinical psychologist you are perfectly placed and ideally trained to fulfill the range of roles outlined here, and through these have asignificant influence on the good work of the ward that extends well beyond the walls of the clinic room.

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