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Character strength-focused positive psychotherapy on acute psychiatric wards: A feasibility and acceptability study

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Highlights

- Brief character strength-focused positive psychotherapy is feasible and acceptable to carry out in a group format on acute psychiatric wards.
- Service users on acute wards can identify character strengths and carry out strength-based activities.
- Positive psychotherapy appears to increase positive mood in service users on acute psychiatric wards.

Abstract

Method: A manualised single-session positive psychotherapy intervention was developed for acute psychiatric wards. Participants were invited to identify positive experiences, link them to a personal character strength, and plan a strength-based activity. Feasibility was evaluated through fidelity to session components, character strengths identification, and activity completion. Acceptability was evaluated with self-reported pre-/post-session mood ratings, a post-session helpfulness rating (both on a 0-10 Likert scale), and narrative feedback.

Results: Participants (N=70) had complex and severe mental health conditions. In 18 group sessions, 89% of components were delivered; 56 (80%) participants identified a character strength, of whom 40 (71%) identified a strengths-based activity, and 23 (58%) completed the activity. Mean (SD) helpfulness (N=23) was 8.5 (1.5) and positive mood significantly increased post-session (5.9 vs. 7.2).

Conclusion: Positive psychotherapy is feasible and acceptable in challenging inpatient settings; and service users with severe and complex mental health conditions find this intervention helpful.

Keywords: positive psychology; psychosis; personality disorders; acute inpatient psychology; psychological symptoms; wellbeing; positive experience.

Introduction

Acute psychiatric wards offer a therapeutic space for people with severe and complex mental health conditions. Despite dominance of the biomedical model, psychological input on acute wards is necessary to stabilise crisis and distress (1), but needs to be provided in efficient, cost-effective ways. Studies indicate that adapted group-based psychological interventions are feasible and effective in inpatient settings (2, 3), and given the resource challenges associated with implementing psychological therapies on acute psychiatric wards, there is a need for innovative approaches.

Positive psychotherapy emphasises strengths and positive wellbeing, as well as difficulties, and can have a positive impact on recovery. Wellbeing is rarely foregrounded in severe mental illness (4); however, positive psychology and wellbeing research in psychosis indicates feasibility (5) and associations with remission (6). Character strengths are popular components of positive psychotherapy and, in psychosis, a focus on strengths such as honesty, authenticity, and genuineness can have positive benefits (7). A manualised group intervention of positive psychotherapy for psychosis (8) was feasible, acceptable, and improved mood (9, 10). However, further research is necessary to evaluate implementation in inpatient settings, with service users who have severe and complex mental health conditions. This study aimed to evaluate feasibility and acceptability of group positive psychotherapy on acute psychiatric wards.

Methods

This study was approved by the South London & Maudsley NHS Foundation Trust. A manualised single-session positive psychotherapy session based on positive experiences and character strengths was developed by SR. It incorporated components and exercises from three

sessions (‘Good things’, ‘Identifying a personal strength’, and ‘Using personal strengths’) in a positive psychotherapy for psychosis manual (8, 11). This positive psychotherapy session was integrated in a full timetable of psychosocial ward activities at a South London psychiatric hospital. A single-session design was purposefully adopted due to the short ward stay of service users, irregular attendance from service users, and limited psychology provision. The intervention was developed in consultation with eight service user and carer researchers who emphasized the need for the session to maximise inclusivity.

Participants were recruited from three of the hospital’s adult acute psychiatric wards (one male, one female, one mixed gender). Ward staff referred service users who were suitable to engage. If service users presented with challenging behaviours, such as violence and aggression, they were not referred. In session, participants were invited to identify recent positive experiences (‘Good things’), consider what they had done to make this good thing happen, then link these experiences to a personal character strength that they possess, and planned an activity for the week, based on their strength. Sessions consisted of nine components and used A4 picture cards representing Values in Actions (VIA) character strengths (12) to aid identification of strengths (‘Gallery of strengths’). Sessions has a target time of 60 minutes. **Table 1** reports session components.

A clinical psychologist (SR) or a trainee clinical psychologist (SK) led sessions with an assistant psychologist or a member of ward staff. Sessions occurred weekly for each ward in a designated room. The session format enabled participants to attend the session more than once if they wished. If so, they were encouraged to select alternative character strengths and activities from ones previously chosen. Ward staff were encouraged to support service users in carrying out activities.

Demographic data were accessed from clinical records. World Health Organisation's International Classification of Diseases 10 (ICD-10) was used to record diagnosis block. Feasibility was measured by recording session duration, fidelity to session components, and whether participants could identify a character strength, plan a strengths-based activity, and carry out the strengths-based activity post-session. One-week post-session, ward staff who were involved in participants' care were consulted and clinical records reviewed to identify whether participants carried out their strengths-based activity. Acceptability was measured by participants self-reporting their mood on a scale from 0 (=most negative) to 10 (=most positive) pre- and post-session, and 'helpfulness' of the session from 0 (=not helpful) to 10 (=extremely helpful) post-session. When measuring acceptability, the aim was not to increase positive mood but rather to determine that there had not been a negative impact on mood. Ratings were collected in session and participants were invited to reflect on any mood changes, a routine approach adopted for other ward-based psychological interventions. Brief narrative feedback on benefits and challenges was collected in a feedback form. Ratings and feedback were optional, and participants were informed their care would be unaffected if they opted out.

Analyses were conducted in SPSS23. Paired samples t-tests compared pre- and post-session mood only for participants who provided both ratings. Mean (SD) helpfulness and narrative feedback themes were reported. Participants who attended sessions more than once were treated as new participants in these analyses.

Results

There were seventy participants. Most participants attended the session once (*N*=55, 79%). Twelve participants (17%) attended twice, two participants (3%) attended three times, and one participant (1%) attended four times. Mean age of participants was 37.1 (*SD* 13.3, *range* 18-74). Forty-six (66%) participants were female. Thirty participants (43%) identified as of White ethnicity and 25 (36%) identified as of Black ethnicity. Twenty-seven participants (39%) had a F20-F29 Schizophrenia, schizotypal and delusional disorders diagnosis, 15 (21%) had a F60-F69 Disorders of adult personality and behaviour diagnosis, and 15 (21%) had a F30-F39 Mood [affective] disorders diagnosis.

Eighteen group sessions were delivered with 89% fidelity to session components (144/162 components). Components 1-6 and Component 9 were almost always delivered. Component 8 was omitted for nearly half of the sessions, due to time constraints. **Table 1** reports fidelity to session components. Fifty-six participants (80%) identified a character strength; of these, forty (71%) identified a strengths-based activity; and of these, twenty-three (58%) carried out the activity. The most reported character strengths were kindness (N=11, 20%), self-regulation (N=6, 11%), creativity (N=6, 11%), love of learning (N=5, 9%) and perseverance (N=5, 9%). Fifteen sessions (83%) lasted 60 minutes and three (17%) were shorter. Mood and helpfulness data were collected from twenty-three participants (33%). Mean (SD) mood scores significantly increased post-session (7.2 (1.7)), when compared to pre-session (5.9 (1.8)), $t(22)=5.3$, $p<0.001$, with a large effect size (d=1.1). Mean (SD) helpfulness rating was 8.5 (1.5).

Forty-nine participants (70%) provided narrative feedback. Participants identified that the session was helpful, and they enjoyed identifying positive experiences. Participants liked Component 5, with some asking for copies of pictures to put on their walls; others reported

enjoying connecting and sharing experiences. One participant reported: "[I] really enjoyed the session, felt it was really good for people in acute crisis" (#17). Another said: "I enjoyed connecting with other group members" (#55). Some participants reported wanting to discuss negative emotions: "[I] can see it being helpful for other patients but prefer to talk about negative emotions, as these are not discussed at home" (#36). Several participants reported that they did not like using numerical ratings for mood and helpfulness and did not want to provide this data.

Discussion

The aim of this study was to evaluate feasibility and acceptability of a single-session positive psychotherapy group on acute psychiatric wards. This is a novel setting for positive psychotherapy, and high completion rates for session components, identification of strengths, and strength-based activities indicate feasibility. The positive effect on mood and high helpfulness rating indicates acceptability and positive impact on service users with complex and severe mental health conditions who are typically hard to engage in psychological interventions. Mood improvements are consistent with positive psychotherapy research on depression reduction in psychosis and positive psychotherapy exercises that positively impact happiness (10). The prominence of character strengths such as kindness is consistent with research in psychosis populations (7) and activity completion rates are consistent with research indicating that positive exercise can be carried on psychiatric wards (10). Narrative feedback about negative emotions is consistent with positive psychology critiques, such as over-emphasis on happiness and the individual, which may overlook underlying structural determinants of mental health and wellbeing (13, 14). This is an important consideration for positive psychotherapy in acute and crisis settings. Delivering positive psychotherapy to service users who are significantly distressed and overwhelmed with negative emotions may

be challenging. It is possible that if service users feel they are unable to think positively they may develop feelings of guilt which can exacerbate original difficulties (15). Future research in acute and crisis settings might therefore investigate how positive psychotherapy might balance validation of distress while promoting the positive benefits of engaging with positive experiences and character strengths.

A strength of this study is its adaptation of positive psychotherapy to acute and crisis settings, with people with severe and complex mental health conditions. Limitations included challenges of collecting numerical data, lack of standardised measures, and collecting data in session, which might have introduced bias. The relatively small proportion of participants who completed pre- and post-measures reflects both the general difficulty of collecting data on acute wards and the fact that irregular attendance is typical of the setting. The service user consultation in the study design was limited and future studies could involve greater service user integration. Use of staff reports and clinical records to collect data, rather than participant self-report, may be a limitation. Service users can lack trust in healthcare services so it is possible that participants may have complied with the intervention and post-intervention activity because they wanted to appear well or be discharged rather than because they were interested in positive psychology.

Future research might test the effectiveness of this standalone character strengths-focused positive psychotherapy intervention in a larger study with a control group, including greater self-report data from service users about their activities and their views about attending the group. Where possible it would be helpful to assess the impact on service users attending more than one session to see whether there is any further change over time. Fidelity to session components might be improved with more time spent planning sessions. Reviewing session

timings might address the lower completion rates for Components 7 and 8, and the potentially associated rate of participants carrying out the strengths-based activity. Providing additional individual support to service users might improve completion rates. Alternatively, future studies that wished to retain the single session format might test a shorter version of the session, with fewer components; or it might be possible to carry out these intervention components over more than one session.

In conclusion, this study indicates that positive psychotherapy is feasible and acceptable on acute psychiatric wards, and that service users with severe and complex mental health conditions finding the intervention helpful.

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Table 1. Character strengths-focused positive psychotherapy group session components and fidelity to session components*

Component	Content	N (%)†
1. Introduction	Facilitator to welcome group members to session, check how group members are feeling, and introduce session as a group discussion on positive experiences and personal character strengths. Facilitator to invite all group members to introduce themselves. *Optional*: Group members to give a numerical mood rating.	18 (100)
2. Guidelines	Facilitator to state group guidelines including listening to and respecting one another, confidentiality and clinical note recording, and use of mobile phones. Facilitator to ask group members if they would like to add any guidelines for the session.	18 (100)
3. Good things	Facilitator to invite group members to think about and discuss a good thing that has happened to them in the last few days, with an emphasis on small things, i.e. "Can you think of a good thing or a positive experience that has happened recently, however small?" Facilitator to use positive responding throughout. *Prompts*: hobbies, interests, skills, social interactions, humour, weather, outdoors, food/drink. *Optional:* Facilitators to self-disclose small examples from their own recent experience. *Optional:* For group members who have attended a previous session, facilitator to ask about how they got on with their strengths-based activity as a way to potentially prompt thoughts about good things.	18 (100)
4. Making good things happen	For each good thing identified by group members (in #3), facilitator to ask group member how they helped to make that good thing happen, i.e. "What did *you do* to help that good thing happen?" *Prompt*: Facilitator to think of any possible enabling conditions, either specific or general, that allowed the group member to be causally involved in the occurrence/experience of that good thing. For good things that group members had *actively* carried out, facilitators to elicit and break down the components that enabled that good thing to happen, e.g. if the good thing was that a group member had enjoyed a positive telephone conversation with their father, then facilitators to elicit that they had made a plan to make the phone call, set a specific time, made sure they had access to a phone etc. For good things that group members had more *passively* witnessed, facilitators to notice that group members had put themselves in a position to witness that good thing and had turned their attention to it, e.g. if the good thing was that a group member had enjoyed the sunshine outside, then facilitators to elicit that they had gone outside rather than stayed in their room and had noticed and actively enjoyed the sunshine.	17 (94)
5. Gallery of strengths	Facilitator to distribute all *pictures representing 24 Values in Actions (VIA) character strengths* on the floor/table/around the room and ask group members what personal character strengths they can see in the pictures or which pictures they like, emphasising that there are no right or wrong answers. Facilitator to use positive responding throughout. Group	16 (89)

	members to view pictures of character strengths and discuss. *Optional*: Facilitator to distribute copies of the 24 VIA character strengths handout (www.viacharacter.org).	
6. Identifying personal character strengths	Facilitator to invite group members to identify a personal character strength that they possess. *Prompt:* Facilitator to help group members think of their strengths by connecting this to how group members made good things happen (in #4), and/or to pictures with which they may identify.	17 (94)
7. Using personal character strengths	Facilitator to connect using our personal character strengths with positive emotional wellbeing. Group members to identify and plan a small activity or task for the coming week that enables them to use their personal character strength. Facilitator to use positive responding throughout. Facilitator to encourage group members to identify a location and time for the activity. *Optional*: Group members who have attended a previous session can be supported to identify new strength/activity.	13 (72)
8. Overcoming obstacles	Group members to identify any obstacles that may arise in carrying out their strengths-based activity and consider how they may overcome these obstacles, i.e. "Is there anything that might get in the way of this plan? How might you overcome that obstacle?" *Optional:* Group members could complete a *Strength-based Activity Worksheet* that enabled them write about their intended activity and to provide written responses to these questions about potential obstacles.	10 (56)
9. Feedback, reflections and session end	Facilitator to invite group members to give feedback and reflections on group. Facilitator to thank all group members to their attendance. *Optional*: Group members can give a numerical mood and helpfulness rating. *Optional:* Group members can complete a *Feedback Form*.	17 (94)

* The session was designed by SR; adapted from three sessions ('Good things', 'Identifying a personal strength', and 'Using personal strengths') in Riches, S., Schrank, B., Rashid, T., & Slade, M. (2016). Wellfocus PPT: Modifying positive psychotherapy for psychosis. *Psychotherapy*, *53*(1), 68–77; †Number of sessions (and percentage of total sessions (N=18)) in which component was delivered.