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Empirical Research

Usefulness of the ACT model for nurses in psychiatric inpatient care: A qualitative content analysis

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ABSTRACT

Alleviating the suffering of patients treated in psychiatric inpatient wards is a great challenge. Preliminary or multiple diagnoses, inherent complexities of the inpatient milieu and the lack of potentially effective psychological treatment form part of this challenge. The present study explored the usefulness of a transdiagnostic psychological treatment model (Acceptance & Commitment Therapy, ACT) as a means of improving inpatient care from the perspective of psychiatric nurses. Nurses ($n = 10$) participated in three ACT workshops, a total of 21 h, and were interviewed about the experienced usefulness and difficulties of the ACT model, as a tool for improving everyday ward work. Results, revealed by qualitative content analysis, suggest usefulness in the areas of alleviating patients symptoms, enriching typical ward duties, and handling one's own thoughts and feelings. Difficulties stemmed from lack of time, the model itself and patients' severe illness. Possible adjustments of the ward context are suggested.

1. Introduction

Patients treated in psychiatric inpatient wards present with severe suffering, often meeting criteria for multiple psychiatric diagnoses. With decreasing numbers of hospital beds (Swedish Association of Local Authorities and Regions, 2010), care is reserved to a large extent for patients with severe suicidality or acute psychosis. This puts pressure on nurses working in the ward to alleviate suffering. At the same time, as little as 50% of nurses' time is spent in direct contact with patients (Sharac et al., 2010), and even less time than that is considered therapeutic. While pharmacological treatment is standard in these settings, integrating psychological treatment with psychiatric inpatient services is challenging on multiple levels (Folke, Kanter, & Ekselius, 2016) because of clinical, cultural, organizational, and competence barriers. Still, several studies indicate that inpatient populations with various diagnoses can benefit from psychological treatment (e.g., Bach & Hayes, 2002; Cuijpers et al., 2011; Gaudiano & Herbert, 2006; Kösters, Burlingame, Nachtigall, & Strauss, 2006; Owen, Speight, Sarsam, & Sellwood, 2015; Tyrberg, Carlbring, & Lundgren, 2017a).

Among the clinical barriers discussed by Folke et al. (2016) is the multiplicity of patients' diagnoses. To exemplify, a typical psychiatric inpatient might present with a primary DSM-5 (American Psychiatric Association, 2013) diagnosis of psychosis, and secondary diagnoses of depression, substance abuse and personality disorder. Furthermore, as also pointed out by Folke et al. (2016), diagnoses are often preliminary. Typically, further assessment takes place after a longer period of observation, often when the patient has been transferred to outpatient care. When admitted, the patient's suffering and need for care are often obvious, while the diagnosis is anything but. This may be so for several weeks of treatment. Thus, a psychological treatment model fit for psychiatric inpatient services would ideally be flexible and transdiagnostic.

One transdiagnostic model of psychological treatment is Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999). ACT is based on behavioral theory and a theory of language and cognition known as relational frame theory (RFT; Hayes, Barnes-Holmes, & Roche, 2001). The aim of ACT treatment is to increase psychological flexibility, defined as the ability to “contact the present moment more fully as a conscious human being, and to change or persist in behavior when doing so serves valued ends” (Hayes, Luoma, Bond, Masuda, & Lillis, 2006, p. 7). ACT has shown effectiveness in treating a number of psychiatric and somatic conditions (A-Tjak et al., 2015; Hayes et al., 2006; Ruiz, 2010). Like the other so-called third wave behavioral therapies (Hayes, 2004), ACT is focused on increased

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values-based living and decreased experiential avoidance (Hooper & Larsson, 2015). Lack of committed action and psychological inflexibility are seen as core symptoms. Interventions are based on an ideographic functional analysis, rather than targeted at specific diagnoses.

Given the inherently complex nature of psychiatric diagnoses and inpatient milieus, training ward staff in the use of flexible, transdiagnostic psychological treatment models might be a plausible alternative to having psychologists performing traditional psychotherapy. There are several previous studies that have investigated the processes and effects of such training (e.g., Gilbody et al., 2006; McCann & Bowers, 2005; Rosebert & Hall, 2009). However, all studies that we are aware of report similar difficulties in applying sufficient experimental control to enable strong conclusions as to the effectiveness of ward staff training.

In a previous study (Tyrberg, Carlbring, & Lundgren, 2017b), we used quantitative methodology to investigate the effects of ACT training on nurses and patients' psychological flexibility, and whether the training affected actual staff behavior. In short, results revealed minor positive changes in psychological flexibility among patients and staff. Further, behavior by staff considered to be ACT consistent followed mostly unpredictable patterns. This was discussed in light of contextual features in the ward, such as irregular staffing, varying workload, varying numbers of daily admissions and discharges, etc.

In the present study, the specific aim was to investigate *how* the ACT model might have been useful for nurses in psychiatric inpatient care, if at all. Further, we wanted to investigate what had made implementation difficult. To accomplish this, we used a qualitative methodology, described in more detail below. The two research questions were the following: 1) In what way have nurses experienced the ACT model as useful in their daily work in the ward? and 2) In what way have nurses experienced the use of the ACT model as difficult?

2. Method

2.1. Participants

Over the course of twelve months (April 2015–April 2016), the staff at a psychiatric inpatient ward specialized in psychosis participated in a research project that investigated the implementation of the ACT model as part of the treatment milieu. The 12 bed ward was located in a psychiatric clinic at a medium-sized hospital in central Sweden (Västmanland County). At the outset of the project, the staff group consisted of 12 assistant nurses and eight registered nurses, some with specialized psychiatry training. Six staff members were men and 14 were women. Ages ranged from 26 to 65 years ($M = 48.75$, $SD = 12.81$).

A total of 12 staff members participated on all workshop occasions. Of these, four exclusively worked night shifts in the ward. Considering their limited abilities to apply the ACT model in daily conversations with patients, they were excluded from analysis. The remaining eight staff members, plus an additional two who participated in the first two workshops and the 14-h expert training seminars were included as subjects in the present study. Participant demographics are presented in Table 1. None of the participants had previous formal psychotherapy training.

Table 1
Staff demographics (n = 10).

Mean age (*SD*)	45.40 (15.78)
Gender	
Male	4
Female	6
Profession	
Assistant nurse	6
Registered nurse	2
Registered nurse with specialized psychiatry training	2
Mean years of experience (SD)	16.40 (13.62)

2.2. Procedure

Interventions implemented during the year consisted of a total of three clinical ACT workshops, 12, 3 and 6 h long. In addition, 1-h weekly supervision sessions were offered at the same weekday and time of day throughout the year, except during summer holidays. All day shift staff members who worked on each particular occasion participated.

The overarching aim of the workshops was teaching staff members a psychological treatment model to be used flexibly in daily ward work. It was stressed that staff were not expected to conduct long therapy sessions. Rather, they were encouraged to infuse the ACT model into tasks they already performed, such as admissions, the formulation of care plans, handling pro re nata medication and handling patients' anxiety attacks.

In the first workshop, the ACT model (Hayes et al., 1999) was introduced by training three response styles, namely *open*, *aware,* and *active* (Oliver, Joseph, Byrne, Johns, & Morris, 2013). *Open* refers to the active embrace of thoughts, feelings, memories and sensations as they present themselves as opposed to engaging in avoidance of them. *Aware* describes the process of taking a certain perspective on private events and oneself and being present in the here-and-now. *Active* refers to the process of actively identifying the values central to one's life, and to engage in concrete behaviors in line with such values. Specific exercises were used throughout the workshop. One exercise that was used for the *open* response style was walking around with a pebble in one's shoe to experience the free choice of how to relate to pain. An exercise that included both *open* and *aware* response styles was silently gazing into the eyes of a colleague for an extended period of time, illustrating how various private events can be experienced in the moment. The response style of *active* was illustrated using the Bull's Eye Values Survey (Lundgren, Luoma, Dahl, Strosahl, & Melin, 2012). The response styles were further exemplified with possible ACT consistent interactions via the use of staff experiences from the ward context. Exercises, discussions, role-plays, and video demonstrations were used. For example, in *mindfulness of the hand* (Harris, 2009) patients are asked to observe their hand for an extended period of time, to promote awareness. Focus questions informed by the ACT model, and potentially helpful in making quick assessments, were also introduced: What are you seeking?, What have you tried?, How has it worked?, and What has it cost you? (Strosahl, Robinson, & Gustavsson, 2012).

The next workshop started with the repetition of the response styles, printed on pocket-sized cards given out to all staff members. In a centering exercise (Eifert & Forsyth, 2005), participants were asked to explore their own values connected to their presence on the workshop. With daily ward work forming the background, the ACT model was trained as a tool for maintaining staff health. An ACT tool called the pause, printed on the backside of the card given out earlier, was suggested as an easy-access way for staff to find their way back to a valued direction, after being caught up in thoughts and feelings. It was also suggested as an aid to hand out to patients. A group values exercise (*What do you want your life to stand for?*, Hayes et al., 1999, pp 215–218) concluded the workshop.

The third and final workshop focused on the formulation of patients' care plans, using the ACT model. Care plans were essentially supposed to contain goals and specific activities to reach those goals, during the time spent in the ward. This was a central task for all staff working in the ward, and a measure of productivity from the perspective of management. Using the central tenets of the ACT model, the workshop aimed at making the care plan work more flexible and better connected to both patient and staff values. While clinical psychologists (the first and third authors) led the two previous workshops, the third was co-led by the first author and a registered psychiatric nurse working daily in

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