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Preliminary Evaluation of a Trauma-Focused Cognitive Behavioural Therapy Group for Female Acute Inpatients

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ABSTRACT

Up to 65% of inpatients may exhibit trauma symptomology, and inpatient admissions in and of themselves may be experienced as traumatic. To date, evaluations of psychological interventions targeting trauma symptomology are limited, despite growing attention in practice being paid to the conduct of psychological therapy groups on inpatient wards. The present practice article describes the preliminary implementation and evaluation of a trauma-focused group for female psychiatric adult acute inpatients. The group protocol was developed using cognitive behavioral therapy and compassion-focused therapy principles, reflecting existing evidence and guidelines for trauma-focused therapy and adult psychiatric inpatient groups. The group recruited women admitted to a psychiatric unit who were self- or staff-identified as experiencing concerns with trauma-related symptomology. For the preliminary evaluation, data were gathered on attendance, retention rates and self-reported experiences of the group. Analyses included descriptive statistics and a qualitative content analysis. Twenty-four patients attended, with 11–29% of the total bed stay attending at least once. Retention was 89%. Qualitative themes indicated that learning psychological concepts and skills, connecting with staff and peers were appreciated and beneficial. The facilitators reflected that female psychiatric inpatients reported finding the group beneficial for providing a safe, constructive space to learn about the impact of trauma. Practical skills alongside group discussions were reportedly beneficial. Challenges included maintaining safety amongst challenging group dynamics and external disruptions from the ward environment. Future groups may benefit from slightly longer sessions, continued focus on practical trauma-focused coping skills, and attention paid to group dynamics.

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Individuals admitted to acute inpatient wards experiencing mental health crises require wrap around, multi-disciplinary support to address acute and severe distress (NHS England [NHS], 2023). Rates of symptoms of post-traumatic stress disorder (PTSD) within inpatient populations are high, with studies suggesting as high as 61–65% (McFarlane et al., 2001; Nowlin et al., 2019). Recent research has also suggested that the severity of PTSD symptomology may be related to the severity of suicidal ideation in inpatients (Stanley et al., 2021), which suggests that it may be an important mechanism for intervention for those admitted to inpatient wards.

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Funding for the provision of psychological therapies within inpatient units in the United Kingdom has recently increased (NHS, 2023), on the recommendation that individual and group-based therapies should be readily available and that wards should be run on the principles of Trauma Informed Care (NHS England, 2024). Trauma Informed Care calls for mental health professionals to be aware of the likely high prevalence of past traumatic experiences; understand how post-traumatic symptomology might present ranging from impacting relationships, avoidance, hyper-vigilance, nightmares and flashbacks; and helpfully respond to such symptomology with compassion and understanding rather than risking re-traumatization, such as through overly restrictive, coercive or invalidating practices (Sweeney & Taggart, 2018). This is particularly important in inpatient settings, with research finding that an admission can result in PTSD symptomology for as high as 74% of a sample post-discharge, with females being at elevated risk (Martinaki et al., 2021). Further research suggests that inpatient admissions are likely traumatic for some due to the re-traumatizing impact that power imbalances, restrictive practices and coercion can have (Prytherch et al., 2020). Increasing ways to address post-traumatic symptomology during admissions is therefore important.

Prior research has found that group-based psychological interventions are efficacious in inpatient settings with specific adaptations to make them feasible (Boynton & Sanderson, 2022). Group-based psychological therapies for PTSD in community settings demonstrate positive outcomes at reducing symptomology, particularly when focused on stabilization through providing psychoeducation and skill-building (Willis et al., 2023). However, despite the call for more trauma-informed ward environments and a need to begin addressing the sequelae of trauma during and beyond admissions, evaluations of trauma-focused interventions on wards remain limited. The present group design and preliminary evaluation aimed to address this gap by developing and evaluating a trauma-focused group of females admitted to an inpatient ward.

Trauma-Informed Psychological Interventions in Inpatient Wards

The Diagnostic and Statistical Manual (DSM-5) defines PTSD as developing after a traumatic event which is defined as an event involving actual or threatened death, serious injury or sexual violence, whether directly experienced or witnessed (American Psychiatric Association, 2013). Symptoms can include intrusive, vivid memories or nightmares of the event, significant avoidance associated with reminders of the event and altered thinking and/or mood (American Psychiatric Association, 2013). Both clinical and sub-clinical PTSD therefore involve the distressing reexperiencing of past traumatic events in the here-and-now, triggered by external reminders of the event as well as internal post-traumatic intrusions (Bryant, 2019). Review studies have examined the effectiveness of individual psychological therapy provision on inpatient wards, finding that it is acceptable, feasible and may reduce symptoms of depression, anxiety, psychosis, PTSD and re-admission rates (Paterson et al., 2018).

Trauma-focused therapies, specifically cognitive behavioral therapy and eye movement desensitization and reprocessing (EMDR), have a growing but limited evidence base for inpatients, suggesting positive outcomes at reducing PTSD symptoms and distress (Cabrera et al., 2020; Phillips et al., 2022). Both cognitive behavioral therapy and EMDR utilize different therapeutic techniques to help individuals relive, re-

appraise and ultimately re-integrate their trauma memories to reduce PTSD symptomology, which are proposed to stop the reliving of memories from being involuntary and distressing (Hudays et al., 2022). Studies examining individual EMDR delivered for inpatients have found positive outcomes, including remission in PTSD symptoms and no further need to engage in trauma therapy post-discharge (Méndez et al., 2018). Inpatients experiencing PTSD may experience significant distress, impacted sleep and increased suicidality (Nowlin et al., 2019), so finding ways to address such concerns is paramount. Trauma-focused therapeutic work is therefore likely to be helpful within inpatient settings, and indeed national guidelines suggest that therapy should begin in inpatient settings wherever possible rather than wait until post-discharge (NHS, 2024).

Delivering psychological therapy on inpatient wards comes with significant barriers, including narratives that individuals may be "too unwell" to engage in therapy whilst an inpatient, cognitive difficulties pertaining to medication and/or poor sleep, and high patient turnover (Kerfoot et al., 2012). Review studies have examined the barriers and facilitators to implementing therapy on wards, noting that the availability of qualified staff, suitable rooms, high levels of distress and fast turnover of patients are all challenges to overcome to ensure effective delivery (Raphael et al., 2021). Facilitators of delivering therapy in inpatient settings appear to be applying adapted approaches such as single-session therapy, focusing on working with high levels of distress and adapting to cognitive challenges such as from medication or poor sleep through shorter sessions to aid concentration and memory, and group-based therapies (Evlat et al., 2021).

Group-Based Therapies in Inpatient Wards

Group-based interventions on wards have a growing body of evidence when delivered in skills-focused, bite-sized, interactive formats, with a range of studies finding that they are acceptable and feasible to patients, demonstrate reductions in risk incidences, and improve a sense of safety, recovery and some symptom reduction (e.g. Heriot-Maitland et al., 2014; Stroud & Griffiths, 2021; Wilson et al., 2011). Most prior evaluations of groups used 30-min group sessions to promote participants' abilities to focus and retain information, relying more on psychoeducation and interactive exercises, such as practicing skills together in-session. Established groups from existing research in inpatient settings also mostly opt to have a series of stand-alone sessions, each with different content aimed at providing psychoeducation and coping skills, rather than requiring participants to attend subsequent sessions, as high patient turnover, clashes and difficulties with attendance all make consistency challenging (Evlat et al., 2021; Stroud & Griffiths, 2021). For these reasons, a group-based approach using 30-min, stand-alone sessions was chosen, aiming to offer participants value from whichever session(s) they could attend. This aimed to facilitate accessibility for group sessions whilst individuals were admitted, rather than excluding people who could not attend multiple sessions due to high rates of patient turnover. In line with other published evaluations, the evaluation aimed to take a preliminary, exploratory investigation of attendees' experiences to ascertain experiences and perceptions of the content and group delivery (e.g. Davies & Pipkin, 2024).

Models of Therapy Groups in Inpatient Settings

Prior studies examining inpatient therapy groups have largely evaluated cognitive behavioral therapy, compassion-focused therapy and dialectical behavioral therapy groups, all finding similarly positive results suggesting their acceptability and feasibility for patients. In secondary care community mental health settings, skills-based groups for PTSD treatment are commonly delivered, which use either cognitive behavioral therapy or compassion-focused therapy and typically provide psychoeducation, emotion regulation skills and grounding skills, and demonstrate medium effect sizes at reducing PTSD symptoms (McLean et al., 2022; Willis et al., 2023). Group-based cognitive behavioral therapy groups in community settings demonstrate reduced PTSD symptoms, depression and anxiety, and notably that gender may be a moderator of treatment outcome, with females achieving better outcomes than males (Schwartze et al., 2017).

Willis et al.'s (2023) systematic review found that qualitative research suggests that attendees find such stabilization groups to be informative, capable of equipping them with skills and useful for group processes. As the first-line recommended psychological therapy in the UK is cognitive behavioral therapy, this was chosen as the primary model (National Institute for Health and Care Excellence, 2018). The accessibility and acceptability of compassion-focused therapy for inpatients and prior research highlighting that compassion-focused group programs in community settings can improve PTSD symptoms (Craig et al., 2020), elements were chosen to be integrated. Notably, to the authors' knowledge, despite individual trauma-focused therapy having been studied in inpatient settings (Cabrera et al., 2020; Phillips et al., 2022), no studies exist evaluating trauma-focused group interventions within inpatient settings. Given that such group therapies may arguably be more cost-effective, accessible and are readily available in the community as a first-line intervention (Willis et al., 2023), the present article describes the implementation and preliminary evaluation of one to ascertain if it ought to be added to the milieu of existing group therapies based on an exploratory evaluation with an inpatient population.

Gender-Specific Inpatient Group Therapies

Gender-specific groups in inpatient settings are increasingly common, given the widespread use of single gender wards in the UK, and the benefits of peer support, with two studies reporting gender-specific groups for men and women, respectively, appear to provide a sense of safety, peer learning and trust (e.g. Davies & Pipkin, 2024; Walsh-Harrington et al., 2020). Research suggests that people admitted to inpatient wards are more likely to have a history of abuse than those without a similar history (Werbeloff et al., 2021), which led to caution around the concept of a mixed gender group. Prior research directly comparing the experiences of women attending single- and mixed-gender trauma-focused groups found higher positive group bonding, working relationships and perceived social support from female-only groups compared to mixed gender, although there was no difference in treatment outcome for rates of PTSD (Philipps et al., 2022).

As some of the women may have experienced abuse from men which may have disrupted their sense of safety and presence within the group, the intervention was deemed appropriate to initially deliver and evaluate on a female ward to promote group dynamics of cohesion, peer support, safety and trust. Existing trauma-focused therapies do not

necessarily focus on gender unless it is relevant to the trauma or related beliefs at hand, and so gender was not made an explicit focus on the topic or setup of the group, rather it formed an inclusion criteria on the hypothesis that it may promote group cohesion and safety. The group also took part on a female-only acute ward, where mixed gender groups were also not possible.

Theoretical Basis and Group Development

The present group was based in a National Health Service (NHS) acute female psychiatric unit in the United Kingdom, where, as noted, funding had recently increased to establish Trauma Informed Care (NHS, 2024). Funding has specifically increased to ensure each ward has access to a qualified clinical psychologist or similar and that psychological therapies are readily available to commence during inpatient admissions (NHS, 2024). The authors had identified numerous individuals on the ward who were reporting PTSD symptomology as a concern, which was impacting their levels of distress, sleep and functioning. As waiting lists for individual trauma therapy in the community were long, ward staff frequently reported struggling with how to help patients meaningfully work through their trauma and feeling under-skilled and fearful of doing so. The group was therefore partly proposed to upskill patients with knowledge and practical coping tools. Given the high rates of trauma in individuals admitted to wards and also how inpatient admissions can be traumatic events (Prytherch et al., 2021), the group was also considered a way of engaging individuals in safe, supportive conversations about trauma and its impact. Many individuals, for example, could find the noise of the ward triggering, or be reexperiencing traumatic interpersonal dynamics within staff relationships. The facilitators therefore aimed to strike a balance between opening up a supportive space about the impact of trauma without requiring disclosure of traumatic events to promote positive coping.

In line with UK national clinical guidelines advocating for cognitive behavioral therapy as a frontline psychological intervention for PTSD (NICE, 2018) and prior inpatient groups suggesting that compassion-focused therapy is an acceptable and feasible adjunct (e.g. Heriot-Maitland et al., 2014; Stroud & Griffiths, 2021), the group was developed integrating both protocols. A cognitive behavioral model of trauma proposes that, during a traumatic incident, the brain is unable to process and encode the experience as a typical memory due to the high level of distress (Ehlers & Clark, 2008). This can result in intrusive re-living experiences such as flashbacks and nightmares, dissociating, avoiding triggers or reminders of the traumatic incident, and negative appraisals of the event (such as taking personal responsibility).

Trauma-focused therapies typically involve a phase-based approach, with the first phase of therapy involving developing an understanding of the impact of trauma on the brain, identifying the symptoms (such as dissociation, flashbacks, nightmares and avoidance), and building coping resources to stabilize the emotional impact, such as grounding techniques, emotional regulation skills and differentiating flashbacks from reality (Ehlers & Clark, 2008). The latter phases involve addressing the trauma memories specifically, using a form of re-processing, aimed at addressing negative appraisals and integrating the trauma memory, which shows large effect sizes at reducing the symptoms of PTSD in routine clinical care (Öst et al., 2023). The group program was therefore based upon the cognitive behavioral model of PTSD,

focusing specifically on psychoeducation about how trauma memories are processed in the brain, how reliving and nightmares work, the role of avoidance and hypervigilance in distress, beliefs about trauma and their role in distress, differentiating then-and-now skills, grounding skills, emotion regulation skills and strategies to manage nightmares and flashbacks.

The group program also drew upon elements of Compassion-focused Therapy, which is a third-wave cognitive behavioral therapy designed to provide psychoeducation and skills to improve emotion regulation skills, self-compassion and reduce shame and self-criticism (Gilbert, 2009). It is based on evolutionary and attachment theories, educating people on the "three systems" of the brain; threat, denoting safety-seeking and emotions such as anxiety, anger and disgust; drive, denoting the motivational and reward systems; and soothing, which is the affiliative, regulating system (Gilbert, 2014). The model considers how evolution has led to "tricky" aspects of human brain development, whereby memories and beliefs may inadvertently trigger our threat system and ultimately maintain distress (Gilbert, 2009). It further draws on attachment theory to highlight how barriers to compassion can exist based on experiences in past relationships. Through providing education, normalization and skills to build up the soothing, affiliative system, it aims to foster self-compassion and emotion regulation (Gilbert, 2014). It arguably has relevance for trauma, given overlaps with how traumatic memories can constitute a significant threat to system activation and result in unhelpful patterns of using the drive system to regulate emotions in lieu of the capacity for self-soothing.

Review studies have found that group-based compassion-focused therapy demonstrates positive outcomes for reducing mental health symptomology and distress, including PTSD (Craig et al., 2020), and bite-sized, skills-focused versions have been evaluated in inpatient settings with positive findings for increased sense of safety, reduced distress, reduced risk and positive user experiences (Heriot-Maitland et al., 2014; Stroud & Griffiths, 2021). Given its accessibility, some psychoeducational and skills-based components from the model were integrated into the group program alongside psychoeducation and skills from cognitive behavioral therapy, specifically psychoeducation about the three systems of the brain based on evolutionary and attachment theory, mindfulness skills and tools for self-soothing.

Group Aims and Facilitation

Utilizing cognitive behavioral and compassion-focused therapies and recommendations from prior research, the group had the following aims:

(1) Introduce experiential exercises that give the participants the opportunity for soothing and increased sense of safety
(2) Encourage an awareness of the window of tolerance and how to be mindful of this during the group
(3) Introduce concepts that are related to the experience of trauma
(4) Normalize the experiences of trauma symptoms
(5) Introduce strategies that may help to manage trauma
(6) Discuss the use of strategies and how to apply them whilst on the ward and when at home

The facilitators focused explicitly on developing a safe, supportive process with clear boundaries to reduce the risk of re-traumatization. This was done by having a clear intake process, with all individuals on the ward that week being made aware of the group by posters, discussions with their named nurses and by the facilitators letting them all know that the group was happening. The group was named a "Skills Group" which focused on trauma, rather than a "Trauma Group," with messaging indicating it was a place to learn rather than to openly discuss past traumas. Group boundaries were therefore made explicit both prior to the sessions and at the start of each session, with facilitators attending closely to affect during the sessions as well as the impact of any disclosures that did occur. The sessions followed a pre-agreed structure, aiming to provide containment and focus, whilst also incorporating group discussion and reflection to promote group cohesion and peer learning.

The group aimed to be accessible rather than overly restrictive, relying as much as possible on individual patients choosing to come. Anyone who expressed an interest was offered a brief individual conversation, where the group topics, boundaries around it not being a space to disclose traumatic events but rather to learn about how trauma impacts the brain and how to cope were explicitly discussed. The group itself was also held in a room on the ward, which meant that patients who were legally detained could attend with ease, as it avoided having to sign leave forms or employing additional safety measures.

Group Protocol

The group sessions were offered weekly in a group room on the ward between April and December 2023. Each session lasted 30 min and was conducted as a stand-alone session without requiring or expecting knowledge from previous sessions, in line with prior research recommendations (Davies & Pipkin, 2024; Evlat et al., 2021; Stroud & Griffiths, 2021) and the fast, high rate of turnover on the ward making requirement to attend prior sessions untenable. Sessions were facilitated with a mixture of experiential exercises, psychoeducational content delivery and facilitated group discussions related to session content. Sessions were facilitated by two members of the psychology team: a Clinical Psychologist or Psychotherapist and an Assistant Psychologist or Trainee Clinical Associate Psychologist.

The layout of each session included: welcome and group rules; agenda for the session; brief grounding exercise (relaxed breathing and safe place meditation); psychoeducational content; group discussion; closing exercises; feedback. Group rules included confidentiality, being respectful of one another, and a reminder that the focus of the group was not to share nor process traumatic incidences which may be challenging for individuals and other attendees, rather to focus on learning and discussing ways to manage the impact of trauma. Gender was not a specific topic nor discussion point in the group, rather it was an inclusion criteria for joining the group, although any gender-related topics arising were attended to within group discussions. The session topics, content and a tally of how many times each session was run can be found below. The group followed cognitive behavioral therapy for PTSD (Ehlers & Clark, 2008) and elements of compassion-focused therapy (Gilbert, 2014).

All sessions began with both facilitators welcoming all attendees to the group and discussing group rules, which included keep the group a safe place by not talking about distressing topics, keep the conversations confidential, participants will be given an

opportunity to leave the group following the mindfulness exercise, but are asked to then stay for the remainder of the group. The facilitators were mindful of giving the participants control with choices to leave the group if required and balancing this with the need to minimize distractions to allow participants to settle and relax in the group. The group then started with a 3-min triangle or square breathing exercise. This introduced a grounding tool that can be used and gives an opportunity for participants to reduce any arousal they may be feeling. Each session then had a session-specific experiential activity and associated group discussion, psychoeducational content, and a further experiential exercise and discussion, all of which are outlined below.

Session One – Soothing

The first session included a safe place exercise, including a rationale for why and when it may be helpful, a live practice and group discussion about the exercise, and practical recommendations for implementing it. An explanation of three systems model was provided, including identifying one's own "threat system," and creating a self-soothing box using the different senses. Session one was delivered three times in total.

Session Two – Flashbacks and Nightmares

The second session included psychoeducation on flashbacks and nightmares and discussion of helpful strategies for managing them, including grounding skills and differentiating then-and-now. Participants are guided to complete flashback and nightmare scripts. Session two was delivered twice.

Session Three – Mindfulness External

Session three focused on a discussion about the aims of mindfulness and various exercises, including mindful eating, and a group discussion of various ways to incorporate mindfulness into daily routines. Session three was delivered three times.

Session Four – Mindfulness Internal

Session four focused on mindfulness of thoughts including a body scan exercise, the leaves on a stream metaphor, and discussion of how to integrate mindfulness to defuse from thoughts with daily practices. Session four was delivered twice.

Session Five – Distraction and Distancing

Session five focused on distraction and distancing skills and how these can be used to manage difficult experiences including self-harm and suicidal thoughts. Participants were encouraged to complete "10 things to do when things are difficult" list. Session five was delivered twice.

Session Six – Dissociation

Session six included psychoeducational content presented on the topic of dissociation. Efforts were made to normalize this phenomenon. A group discussion was facilitated about strategies that can help with dissociation such as grounding and how to go about practicing these skills. The concept of the window of tolerance was described. Participants were encouraged to pay attention to how they are feeling and are invited to use skills as

needed during the session. Participants are provided with a pen that can be used for grounding. Session six was delivered twice.

Session Seven – Distress Tolerance

Session seven focused on psychoeducation about emotion regulation and distress. Participants engaged in distress tolerance exercises to build skills for managing intense emotional experiences. Session seven was delivered once.

During delivering the group, the lead facilitator primarily led the delivery of psychoeducational content, group discussions and skills practice, and the second facilitator monitored and supported group dynamics (such as checking on people who left; ensuring turn-taking; monitoring affect through observing) and co-delivered elements of the content, such as guided exercises. Although participants were not explicitly required nor asked to self-disclose, group discussions and sharing of thoughts about the content were encouraged to promote group cohesion and peer support. As per previous research on female-only trauma-focused therapy groups, it was theorized that the shared demographic of the group would work to facilitate cohesion and peer learning, rather than it being an explicit topic or focus of the sessions over trauma-focused content (Philipps et al., 2022).

Evaluation Approach

Design

To evaluate the implementation of the group, in line with existing evaluation methods in the service and prior research studies, quantitative responses and qualitative data to initially ascertain attendees' experiences of attending the group based on attendance, retention rates and self-reported experiences. For the quantitative design, as the evaluation was preliminarily interested in whether the group was of interest to participants, a descriptive approach was taken to examine rates of uptake, attendance, retention and satisfaction, based upon similar preliminary evaluations of inpatient groups (Davies & Pipkin, 2024; Heriot-Maitland et al., 2014).

The qualitative design incorporated written responses to open-ended questions about the experience of the group, again similar to previous studies, on the recognition that interview-based designs may be less practical due to high levels of distress during admissions (Raphael et al., 2021). Qualitative data were gathered to enable an overview of the key experiences that participants reported about attending the group and to ascertain its acceptability to them. The overall design therefore involved self-reported, written data collection at one time-point from attendees at the end of each group session.

Participants

Participants were females over the age of 18 admitted to a 17-bed acute inpatient ward for a mental health crisis in the UK. The ward had an existing, newly established psychological therapy group program, of which the present group formed an addition following the identification of numerous patients reporting difficulties with post-traumatic symptomology during their admission. Patients were selected from the ward if they themselves and/or ward staff deemed they would benefit from a trauma-focused

therapeutic intervention (i.e. expressed having difficulties with trauma response symptoms; had self-reported struggling with trauma-related difficulties at present). Participants were excluded if they were assessed on the day to be a significant risk to others, or if they were a significant disruption to the group during the session (such as talking over others and/or displays of aggression), in which case they were asked to leave the group and offered an individual session instead. All participants were aware it would be a female-only group as per the advertising through posters and discussions, and in line with the ward being a female-only ward.

Twenty-four patients in total attended at least one session. The age range was 22–64 (mean = 46), all but three patients were White British, with two being Black African and one being Pakistani. Nine had a primary diagnosis of a psychotic disorder; five had a diagnosis of borderline personality disorder; five had diagnoses of depression and/or anxiety; one had a diagnosis of alcohol dependence; one of dementia; one of complex post-traumatic stress disorder; and two had a diagnosis of bipolar disorder. Thirty-seven individual completed measures were received, including the quantitative and qualitative measures outlined below.

Materials

The Group Session Rating Scale (GSRS) was the primary quantitative measure (Duncan & Miller, 2007). The GSRS is a 4-item, self-report measure using linear visual analogue Likert scales rated from 0 to 10 about participants' experience of the session. It asks participants to rate four aspects of the group they attended on a 10-cm line on the following domains: relationship with facilitators and group members; the suitability of the goals of the session; the acceptability of the approach used within the group; and a sense of overall fit with the group. Each domain was measured using a ruler and given a score of 0–10, with higher scores denoting more positive experiences within each domain. GSRS has been found to have good levels of reliability and validity and has been found to be predictive of early therapeutic change in short group interventions (Quirk et al., 2013).

Three open-ended, written qualitative questions were also provided, asking participants what they thought had worked well about the group, if anything; what could be improved about the session; and if they had any requests for topics to be discussed in future groups to help its ongoing development. These questions were developed by the research team for use in evaluating the existing group therapy program. They aimed to be open questions to enable capturing attendee feedback about the sessions to understand what they viewed worked well, what needed improvement and suggestions for further development, ensuring practice-based evidence collation and future service development, such as informing adjustments to group content, process and/or focus. They were also based on prior published research studies to ensure consistency (Davies & Pipkin, 2024).

Feedback forms were printed and taken to each session, which contained the GSRS on one side and the qualitative feedback questions on the reverse side. An excel spreadsheet was maintained with tallies of each session's attendance, demographic information which was pulled from the clinical record to provide context of the participants (age, diagnosis, ethnicity), repeat attendance, noting anyone leaving a session up to 15 min in, and reasons for any canceled sessions. All participants received printed handouts with psychoeducation and coping skills from each session.

Procedure

Following ethical approval from the hosting Trust's Psychology Research Ethics Committee, the group was advertised via the ward timetable, posters on the ward, and via ward staff. On the day of the group, in discussion with the nurse in charge, eligible patients were invited to attend the group. Participants were invited to attend via two routes. Firstly, participants had either expressed an interest in attending to the nursing team throughout the week in response to the advert, discussion with the nursing team or having attended previously, and were noted on a list and were then invited to attend on the day. Secondly, participants meeting the inclusion criteria following discussion with the nurse in charge (i.e. had concerns with trauma symptomology and an absence of active risk toward others) were approached on the day by the facilitators and asked if they would like to attend. At the end of each group session, participants who provided written informed consent were handed the feedback form containing the GSRS and qualitative questions to complete and return anonymously in a box. Demographic information was collected for those who had provided consent from their clinical record. Data were then analyzed.

Analysis

An exploratory analysis approach was undertaken, incorporating quantitative and qualitative data. For the quantitative data, descriptive statistics were used, presenting attendance as a tally and percentage of the total bed stay; repeat attendance; in-session retention (by dividing the number of times a participant left a session up to 15 min in by the number of total attendances); and the mean GSRS scores. This was based upon previous published group evaluations in inpatient wards (Davies & Pipkin, 2024; Heriot-Maitland et al., 2014) to enable an overview of participant uptake and retention, as an assessment of its feasibility for the patient group.

For the qualitative written feedback, content analysis was used (Krippendorff, 1980) for its systematic approach to organizing meanings expressed in qualitative data. Based upon Krippendorff's (1980) protocol and previous group evaluations using this method (e.g. Davies & Pipkin, 2024), the analysis followed three key stages. Firstly, the first two authors separately assigned codes to each statement made in each written comment that best summarized its semantic meaning (e.g. "I wanted to say thank you, truly!" was assigned the code "expressed gratitude"). Secondly, once each author had separately allocated codes to every statement within the data, codes allocated across the two authors were then compared using Cohen's Kappa coefficient (McHugh, 2012) to establish inter-coder reliability. The analysis found a Kappa value of 0.85, indicating excellent agreement. Differences were discussed until consensus was reached. Any disagreements were managed via discussion, with close attention paid to the language used and meaning expressed in the original data when deciding upon code names. In the third and final stage, the agreed upon codes were then grouped into themes of similar or shared meaning, and further sub-categorized into "positive" and "negative" comments. For example, all codes related to "thank you" or "expressed gratitude" were grouped together into the category "gratitude," and were labeled as "positive" comments.

It is recognized that author perspectives will have influenced the analytical process, in line with qualitative research. A "critical realist" epistemological perspective was held by

the researchers, assuming that a reality exists "out there" that can be examined but that individual perspectives may influence its interpretation (Willig & Stainton Rogers, 2017). The first two authors were involved in the primary qualitative analysis. The first author is a white British male who was the lead clinical psychologist for the inpatient psychology service. He holds clinical and research interests in stigma, gender in mental health care, and improving user experiences of services through relational and participatory approaches. He was not directly involved in the delivery of the group, enabling some distance from the data. The second author is a female, mixed race Latin American who was the senior assistant psychologist in the inpatient psychology service who was also a co-facilitator of the group. She holds clinical and research interests in the application of psychological strategies in inpatient mental health settings, and the inclusion of diversity and gender in clinical practice. Attempts were therefore made to manage author bias by both coders initially operating separately and then comparing their codes. Peer supervision between the two first authors was used with reflective diary keeping during the analytic process to attempt to identify and bracket any assumptions or biases. All four authors reviewed the final analysis before approving, enabling an element of team-based coding and supervision.

Findings

Attendance and Retention

Sixteen sessions in total were facilitated. Twenty-four patients in total attended at least one session each, with 12 patients attending at least two sessions. The range of the number of patients per group was 2–5, with the mean number of patients per group being 3. The percentage of the total patients on the ward ($n = 17$) who attended the group sessions therefore ranged from 11% to 29%. The range number of sessions each individual patient attended was 1–6, with the mean being 2. Five patients left a session early once each; with there being 48 instances of individual attendance for an entire session and five instances of leaving early, the total in-session retention was 89.6%. The five patients who each left a session early were all noted to be voluntary.

Group Session Rating Scale

The mean response rates to the GSRS were as follows: relationship with group ($n = 37$) mean = 8.51 (std dev. =2.32); topic ($n = 36$) mean = 7.86 (std dev. =2.84); skills ($n = 37$) mean = 8.21 (std dev. =2.64); overall ($n = 36$) mean = 8.54 (std dev. =2.24). As higher scores on the GSRS denote more positive experiences, with 10 being the highest, participants' mean responses rated all aspects of the group as 7.86 or above, suggestive of positive self-reported experiences within each domain.

Qualitative Feedback

Of the 37 feedback forms received, 32 contained written feedback. There were 92 individual statements across the feedback forms which were assigned codes which were refined to 59 codes. Five themes were identified in the data: Experience of the group process; Group

content; Facilitators; Benefits from attending the group; and Gratitude. Quotes are presented verbatim.

Theme 1: Experience of the Group Process

Nineteen comments referred positively to the experience of the process of the group and five contained suggested improvements. Seven comments noted how the group atmosphere made them feel: that they could "open up and feeling comfortable to do so," "not feeling judged," "feeling understood," "balanced," "safe," "quiet" and "calm." One participant stated they left "feeling more positive." Six commented that the group discussions were beneficial as "everyone participated," that they enabled "time to talk; say/express," "moments to prompt," and "being able to share ideas" and "suggestions" with others. One participant expressed appreciation for the "consistency" of the group being on the same time and day.

For improvement, two comments referred specifically to the patient mix in the group, with one commenting that "taking the tricky patient out of the group" had been helpful for the group atmosphere. Another suggested: "keep the group more closed only invite patients who can at least partly engage so as not to put off other patients who could benefit from coming," suggesting some challenges with some finding it difficult to engage. One participant suggested that the facilitators should "also have a cup of tea" during the group, suggesting a caring attitude toward them. One participant did not find the length of time the group ran for nor the atmosphere therapeutic: "the breathing exercise and safe space exercise wasn't long enough to relax – didn't find the atmosphere right to get the benefit." This suggests an importance placed on the overall atmosphere of the group, with facilitators needing to pay close attention to attendees' experiences of the room as it unfolds.

Overall, this theme highlights that participants found the interactive nature of the group helpful for being able to connect with others and to learn from the facilitators and others. Conversely, they felt that having a longer duration and more proactive addressing of interpersonal dynamics in the group such as having a closed group would be beneficial. This was suggestive of the general setup and process of the group being acceptable and helpful, with participants desiring longer sessions and further attention paid to interpersonal dynamics, which can notably be tricky given high levels of distress, agitation and the unpredictability of inpatient environments. Participants' comments reflected general group therapy components, such as safety, atmosphere, cohesion and dynamics, as opposed to trauma-focused group therapy-specific aspects.

Theme 2: Group Content

Three written comments referred positively to the group content, while six contained recommendations for improvement. Participants described the content as "helpful" and "productive." An explanation of the three systems model was highlighted as helpful by one participant in particular: "The explanation around drive, threat and soothe was very well explained and made a lot of sense." They further commented that "self soothe boxes are very beneficial and are a good tool/strategies to have," suggesting that the practical focus was particularly useful for them. To improve, three participants stated they would like more practical exercises in sessions, including "writing my story," "drawing" and "having examples of actual tools eg fidget spinners, stress ball, etc." One participant felt that more time to engage in guided exercises such as breathing would be helpful. Two participants felt that

more clarity about the topic of the group prior to the session on the ward timetable, and more information about the topics to come at the start of the group would be helpful. One participant suggested avoiding talking "about NEWS or confusing subjects in groups," with NEWS being a routine physical health check conducted by the nursing team. One participant expressed concerns with the wider ward atmosphere in their interactions with the nursing team and suggested that a topic for the group could be included on "learning how to get staff to listen and take feedback constructively and resolve problems rather than being defensive." This suggests concerns and challenges with the relationship with wider ward team dynamics and seeking support for how best to navigate and manage it.

This theme highlights that participants seemed to find the skills taught, particularly soothing and emotion regulation skills, beneficial. It also highlights participants bringing concerns with wider ward dynamics to the group and dislike when group discussions drifted into broader ward-related issues. Participants appeared to find the trauma-focused content helpful, particularly cognitive behavioral therapy-based strategies and tools, and psychoeducation from compassion-focused therapy for understanding the impact of trauma, suggesting acceptability.

Theme 3: Facilitators

Five written comments commented positively on the facilitators, while one had suggestions for improvements. Participant comments reflected that the facilitators "seemed prepared," had "good leadership," and that the content was "well explained and made a lot of sense." One participant commented that having two facilitators helped "group discussion with more ideas and viewpoints." Conversely, one participant seemed confused with the presence of a co-facilitator as they did not speak within the group much, in making sense of this they commented: "It was not clear if all staff knew what was on the handout as they didn't have a copy, so may have been a reason they did not contribute to the discussion." The same participant further felt that facilitation could be improved by having "more flexibility around patient comments/questions to enable clarity and discussion to avoid patients being left feeling like they are lying." This suggests that participants had various interpretations of how the content was delivered, such as how (in)active the facilitators were, and of the interpersonal dynamics within the session. Participants talked of the content and its delivery being relevant and helpful in understanding their symptoms, though it was clear that they paid attention to what the facilitators were doing which may have influenced their sense of group cohesion and safety. While it is possible that the latter may be a feature of their trauma symptomology, such as hyper-vigilance in relationship with the facilitators, their comments largely reflected general group therapeutic processes.

Theme 4: Benefits from Attending the Group

Eleven comments spoke to benefits from being in the group. There were no negative comments identified for this theme. Four found benefits in being "relaxed," "present," "calm and "positive" following the group. Three particularly commented on relaxation and imagery exercises, using words such as "grounding" and "being present." Two found benefits from the group discussions, including feeling reassured and validated in their recovery efforts: "I liked hearing that the things I have already done and continue to do are right for me." One referenced gaining an increased awareness of a need to "do more time trying to soothe rather than drive myself," and one spoke to a desire to attend the group

again both inside and outside of the hospital after their first attendance. This suggests the group instilled a sense of relaxation and calm on the ward, alongside some awareness and skills to ground oneself, be present and focus on self-soothing. Trauma-focused content appeared acceptable and useful to participants, notably grounding, imagery and relaxation skills from cognitive behavioral therapy, and consideration of the three systems model seemed appropriate for encouraging self-reflection whilst managing trauma symptomology.

Theme 5: Gratitude

Nine comments expressed gratitude for the group and the facilitators. Comments included "I wanted to say thank you, truly!"; "very very productive and helpful!"; that it was "very good and "a nice group"; three expressed that it was "enjoyable"; and one that "I felt relaxed for a while so thank you, both of you." These comments suggested appreciation for the group being held. The comments were not specific to gratitude for the content necessarily, suggesting that the group space and facilitators' approaches in and of themselves were appreciated by participants. Expressing gratitude and appreciation is also a tenet of compassion-focused therapy, so it may be that the atmosphere of the group had invited some participants to express their appreciation to the facilitators.

Discussion

The implementation and evaluation presented reflect prior research studies on brief, adapted psychological therapy group interventions on acute inpatient wards: the intervention seemed to provide a space to connect with both staff and others (Davies & Pipkin, 2024), afforded some psychological insights and coping skills (Heriot-Maitland et al., 2014), and seemed acceptable due to its duration, content and relative consistency (Stroud & Griffiths, 2021). The GSRS data suggested positive experiences of group relationships, group content and the skills taught, indicating that trauma-focused groups may be appropriate and helpful for a sub-section of female inpatients. Combined with the qualitative data, it seems that aspects of the content were relevant and beneficial, and the setup, delivery and conduct of the group in and of itself was helpful, reiterating that group therapies in inpatient settings are valued by participants and therefore an important endeavor. Taken together, group therapies seem to be important and valued spaces for inpatients, and trauma-focused content and skills appears to be acceptable and useful. The authors would reflect that trauma-focused content is likely suitable to add to the existing milieu of inpatient group programs.

In delivering the intervention, as qualitative research about the barriers to implementing psychological interventions on wards reflects (Evlat et al., 2021), the facilitators faced tensions in ensuring accessibility without sacrificing a safe group dynamic. As some of the feedback reflected, the group being conducted on the ward itself improved accessibility though brought challenges such as noise, attendees leaving and returning, and at times attendees becoming disruptive, which was taken as reflecting their mental state. These represent daily experiences on the ward, so the facilitators reflect that avoiding such disruptions completely is probably unrealistic, and perhaps reflect part of the group process to be managed in inpatient settings.

The attendees' qualitative feedback and facilitators' experiences of delivering the group suggest that the group was beneficial in providing a supportive, regular space to think about

the impact of trauma, though it did require additional thought and effort given to establishing group boundaries prior to and during the group. Events such as noise from the ward, discussions about dynamics with ward staff and disruptions all provided material to reflect upon with the group, such as how it might have triggered hypervigilance or anxiety, and how coping skills could be employed. However, the tension between making sure groups are accessible but effective in inpatient settings remains a constant balancing act (Raphael et al., 2021). Trauma-focused interventions perhaps call for closer attention given the risk of re-traumatization through disclosure and disruption in the process of the group (Willis et al., 2023). The authors would reflect that contracting with potential attendees prior to attending to establish boundaries and having two facilitators was helpful to this end. The facilitators found it helpful for themselves to recognize that disruptions in various forms may be part of the process of delivering inpatient groups, to expect and anticipate it with active management rather than see it as avoidable altogether. This enabled more proactive discussions about boundaries, about the impact of disruptions and live application of grounding skills key to the delivery of the group.

The attendees were self-selecting and identified by staff based on a known or suggested relevance of trauma-related concerns and notably represented only 11–29% of the total ward population of 17, so whether this suitability of the topic and content extends beyond up to 29% of the present ward's population is not known. Repetition is therefore advised to examine broader populations and assess uptake. Prior research on the prevalence of trauma suggests that as many as 65% of inpatients may exhibit PTSD symptoms (McFarlane et al., 2001; Nowlin et al., 2019), which is notably higher than the proportion of the ward who attended the group. This may have been for a few reasons. It could be that the advertising around the group as a trauma-focused may have impacted those who did not self-select, such as not relating to PTSD symptoms due to lack of awareness or knowledge, having a different primary diagnosis, or by not feeling in the right place to come forwards for such support.

Given that people with mental health difficulties who have a history of abuse are more likely to be admitted to inpatient wards than those without, it is possible that trauma-focused ideas are more relevant to a wider pool of the population beyond a narrower focus on PTSD symptomology (Werbeloff et al., 2021). Therefore, future groups might consider being slightly more open in their inclusion and recruitment criteria and subsequent advertising, such as recruiting to specific sessions focusing on stabilization, grounding skills and managing specific issues like nightmares or relationships, which may be more applicable to a wider pool of people than a blanket trauma-focused group. It could also be that staff did not actively identify and suggest certain people who may otherwise have benefitted, such as for reasons of risk, clinical complexity or not knowing about a trauma history. This may require further work on Trauma Informed Care, such as time taken to discuss with staff who may benefit and why, and further training on trauma, which is known to improve a range of elements of inpatient care (Saunders et al., 2023). Future groups could consider broader ways to advertise and recruit to the group, such as by using more outreach-based approaches on the ward with brief discussions with the facilitators to see whether those who do not initially come forwards may find some benefit. This may also help to increase the diversity of those who ultimately attend.

Regarding the attendees, the facilitators observed two broadly distinct groups of attendees: those who had a higher acute symptom burden and those who had a lower acute

symptom burden, which was perceived to, at times, impact their capacity to be present and engaged in the group. The higher acute symptom burden group tended to be experiencing psychosis, acute bipolar disorder or severe depression, were deemed "acutely unwell" by the ward team and tended to have longer admission times over weeks or months. In research, such presenting difficulties have been deemed "too unwell to engage" meaningfully in psychological therapy in psychiatric inpatient settings due to perceived functional impairment and the cognitive impacts from medication and acute distress (Kerfoot et al., 2012). Observationally, this group tended to struggle more with self-monitoring what a relevant contribution to group discussions might be, tended to move around such as leaving and returning and tended to be more openly distressed or agitated within the group, at times causing disruption to discussions or the process. They seemed to get quite live benefits from the various grounding exercises, such as soothing strategies, mindfulness and imagery, and seemed to benefit from repetition of content and exercises across group sessions, which often enabled them to make more relevant contributions to group discussions.

The lower acute symptom burden group comparatively had shorter admission times, often 2 weeks maximum, often being in crisis initially though stabilizing fairly quickly. This group presented with an observed higher capacity to be present and reflective than the other group and tended to engage well with group discussions, longer exercises and more theoretical considerations. At times, this group seemed to become frustrated and/or bored with repetition across sessions. Each group broadly benefited from slightly different exercises and had slightly different needs from a group process, with one benefitting from structure, briefer exercises and repetition and the other benefitting from depth and a faster pace. Each also had different needs regarding frequency. In future, the facilitators would consider running multiple sessions across the week to allow those with shorter admissions more scope to access more content. This would also enable more repetition for those who are struggling more cognitively, perhaps enabling more learning. The overall structure of the group through its structured agenda but inclusion of group discussions seemed to cater to both groups' needs, as the higher acute symptom burden group did seem to gain benefit from discussions and connecting with peers.

As this is the first trauma-focused group intervention evaluated on an inpatient ward to the authors' knowledge, it adds to the previous body of practice-focused evaluations that trauma-focused psychoeducation and skill-building appears useful, validating and constructive for some female inpatients. The integration of both cognitive behavioral and compassion-focused ideas seemed to be valued by participants in the qualitative data. This builds on prior research highlighting the utility of compassion-focused psychoeducation on wards (e.g. Stroud & Griffiths, 2021), and adds that utilizing trauma-focused cognitive behavioral psychoeducation and skills may be of benefit to some female inpatients. The three systems model from compassion-focused therapy in particular was mentioned as valued by some participants, as were specific stabilization-based skills from cognitive behavioral therapy. Further groups can continue to utilize these principles and, importantly, future research should examine clinical outcomes.

Although the group was gender-specific to females, the group content and process did not explicitly attend to gender. None of the qualitative feedback pertained to issues of gender, although the setup, delivery and content were mostly positively received, so whether the group being single gender made any difference is not known. Community-based trauma-focused groups show more positive ratings for female-only groups compared to

mixed gender groups although no difference on clinical outcomes, so it may be worth surveying female inpatients about any preference in this regard before trialing a mixed gender group (Philipps et al., 2022). This might introduce further complexities for the risk of re-traumatization for those who have experienced gender-based violence that needs to be carefully considered. Future groups could also explicitly ask about whether the gender-specific nature of the group was of relevance to their experience and/or attendance to tease out whether gender has any relevance here or not. Future groups may also want to try making the gender-specific nature of the group explicit, as the present implementation did not, to see whether participants have any thoughts or identify any processes relevant to it.

Four of the present participants requested the sessions to be longer than 30 min, so while shorter groups are recommended on inpatient wards (Raphael et al., 2021), this may be a consideration for future practice where feasible. It may be that the smaller cohort of patients who attended, mostly who self-selected due to perceiving a possible benefit from a trauma-focused intervention, may benefit from slightly longer session durations. Just under half of the prior published evaluations of ward-based therapy groups have been conducted on psychiatric intensive care units (e.g. Davies & Pipkin, 2024; Walsh-Harrington et al., 2020), where clinical acuity and distress are notably high and therefore more adaptations such as shorter sessions may be more helpful. It may be that longer groups could be suitable on acute wards, particularly with specific content such as trauma-focused groups, which is worth trialing.

Participants requested more practical exercises, such as the use of writing, drawing and sensory regulation tools in-session. Groups run jointly with occupational therapy may support this aim further in future groups. Participants also frequently commented on the broader ward environment and staff dynamics, which relates to psychologically informed ward environments, whereby support for both staff and patients to engage in therapeutic conversations, reduce use of restrictive practices and increase a sense of safety can be efficacious at improving experiences of care and outcomes (Araci & Clarke, 2017). Psychologically-framing and having conversations about the impact of trauma may go some way to promote Trauma-Informed Care for both staff and patients, which is particularly important given that inpatient admissions themselves can induce PTSD symptoms in some (Martinaki et al., 2021). Engaging wider ward staff and patients in joint psychoeducational conversations about trauma warrants further evaluation to ascertain any impact on individual and ward-based outcomes.

The present findings also reflect broader research on group processes. Participants frequently commented positively on the facilitators' active, calm leadership style and appreciation for group discussions. This relates to prior research on group processes, whereby group cohesion, instilled positive experiences and emotions by group process, and facilitators' attunement and responsiveness to the groups' needs are facilitative factors of positive outcomes of group interventions (Marmarosh et al., 2022). Regarding challenges to group dynamics, inpatient environments are notably unpredictable, ranging from noise, unexpected disruptions due to routine care delivery and/or emergency situations, and due to high levels of clinical acuity (Evlat et al., 2021). The facilitators attended to dynamics within the group, though would reflect that a small proportion of participants talking over one another was at times disruptive of the group process, which was commented on in the qualitative feedback as the "tricky patient" and wanting only people who "could at least partly engage" within the group. The five participants who left a group session early may

also constitute a form of disruption to the process, though less is known about this given that they did not provide feedback. This represents a constant tension within inpatient settings, on the one hand, striving to ensure accessibility and inclusion in groups regardless of clinical acuity and various types of risk, and on the other hand, working to protect group cohesion and flow from disruption (Raphael et al., 2021). For the present group, care was taken to try to limit disruptions given the sensitivity of the topic at hand, and a concern that too much disruption within the group may be somewhat re-traumatizing, such as loud noises, shouting, aggression and perceived or enacted power imbalances or exclusion from staff potentially being triggering (Saunders et al., 2023). It was ultimately not possible to mitigate this entirely and indeed was reflective of what happens on the ward on a daily basis, as was commented on by participants.

For future groups, although it would require more time from facilitators, it may be that conversations with people on the ward to promote the group, discuss the group rules and focus, and to begin attempts to manage group processes before the group has even begun might go some way to mitigate this, as would happen in a closed community group. It could also be that the growing milieu of inpatient therapy groups means that there are more general, skills-based groups, which may be more open and accessible, such as general open cognitive behavioral or compassion-focused groups (e.g. Davies & Pipkin, 2024; Stroud & Griffiths, 2021), and then more focused, closed-style sessions for people with more specific challenges, such as trauma-focused groups, allowing more depth and process into specific topics relevant for fewer people. Such ideas may be best co-produced and taken forwards with people with experience of inpatient admissions. Although clinical and process-based outcomes were not evaluated in the present evaluation, future formal studies could pay closer attention to how these processes are best managed in inpatient settings, where high levels of distress and disruptive ward environments may interfere. Additionally, prior research on groups finds that outcomes from PTSD groups are larger for women and vary by trauma type (Rosendahl et al., 2021), so further work is needed on who may benefit from this type of intervention on wards, and how.

Limitations

The evaluation is limited by its lack of use of a pre-post design to assess any quantitative changes, and not employing formal psychometric outcome measures to ascertain any clinical benefits. The inclusion criteria was fairly stringent in requiring either self- or staff-identified concerns with trauma, which may have inadvertently excluded some who may have benefited. The relatively low uptake rate is a further limitation and may be a result of this criteria. Only three participants of the 24 included were from a non-White British ethnic background which is a further limitation of the evaluation. Although it was not assessed, future formal studies should continue to examine uptake from non-White participants, and consider efforts to increase uptake to ensure that interventions are appropriate for diverse populations. Future groups could offer the group more widely to inpatients rather than relying on self- or staff-reported trauma symptoms, as it may be systemic biases that limited both general and non-White participant uptake.

Power dynamics regarding seeking qualitative feedback from inpatients may have influenced the findings, as may have the research teams' own perspectives in identifying themes within the data. It is also acknowledged that, although attempts were made to manage

researcher bias, researcher perspectives will have influenced the analysis and interpretation of the qualitative data, so future studies may employ further efforts, such as including people with lived experience. The qualitative findings and small sample size mean that findings are not generalizable beyond the present sample, so replication elsewhere is recommended.

Conclusion

The present article evaluated the implementation of a trauma-focused psychological therapy group for women admitted to an acute inpatient ward. While attendance of the total bed stay was low, repeat attendance and in-session retention suggested feasibility. Qualitative feedback suggests that the group was acceptable to participants by providing a safe space to be heard, learn and share ideas, and to gain coping skills. Suggestions for improvements build on prior qualitative studies evaluating similar groups on wards, with considerations for longer sessions, more practical activities and exercises, and close attention to group dynamics to facilitate a therapeutic space. Further research to establish any clinical benefit of such groups is recommended.

Author Contributions

All authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by Dr Alastair Pipkin, Luz Rodriguez and Dr Lenita Wambeek. The first draft of the manuscript was written by Dr Alastair Pipkin and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Disclosure Statement

No potential conflict of interest was reported by the author(s).

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Data Availability Statement

Data are not available to protect the confidentiality of the participants.

Ethical Statement

Approval was obtained from the ethics committee of the hosting NHS Trust, who deemed it to be an evaluation of routine clinical practice. The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008.

References

American Psychiatric Association. (2013). Posttraumatic stress disorder. In *Diagnostic and statistical manual of mental disorders* (5th ed., pp. 271–280). American Psychiatric Publishing. https://doi.org/10.1176/appi.books.9780890425596

Araci, D., & Clarke, I. (2017). Investigating the efficacy of a whole team, psychologically informed, acute mental health service approach. *Journal of Mental Health*, *26*(4), 307–311. https://doi.org/10.3109/09638237.2016.1139065

Boynton, V., & Sanderson, C. (2022). Open group cognitive behaviour therapy on acute in-patient units. *Behavioural and Cognitive Psychotherapy*, *50*(1), 106–110. https://doi.org/10.1017/S1352465821000011

Bryant, R. A. (2019). Post-traumatic stress disorder: A state-of-the-art review of evidence and challenges. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, *18*(3), 259–269. https://doi.org/10.1002/wps.20656

Cabrera, N., Moffitt, G., Jairam, R., & Barton, G. (2020). An intensive form of trauma focused cognitive behaviour therapy in an acute adolescent inpatient unit: An uncontrolled open trial. *Clinical Child Psychology and Psychiatry*, *25*(4), 790–800. https://doi.org/10.1177/1359104520918641

Craig, C., Hiskey, S., & Spector, A. (2020). Compassion focused therapy: A systematic review of its effectiveness and acceptability in clinical populations. *Expert Review of Neurotherapeutics*, *20*(4), 385–400. https://doi.org/10.1080/14737175.2020.1746184

Davies, M., & Pipkin, A. (2024). The acceptability and feasibility of a cognitive behavioural therapy managing emotions group on a male psychiatric intensive care unit: A mixed methods evaluation. *Journal of Psychiatric Intensive Care*, *20*(1), 29–34. https://doi.org/10.20299/jpi.2023.008

Duncan, B. L., & Miller, S. D. (2007). *The group session rating scale*. Author.

Ehlers, A., & Clark, D. M. (2008). Post-traumatic stress disorder: The development of effective psychological treatments. *Nordic Journal of Psychiatry*, *62*(sup47), 11–18. https://doi.org/10.1080/08039480802315608

Evlat, G., Wood, L., & Glover, N. (2021). A systematic review of the implementation of psychological therapies in acute mental health inpatient settings. *Clinical Psychology and Psychotherapy*, *28*(6), 1574–1586. https://doi.org/10.1002/cpp.2600

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment*, *15*(3), 199–208. https://doi.org/10.1192/apt.bp.107.005264

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *The British Journal of Clinical Psychology*, *53*(1), 6–41. https://doi.org/10.1111/bjc.12043

Heriot-Maitland, C., Vidal, J. B., Ball, S., & Irons, C. (2014). A compassionate-focused therapy group approach for acute inpatients: Feasibility, initial pilot outcome data, and recommendations. *The British Journal of Clinical Psychology*, *53*(1), 78–94. https://doi.org/10.1111/bjc.12040

Hudays, A., Gallagher, R., Hazazi, A., Arishi, A., & Bahari, G. (2022). Eye movement desensitization and reprocessing versus cognitive behavior therapy for treating post-traumatic stress disorder: A systematic review and meta-analysis. *International Journal of Environmental Research and Public Health*, *19*(24), 16836. https://doi.org/10.3390/ijerph192416836

Kerfoot, G., Bamford, Z., & Jones, S. A. (2012). Evaluation of psychological provision into an acute inpatient unit. *Mental Health Review Journal*, *17*(1), 26–38. https://doi.org/10.1108/13619321211231798

Krippendorff, K. (1980). *Content analysis: An introduction to its methodology*. Sage.

Marmarosh, C. L., Sandage, S., Wade, N., Captari, L. E., & Crabtree, S. (2022). New horizons in group psychotherapy research and practice from third wave positive psychology: A practice-friendly review. *Research in Psychotherapy (Milano)*, *25*(3), 643. https://doi.org/10.4081/ripppo.2022.643

Martinaki, S., Kostaras, P., Mihajlovic, N., Papaioannou, A., Asimopoulos, C., Masdrakis, V., & Angelopoulos, E. (2021). Psychiatric admission as a risk factor for posttraumatic stress disorder. *Psychiatry Research*, *305*, 114176. https://doi.org/10.1016/j.psychres.2021.114176

McFarlane, A. C., Bookless, C., & Air, T. (2001). Posttraumatic stress disorder in a general psychiatric inpatient population. *Journal of Traumatic Stress*, *14*(4), 633–645. https://doi.org/10.1023/A:1013077702520

McHugh, M. L. (2012). Interrater reliability: The kappa statistic. *Biochemia Medica*, *22*(3), 276–282. https://doi.org/10.11613/BM.2012.031

McLean, L., Steindl, S. R., & Bambling, M. (2022). Compassion focused group therapy for adult female survivors of childhood sexual abuse: A preliminary investigation. *Mindfulness*, *13*(5), 1144–1157. https://doi.org/10.1007/s12671-022-01837-3

Méndez, M. Z., Nijdam, M. J., Ter Heide, F. J. J., van der Aa, N., & Olff, M. (2018). A five-day inpatient EMDR treatment programme for PTSD: Pilot study. *European Journal of Psychotraumatology*, *9*(1), 1425575. https://doi.org/10.1080/20008198.2018.1425575

National Institute for Health and Care Excellence. (2018). Post-traumatic stress disorder (NG116). 13 July. 2024 from https://www.nice.org.uk/guidance/ng116

NHS England. (2023). *Acute inpatient mental health care for adults and older adults*. Retrieved June 20, 2024, from https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/

NHS England. (2024). *Culture of care standards for mental health inpatient services*. Please update Retrieved format https://www.england.nhs.uk/long-read/culture-of-care-standards-for-mental-health-inpatient-services/

Öst, L. G., Enebrink, P., Finnes, A., Ghaderi, A., Havnen, A., Kvale, G., Salomonsson, S., & Wergeland, G. J. (2023). Cognitive behavior therapy for adult post-traumatic stress disorder in routine clinical care: A systematic review and meta-analysis. *Behaviour Research and Therapy*, *166*, 104323. https://doi.org/10.1016/j.brat.2023.104323

Paterson, C., Karatzias, T., Dickson, A., Harper, S., Dougall, N., & Hutton, P. (2018). Psychological therapy for inpatients receiving acute mental health care: A systematic review and meta-analysis of controlled trials. *The British Journal of Clinical Psychology*, *57*(4), 453–472. https://doi.org/10.1111/bjc.12182

Philipps, A., Hepp, T., Silbermann, A., Morawa, E., Stemmler, M., & Erim, Y. (2022). Women-only versus mixed-gender groups in multimodal, day clinic treatment of trauma-related disorders. *Zeitschrift Fur Psychosomatische Medizin Und Psychotherapie*, *68*(4), 378–396. https://doi.org/10.13109/zptm.2022.68.4.378

Phillips, R., Pinto, C., McSherry, P., & Maguire, T. (2022). EMDR therapy for posttraumatic stress disorder symptoms in adult inpatient mental health settings: A systematic review. *Journal of EMDR Practice and Research*, *16*(1), 4–24. https://doi.org/10.1891/EMDR-D-21-2021-00022

Prytherch, H., Cooke, A., & Marsh, I. (2020). Coercion or collaboration: Service-user experiences of risk management in hospital and a trauma-informed crisis house. *Psychosis*, *13*(2), 93–104. https://doi.org/10.1080/17522439.2020.1830155

Quirk, K., Miller, S., Duncan, B., & Owen, J. (2013). Group session rating scale: Preliminary psychometrics in substance abuse group interventions. *Counselling and Psychotherapy Research*, *13*(3), 194–200. https://doi.org/10.1080/14733145.2012.744425

Raphael, J., Price, O., Hartley, S., Haddock, G., Bucci, S., & Berry, K. (2021). Overcoming barriers to implementing ward-based psychosocial interventions in acute inpatient mental health settings: A meta-synthesis. *International Journal of Nursing Studies*, *115*, 103870. https://doi.org/10.1016/j.ijnurstu.2021.103870

Rosendahl, J., Alldredge, C. T., Burlingame, G. M., & Strauss, B. (2021). Recent developments in group psychotherapy research. *American Journal of Psychotherapy*, *74*(2), 52–59. https://doi.org/10.1176/appi.psychotherapy.20200031

Saunders, K., McGuinness, E., Barnett, P., Foye, U., Sears, J., Carlisle, S., Allman, F., Tzouvara, V., Schlief, M., Vera San Juan, N., Stuart, R., Griffiths, J., Appleton, R., McCrone, P., Rowan Olive, R., Nyikavaranda, P., Jeynes, T., K, T., Mitchell, L. . . . Johnson, S. (2023). A scoping review of trauma informed approaches in acute, crisis, emergency, and residential mental health care. *BMC Psychiatry*, *23*(1), 567. https://doi.org/10.1186/s12888-023-05016-z

Schwartze, D., Barkowski, S., Strauss, B., Knaevelsrud, C., & Rosendahl, J. (2017). Efficacy of group psychotherapy for posttraumatic stress disorder: Systematic review and meta-analysis of randomized controlled trials. *Psychotherapy Research*, *29*(4), 415–431. https://doi.org/10.1080/10503307.2017.1405168

Stanley, I. H., Marx, B. P., Keane, T. M., & Vujanovic, A. A. (2021). PTSD symptoms among trauma-exposed adults admitted to inpatient psychiatry for suicide-related concerns. *Journal of Psychiatric Research*, *133*, 60–66. https://doi.org/10.1016/j.jpsychires.2020.12.001

Stroud, J., & Griffiths, C. (2021). An evaluation of compassion-focused therapy within adult mental health inpatient settings. *Psychology and Psychotherapy*, *94*(3), 587–602. https://doi.org/10.1111/papt.12334

Sweeney, A., & Taggart, D. (2018). *(Mis) understanding trauma-informed approaches in mental health*. Taylor & Francis.

Walsh-Harrington, S., Corrigall, F., & Elsegood, K. (2020). Is it worthwhile to offer a daily 'bite-sized' recovery skills group to women on a psychiatric intensive care unit (PICU)? *Journal of Psychiatric Intensive Care*, *16*(1), 29–34. https://doi.org/10.20299/jpi.2019.017

Werbeloff, N., Hilge Thygesen, J., Hayes, J. F., Viding, E. M., Johnson, S., & Osborn, D. P. J. (2021). Childhood sexual abuse in patients with severe mental illness: Demographic, clinical and functional correlates. *Acta Psychiatrica Scandinavica*, *143*(6), 495–502. https://doi.org/10.1111/acps.13302

Willig, C., & Stainton Rogers, W. (2017). *The sage handbook of qualitative research in psychology*. SAGE.

Willis, N., Dowling, C., & O'Reilly, G. (2023). Stabilisation and phase-orientated psychological treatment for posttraumatic stress disorder: A systematic review and meta-analysis. *European Journal of Trauma & Dissociation*, *7*(1), 100311. https://doi.org/10.1016/j.ejtd.2022.100311

Wilson, H., Barton, L., & Maguire, T. (2011). Implementation of anger management interventions in a psychiatric intensive care unit. *Journal of Psychiatric Intensive Care*, *7*(1), 35–39. https://doi.org/10.1017/S1742646410000208