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Patient's Experiences of a Cognitive Behaviour Therapy Informed Crisis Intervention for Psychosis Delivered in Inpatient Settings: A Qualitative Exploration

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ABSTRACT

Cognitive behaviour therapy for psychosis (CBTp) should be offered to patients receiving psychiatric inpatient care, yet very little is known about patients' perspectives on this. The aim of this study was to examine patients' experiences of a CBTp-informed intervention delivered in inpatient settings. We recruited 10 participants from the intervention arm of a randomised controlled trial examining the feasibility and acceptability of a CBTp-informed intervention for psychiatric inpatient settings. We undertook semistructured interviews examining their experiences of the intervention and analysed them using thematic analysis. The study was conducted in partnership with a coproduction group of key stakeholders (people with lived experience, family and carers, and clinicians). The intervention was found helpful by almost all participants, and all participants would recommend it to others in similar situations to themselves. The results demonstrated that participants valued the therapist's professionalism and emphasised the importance of the therapeutic relationship. Participants highlighted the importance of the therapy focusing on navigating admission and developing skills to manage the crisis experience so they could return to their normal lives. Participants described challenges to having psychological therapy in the acute crisis context including therapy interruptions and ongoing distressing experiences of psychosis. The study demonstrated the importance of prioritising the therapeutic relationship, that therapy was a valued process to navigate admission and discharge, but that some environmental and patient-level challenges were present. Further research is needed to explore inpatients' experiences of psychological interventions in this setting.

Trial Registration: ISRCTN trial registry: ISRCTN59055607

1 | Background

Acute psychiatric inpatient settings care for patients experiencing distressing mental health difficulties who are often at risk of harm to themselves or others, or from others, and whose needs have not been addressed sufficiently by community mental health services (Shah, Leontieva, and Megna 2020). As bed numbers have been reduced and community alternatives established, inpatient settings generally only care for those with the most complex and high levels of needs (De Girolamo, Barbato, and Bracco 2007; Shah, Leontieva, and Megna 2020). Inpatient units should be offering multidisciplinary care

Summary

- The Cognitive behaviour therapy for psychosis (CBTp)–informed intervention for psychiatric inpatient settings was overall deemed to be acceptable to those receiving it.
- Participants valued the therapist professionalism and having a positive therapeutic relationship.
- Participants valued having therapy to increase their understanding of psychotic crises and how to manage them.
- Challenges to delivering the therapy included interruptions to therapy sessions, a chaotic ward environment and having to undertake therapy whilst dealing with distressing experiences of psychosis.

underpinned by a biopsychosocial model, as recommended by the Royal College of Psychiatrists (2010). However, it is regularly reported that care is often dominated by pharmacological treatments (Wood et al. 2019a, 2019b). NHS England (2023) published guidance on acute and inpatient care delivery and outlined the importance of care being therapeutic and trauma informed, including access to high-quality psychological interventions. However, patients continue to report restrictive and coercive treatments and a lack of access to psychological interventions despite wanting them whilst in inpatient care (Voskes et al. 2021).

Cognitive behaviour therapy for psychosis (CBTp) is an individual psychological intervention for those experiencing psychosis recommended by the National Institute of Health and Care Excellence, and it can commence in the acute phase (NICE 2014). However, NICE do not offer any guidance about how to deliver this therapy in crisis and inpatient settings. Inpatient settings provide unique challenges to delivering CBTp: The environment is restrictive, and patients have only brief admissions (average of 39 days, NHS Benchmarking 2023) and often present with acute and distressing psychosis (King's Fund 2017). Several systematic reviews have been undertaken and demonstrated there is only a small evidence base on the effectiveness of CBTp and little research to guide its delivery in inpatient settings (Jacobsen et al. 2018; Paterson et al. 2018; Wood et al. 2020). The available evidence is based on small sample sizes, is not coproduced with patients, which is important to ensure it meets their needs, and is only of moderate methodological quality. There is a clear need to coproduce an appropriately adapted CBTp intervention for inpatient settings.

Due to the lack of evidence on delivering CBTp in inpatient settings, we have developed a CBTp-informed crisis-focused intervention following guidance from the Medical Research Council (Skivington et al. 2021) for the development of complex interventions and examined it for feasibility and acceptability in a randomised controlled trial (RCT; Wood et al. 2022). The intervention is underpinned by a modularised protocol that aims to deliver approximately six to eight sessions of therapy to patients. The crisis-focused CBTp-informed intervention included several modules: engagement and assessment and identifying priorities; formulation of the crisis; stabilisation and safety; coping skill development, psychoeducation and problem-solving; crisis plans and crisis cards; change strategy work focusing on crisis appraisals and safety behaviours; and discharge and relapse (recovery) planning. The intervention was delivered by clinical and counselling psychologists working in the inpatient setting who had received training in delivering CBTp. More detail on the intervention modules can be found in Wood et al. (2022) and Wood et al. (2023). Examining patient's experiences of new interventions is crucial to ensure that it is acceptable to them and does not cause them harm (Sekhon, Cartwright, and Francis 2017). Therefore, examining the acceptability of the adapted CBT-informed crisis intervention seemed imperative.

Existing literature has examined the acceptability of CBTp interventions in community settings. A study led by lived experience researchers found that patients see CBTp as an active process of person-centred engagement and structured learning which improves personal understanding but can be hard work (Kilbride et al. 2013). Two systematic reviews of qualitative literature examining patient experiences of CBTp identified that the key ingredients of CBTp were an increased understanding of psychosis, increased coping strategies, considering alternative explanations and normalising (Berry and Hayward 2011; Wood, Burke, and Morrison 2015). However challenges have also been identified including therapy being emotionally demanding, having to take ownership and responsibility of therapy and talking about personal difficulties (Berry and Hayward 2011; Wittorf et al. 2013). However, to date, no published qualitative studies have examined patients' experiences of CBTp in inpatient settings. This is an important difference as patients are often experiencing distressing symptoms of psychosis, may be a risk of harm to themselves or others, or from others, are being cared for in a restrictive environment and are often receiving high doses of psychiatric medication. Therefore, the aim of this study was to examine patients' experiences of receiving CBT-informed crisis-focused intervention adapted to this environment.

2 | Method

This present study was a nested qualitative study part of a single-centre, individually randomised, parallel-group, feasibility RCT design, which examined participant experiences of an adapted CBTp intervention (the CRISIS study). In the trial, participants were randomly allocated to either treatment as usual (TAU) or CBTp plus TAU in a 1:1 ratio. The trial was registered on the ISRCTN trial registry (ISRCTN59055607), and more detail can be found in the trial protocol paper (Wood et al. 2022). Full Health Research Authority NHS Research Ethics Committee (REC) approval was granted (IRAS ID: 272043; 20/LO/0137/AM01), and the study is sponsored by University College London. This present study was undertaken in partnership with a coproduction group of 11 people who either had lived experience of psychosis and inpatient care. Were family members/carers, inpatient clinicians or researchers. The qualitative interviews aimed to examine the acceptability of the intervention and followed an acceptability framework for qualitative interviews (Sekhon, Cartwright, and Francis 2017).

2.1 | Participant Sampling

Purposive sampling was conducted for the primary trial to ensure that the sample was representative of the inpatient population, with at least 50% from racially minoritised backgrounds and at least 30% of the total sample from Black ethnic backgrounds. We aimed to interview at least half of the trial participants receiving the intervention; therefore, an estimated total of $n = 12–15$ participants were included, depending on the quality, depth and diversity of data collected, as this is recommended as an adequate sample size for qualitative interviews analysed by thematic analysis.

2.2 | Participant Eligibility Criteria

The inclusion criteria for participants were (i) aged 18 and above, (ii) who meet criteria for a schizophrenia-spectrum diagnoses (schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder or psychotic disorder not otherwise specified; ICD-11) or meet criteria for an early intervention service (EIS) for treatment of psychosis to allow for diagnostic uncertainty, (iii) able to give informed consent and have the capacity to consent, (iv) currently receiving care from an acute psychiatric inpatient team and (v) able to complete the research in English. The exclusion criteria were (i) non-English speakers, (ii) an acquired brain injury or substance misuse judged to be the acute cause of the psychotic experiences and (iii) those already undertaking a structured psychological intervention delivered by a psychologist or trained therapist at the time of the study. All participants in this study had received therapy in the CRISIS feasibility RCT (Wood et al. 2022).

2.3 | Materials

A semistructured interview guide was developed in partnership with the coproduction group. Firstly, the coproduction group was presented with draft interview questions, which were developed by LW and qualitative expert NM, underpinned by guidance from Sekhon, Cartwright, and Francis (2017), which is a framework used to assess the acceptability of health interventions. The coproduction group discussed these key areas and what they thought was missing, the wording of the questions, potential question prompts and anything else that might be important to include in the interview. The final interview schedule can be found in Table 1.

2.4 | Procedure

All participants in the therapy arm were invited to complete a semistructured interview one to three months after the intervention was completed. All interviews were conducted remotely. Three interviews were conducted by a lived experience researcher and seven by an assistant psychologist. The interviews lasted an average of 23:49 min (range 12:10–45:31), which is line with previous interviews conducted with this population (Wood et al. 2018).

TABLE 1 | List of semistructured interview questions.

1 *Can you tell me about your experiences of having therapy with [insert therapists name]? Prompt: What did you cover/ discuss? What was the focus of the therapy?*
2 *What was your relationship like with [insert therapists name]? OR how did you get on with [insert therapist name]?*
3 *Have you noticed any changes as a result of taking part in the therapy? What changes have you noticed? Was therapy effective for you?*
4 *What were the helpful components of the therapy? What went well? What did you take from the experience?*
5 *What were the challenging components of the therapy? What didn't go so well? What was more difficult? Was it burdensome?*
6 *What were the main things you got out of the therapy? What were the key take home messages?*
7 *(Skip to Q8 if this participant did not drop out) What led you to dropping out?*
8 *How could the therapy be improved for people in your situation?*
9 *Would you recommend this therapy to someone else in the same position?*
10 *Is there anything else you would like to add to about what we have spoken about so far? Is there anything else you think is relevant about your experiences of therapy that we haven't spoken about yet?*

2.5 | Analysis

The qualitative interviews were audio recorded, transcribed verbatim, anonymised and analysed using thematic analysis (Braun and Clarke 2006) on NVIVO (2017). The thematic analysis was conducted from a critical realist position and combined inductive and deductive approaches, seeking to explore participants' experiences of receiving CBTp and to answer questions about the acceptability of the therapy. The analysis was undertaken using Sekhon's acceptability guidance as a framework to code and identify themes. Data were analysed at semantic level (i.e., more surface level) rather than latent or interpretative (Braun and Clarke 2006).

Initially, each transcript was read and reread to ensure the researcher is fully immersed in the data and then initially coded. LW coded all interviews, and members of the coproduction also independently coded a sample of the interviews. Six members of the coproduction group each coded an interview meaning 60% of interviews were second coded in total. Codes were cross-checked and any discrepancies in coding were discussed between the coders and resolved. Overall, there was a high level of agreement across codes with only a few minor disagreements, which were resolved through discussion. Codes were then collated together across interviews and grouped together to form analytical themes. The theme structure was developed in partnership with the coproduction group and agreed with the whole research team.

2.6 | Reflexivity

The research team comprises people from diverse backgrounds in terms of age, ethnicity, gender, race, religion and profession. Our group comprised people with lived experience of psychiatric inpatient care and psychosis, family/carers of people with experience of inpatient care and psychosis, researchers, and clinicians. All members were involved in the development of the interview schedule, data collection, analysis and write up of this manuscript. All group members believed that psychological therapy and a positive therapeutic relationship were important to people experiencing psychosis in inpatient settings. Not all always felt that CBTp was the most appropriate approach but were in agreement that it should be available and tailored to the group to make it as useful as possible.

3 | Results

We approached all 26 participants who were allocated to the CBTp arm of the trial to take part in this study. One declined to participate and 15 were not contactable and/or had moved out of the area leaving a total of 10 people participating in the research. Two interviews were conducted via teams and eight via telephone.

The sample demographics can be found in Table 2. The samples were equally distributed in terms of gender, White British and other White Background people were the largest ethnic group and the most frequent diagnostic category was Schizophrenia.

3.1 | Thematic Analysis

A thematic analysis was undertaken on the interview data and resulted in three key themes and related subthemes (see Table 3). The themes were (i) therapist qualities and the therapeutic relationship, (ii) helpful aspects of crisis-focused therapy and (iii) the challenges of having psychological therapy in the acute crisis context.

3.1.1 | Therapist Qualities and the Therapeutic Relationship

This theme outlines the importance of the therapeutic relationship and the personal qualities the participants valued about the therapist. Several aspects of the relationship were identified as particularly important, which are described further below.

3.1.1.1 | Professionalism and Advocacy. Participants spoke about how the therapist's professional skills and values, such as integrity, honesty, trustworthiness and reliability, were important because they did not often find these qualities in the wider inpatient care team. This appeared to be an important part of rapport building.

> I'll start with her professionalism and how she's been erm I found she's dealt with the patient wonderfully, erm she's listened to everything ... I feel she done everything within her power, I don't feel she's failed me in any ways, always refreshing to meet a competent professional given my track history and I know that hasn't always been then case.
>
> (p44)

Moreover, participants highlighted the importance of the therapist being an advocate for them and liaising with the wider care team on their behalf and integrating a psychological perspective into their wider care plan. This was important as often

TABLE 2 | Sample demographics.

Demographic	Subcategory	M (range)
Age		38.62 (20–65)
Number of therapy sessions attended		11 (range 5–17)
		N
Gender	Male	5
	Female	5
Ethnicity	White British and other White backgrounds	6
	Black Africa and Caribbean	3
	Asian	1
Diagnosis	Schizophrenia	4
	First episode psychosis	1
	Bipolar affective disorder	1
	Schizoaffective disorder	1
	Acute and transient psychotic disorder	1
	Other	2
Admission status	Voluntary	2
	Section 2	3
	Section 3	5

TABLE 3 | Themes and subthemes.

Therapist qualities and the therapeutic relationship	Helpful aspects of crisis-focused therapy	The challenges of having therapy in the acute crisis context
Professionalism and advocacy A human relationship	Therapy priorities: Managing the crisis, hospital and returning home	Therapy interruptions, logistics and room challenges
Providing a safe space and listening	Feeling empowered through learning and understanding myself	Distress and personal difficulties getting in the way
Therapist flexibility	Developing skills to cope with a crisis Getting ready to return back to normal life Benefits of therapy Practical aspects of therapy	Talking about past trauma Having therapy in an unhelpful wider care context Not the right therapist, time or environment

participants did not feel that they were always listened to by the staff team.

> Yes she proved it, she did actually talk to people [other staff members], when you come over she could advise them.
>
> (p17)

Participants commented on the therapist's reliability and punctuality as important qualities given the chaotic ward environment. The dependability of the therapist was appreciated.

3.1.1.2 | A Human Relationship. Participants spoke about how a human relationship with the therapist was an important component. Participants valued the therapeutic bond and the therapist showing empathy and authenticity. The relationship with the therapist was commented upon by all participants demonstrating how integral it is to a positive therapy experience.

> it was good, sometimes we even make a few jokes but to be honest she kept it real, she listened, asked me questions to make sure I can in the same way explain better.
>
> (p44)

> you really have [to have] some empathy from the person carrying it out [therapist], you would have to have some sort of bonding to make it work.
>
> (p17)

3.1.1.3 | Providing a Safe Space and Listening. Participants spoke about how the therapist provided a 'comfortable and safe' (p10) space to talk about things that they would not routinely be able to talk about with inpatient staff, such as trauma experiences and difficult experiences during admission. Participants spoke about the importance of being listened to as they did not feel like this often during their inpatient care.

> I didn't feel I was having any opportunity to speak to anybody, like there was nobody on the ward that I spoke to or who ever asked me really about how I was or what had been going on for me, so [therapist] was really the first point of contact that I had had to actually discuss anything about what was going on for me ... like she did give me that space just to speak and just to explain a bit about what had been going on for me and what had led to the admission.
>
> (p29)

One participant highlighted that they wanted to talk to someone on the ward about specific issues, and the therapist was one of the few people who gave them the opportunity to do so.

> erm it [sessions with therapist] was like the point to connect mainly most of things of the past, for me to then be comfortable and actually talk about things I wanted to talk with someone since but I really didn't get the chance with many [other ward staff members].
>
> (p40)

> I just talked to her[therapist] ... about things that I wouldn't usually talk to someone about.
>
> (p52)

3.1.1.4 | Therapist Flexibility. All participants valued the flexibility therapists offered with their care including where the sessions took places, number of sessions, session agenda and being tolerant of lateness and missing of sessions. They valued therapists being patient and booking sessions at times which fitted with their daily plans and routines.

> There was a point where I was coming very very late and she will be patient but also in the same way also like help me to fix a better time to arrive and also sometimes I even start to come in early.
>
> (p40)

> She fitted me in when it was convenient for me.
>
> (p14)

Participants also spoke about the importance of the therapist being flexible with when the therapy ended. Some participants wanted more sessions than the therapist could offer and others wanted to complete sessions on the ward. This demonstrates

the importance of being patient led regarding the frequency and number of sessions.

> I think it would be better if there was like three sessions a week.
>
> (p14)

> I don't mind seeing her but I think we've covered everything we can because I'm in the community now so I don't see the need for more psychology.
>
> (p41)

Another thing participants wanted was more flexibility and informality in the relationship. Three participants spoke about wanting their therapist to have a cup of tea with them, which the therapist did not do.

> Maybe have a cup of tea. Go somewhere and have a cup of tea and talk.
>
> (p52)

> No, she wouldn't have a cup of tea.
>
> (p3)

> I'm British, so, being offered a cup of tea.
>
> (p44)

3.1.2 | Helpful Aspects of Crisis-Focused Therapy

This theme highlighted the key aspects of therapy that participants described as beneficial. These appeared to relate to supporting people with their crisis experiences, navigating admission and helping them return to their normal life back at home.

3.1.2.1 | Therapy Priorities: Managing the Crisis, the Hospital and Returning Home. Eight participants spoke about their goals for therapy which broadly related to managing the current crisis and admission with the aim of returning to their normal life. Participants spoke about how coping with their experiences of psychosis, managing the impacts of inpatient care and discharge planning facilitated this.

> Just how to get better and how to cope.
>
> (p10)

> Well, we were sort of talking about the voices and things like that, but it was mainly just trying to get out [of hospital], you know.
>
> (p14)

One participant spoke about how the therapy supported them to communicate their needs to the clinical team more helpfully. This was the participant's first inpatient admission, and the therapist supported them with understanding the jargon and processes associated with admission which allowed them to better communicate their needs.

> I said I don't know how to communicate so I might sound blunt or straight to the point or not making sense at the same time and that's how [therapist] also was trying to help me to learn how to say it properly I guess.
>
> (p40)

3.1.2.2 | Feeling Empowered Through Learning and Understanding myself. Participants explained that the sessions provided an opportunity for them to understand themselves and their experiences better, which they found empowering. Participants spoke about how the sessions provided them with knowledge and helped them develop an understanding of their difficulties that led to the crisis.

> It helped me to understand myself more, my weak points and my strong points. It helped me to understand exactly what I really went through last year, like the last year has been one of the worst years I've had [build-up of difficult events that ultimately led to admission], no like the actual worse year I ever had.
>
> (p40)

> they [sessions] mainly consisted of me asking for her professional advice in terms of psychological and emotional impacts of maintaining relationships with people who previously resulting in causing emotional and mental problems, erm also asking for I guess to sum it up simply, the science behind some things as to erm why the brain acts the way it acts, what causes it, as well as some coping mechanisms for some of the issues that I've been having.
>
> (p44)

Due to acquiring a better understanding of their experience, participants reported that they were able to undertake plans for staying well and avoiding future crises.

> The last two [sessions] were like about staying well and what I can do to kind of hopefully well certainly prevent an admission or just you know how to recognise if I was becoming unwell, sort of what to do if that happens.
>
> (p29)

3.1.2.3 | Developing Skills to Cope With a Crisis. Eight participants spoke about how they had developed coping strategies because of the therapeutic intervention. The coping strategies included distraction techniques, coping with voices, safe place imagery and reading. These helped them manage the upsetting feelings they were having during their crisis.

> She was saying erm distractions, any of them, count the pictures, erm ... phone people.. bad thought ... when it comes I have to let it go.
>
> (p3)

> I've been reading my Bible and reading the Hobbit and other books about recovery I've been reading.
>
> (p41)

3.1.2.4 | Getting Ready to Return Back to Normal Life. Lastly, participants reported that preparing for discharge and returning to normal life was an important component of the intervention as it helped them transition from the ward back home, which was quite a big change for participants.

> she [therapist] helped me to, she helped me to, to get a list for job opportunities, erm, she helped me with directions for somewhere I needed to go, she personally helped me, erm, well she helped me definitely through the therapy sessions, erm yeah, also to get back into community in terms of socialising.
>
> (p40)

One participant spoke about how it helped them progress forward from hospital, and without the research, their routine care would not have provided this opportunity.

> it was good to have her contact and I think I was very aware that if I hadn't been part of the study then I wouldn't have had that opportunity either, I probably would've just been discharged, left with a bunch of medication, and not actually helped at all, so I felt that the sessions were really valuable in like reflecting and like as a way to like progress from the hospital.
>
> (p29)

3.1.2.5 | Benefits of Therapy. Nine out of the 10 participants described a range of benefits experienced from the intervention. These included restoring their trust in services, psychoeducation regarding psychotic crises and inpatient care, coping with their experiences of psychosis and support with discharge from the ward.

> the interaction I've had [with the therapist] it has helped me sort of keep in touch with reality a little bit [and] which areas I need to work with in terms of treatment ... because it's stopped me from spiralling any worse if that's possible.
>
> (p44)

> Yeah basically it helped a lot, I would just mull over old ground, and now I can look forward to my future goals.
>
> (p41)

One participant did not find the therapy helpful as they did not feel they needed it:

> No, it was pretty boring. Yeah, we had nothing to talk about and it was just small talk.
>
> (p10)

Nevertheless, all 10 participants would recommend the therapy for others in a similar situation.

> I would [recommend the therapy] if someone needed it, but unlike me I didn't need it so didn't find it helpful.
>
> (p10)

3.1.2.6 | Practical Delivery of Therapy. The participants highlighted several practical aspects about how the therapy was delivered that they found helpful. Participants described having structure, the predictability of sessions, print outs and summaries and clear goals as important. This demonstrates the importance of crisis therapy being structured, predictable and contained, which may be due to the otherwise chaotic hospital environment.

> she obviously always had her set agenda, things she needed to accomplish from each session ... I guess just try and establish what our goals were for the 8 sessions, erm, and then like and then like session 5 I'd just like set the agenda and then we worked erm, ... and then like tools and techniques erm and then the last 3 sessions we more about like erm coping strategies, then the last 2 were like about staying well and what I can do to kind of hopefully well certainly prevent an admission or just you know how to recognise if I was becoming unwell, sort of what to do if that happens.
>
> (p29)

> There were strategies. [inaudible] Print outs erm concentrating on the topic erm that we would run through together.
>
> (p17)

3.1.3 | The Challenges of Having Therapy in Psychiatric Hospital

Participants highlighted several challenges with undertaking therapy during the inpatient stay. These included practical challenges relating to the setting and wider treatment but also personal challenges with discussing upsetting issues.

3.1.3.1 | Therapy Interruptions, Logistics and Room Challenges. One key challenge in the delivery of the intervention was finding a quiet space where there would not be interruptions. Participants explained that staff and patients would occasionally interrupt sessions and come into the room. Participants also mentioned general noisiness of the ward and staff alarms going off.

> The room was okay. We could close the door and things like that. Trouble was people coming in and checking up all the time, also the bleep things going off and some of the patients.
>
> (p17)

> There was one occasion which wasn't due to [the therapist] fault erm but the door was left unlocked and we were using one of the rooms on the ward and erm someone came in and tried to use the computer which is not what you want happening in the middle of a session but thankfully ... [therapist] helped him leave.
>
> (p44)

Participants also spoke about how the therapist had difficulty booking rooms and how the struggle with room access did impact upon them. Going back to the hospital postdischarge was also upsetting, and sessions in alternative locations or online were preferred at this stage.

> I think than the experience of having to go back to [psychiatric hospital for sessions post-discharge] and it was often difficult, like, her booking for the room was changed or we had to go to a different building and you know, just travelling there from [home] to there [psychiatric hospital] is, it's not very easy and especially in that initial discharge phase.
>
> (p29)

3.1.3.2 | Personal Difficulties Getting in the Way. Participants spoke about how their mental health difficulties, mainly their experiences of psychosis, made engaging in the therapy difficult due to paranoia about therapy or hearing voices telling them that they should not be going to therapy.

> I got annoyed because of the voices. They didn't allow me to be my true self. They paranoid me ... I was uncomfortable to be honest with you [in the therapy sessions]. They're chatting like 'Oh there's no need for you to be there'. They're bullying you. ... So, I was reluctant to continue [therapy] because it was a lot hard for me to be honest.
>
> (p31)

For one participant, the voices were contributing to her suicidality by telling her to kill herself, which was impacting on her ability to be discharged. This patient described the conflict due to not wanting to challenge the voices.

> Hmm, we had some difficulty challenging the voices. I don't think I was prepared to challenge the voices too much.
>
> (p14)

One participant spoke about how difficulties with their concentration and memory made engaging in therapy difficult.

> yeah, keeping concentrating on the erm the ideas that were put forward and I learned to write down things otherwise I forget.
>
> (p41)

3.1.3.3 | Talking About Past Trauma. Participants spoke about how talking about their personal experiences, particularly trauma, was difficult for them. Participants had mixed views about whether talking about trauma was helpful or not, which indicated the importance of the therapist treading cautiously with such topics.

> Yeah, touching on past memories, especially ones that I feel have had a deep psychological impact on me, obviously I did find that difficult at times to be included but once again that was down to the nature of it.
>
> (p40)

> The early stages, like going back to the past [was difficult]. Erm. Generally, otherwise it [therapy] was okay.
>
> (p17)

3.1.3.4 | Delivering Therapy in an Unhelpful Wider Care Context. Some participants spoke about the impact of wider treatment in the usefulness of the therapy. Some described staff not listening to the psychologist and their recommendations for their care, which was frustrating for the participants. This demonstrated that patients can be impacted, and noticed when teams are not working well together.

> it might've took a couple of attempts to try and get the answers [about inpatient care from ward staff] because she had difficulties in getting answers out of the staff and as I say, especially when she [therapist] wasn't being listened to by the previous consultant psychiatrist.
>
> (p14)

Other participants spoke about the dominance of medical approaches and lack of alternative treatments. One participant reported that she only got offered therapy due to being part of this research study. Participants highlighted that patients want and need access to holistic care whilst on the ward but are not receiving it.

> I didn't see anyone whilst I was on the ward, I saw nobody, nobody consulted me about anything. It was only because of the research that I ever saw [the therapist]. Like, other people were just happy to put a massive great prescription, take this pill, take that pill that pill, you have to take them in the morning, you have to take them at night, and that was it, nobody spoke to me. I was never, I didn't even know I could go outside.
>
> (p29)

3.1.3.5 | Not the Right Therapist, Time or Environment. The final subtheme highlights that for some people, the time, place and therapist offered were not right for them, hindering engagement in therapy. This was due to

factors such as motivation, distressing symptoms and perceived helpfulness of therapy.

> There were a few things for me to do, in terms of my situation but because of the hearing voices 24/7 and I'm reluctant to do things the things ... I'm paranoid, I'm not paranoid ... I'm just a bit scared to do things. Yeah, I'm alone, a bit alone the moment. I think I need to help myself but I'm not in the position to take that step further.
>
> (p31)

One participant spoke about the fact that she had nothing to talk about with the therapist and did not feel the therapist supported her in the way she wanted, which may indicate that it was not the right therapist or right time for the participant.

> erm yeah there was nothing to talk about and I told her about my problems but she didn't really help, she didn't really give good advice out.
>
> (p10)

4 | Discussion

This study is aimed at examining the experiences of patients receiving CBTp as part of the CRISIS study. Nine out of 10 participants reported described benefits they had experienced from the therapy, and all participants said that this therapy should be available to people in similar situations to themselves.

Participants identified the importance of the therapeutic relationship with the therapist, which was particularly valued as the participants did not feel they had this relationship with many other inpatient staff members. Participants highlighted the importance of empathy, active listening, professionalism, honesty, integrity and advocacy. The importance of the therapeutic relationship has been identified in other qualitative evaluations of CBTp (Berry and Hayward 2011; Wood, Burke, and Morrison 2015), but this study has identified that it is crucial to inpatient therapy delivery potentially due to the challenging inpatient context and levels of distress patients are experiencing. Participants valued having a dependable and reliable individual who also spoke up for their needs, which has not been identified in previous qualitative CBTp studies (e.g., Berry and Hayward 2011). We also identified the importance of therapist flexibility, which is not always part of traditional CBTp. Whilst therapists should endeavour to provide structure and containment, as identified in the findings, inpatient therapists should ensure they are flexible where possible with timings, agendas, session frequency and location and make allowances for nonattendance. This demonstrates that a flexible approach to therapy delivery, with the therapeutic relationship at the centre, are the key priority area for patients.

In terms of valued aspects of therapy, it was identified that participants prioritised using therapy to help them manage their crisis and experiences of admission and return home. This suggests that therapists may want to consider helping patients with developing an understanding of the crisis, their admission and current distress which facilitates empowerment; developing skills and confidence in assertiveness and communication; staying well/crisis planning; and discharge planning. Previous qualitative literature has identified that establishing goals, developing an understanding of their difficulties and coping were key tenets of CBTp (Berry and Hayward 2011; Kilbride et al. 2013; Wood, Burke, and Morrison 2015), but this study has been able to explore in more detail potential strategies for an inpatient and crisis contexts. Further research should consider examining these therapy components as potential mechanisms for change.

Finally, the study was able to highlight key practical and personal challenges to undertaking therapy which related to patient-level challenges and wider service-level difficulties. Specifically, participants described their cognitive and emotional difficulties and disclosing distressing experiences as factors that understandably would potentially hinder their ability to engage in therapy, but importantly, these did not prevent them from attending sessions and deriving benefit from the intervention. This demonstrates the importance of therapists being mindful of these potential patient difficulties and making appropriate adjustments for them in therapy, such as seeking more regular feedback from patients about how sessions are going, being flexible about session length, having breaks and being flexible about the focus and content of sessions. Service-level difficulties, such as lack of room space, noisiness, delivering therapy in the context of a dominant medical model and lack of supportive talking spaces from other staff members, were also described, which has been highlighted in previous research (Jacobsen 2019; Wood et al. 2019a, 2019b). This demonstrates the importance of the therapist working with service leads in trying to address environmental issues, delivering more psychologically informed care and offering indirect work such as training, consultation and supervision to try and improve the wider context.

This study attempted to interview all participants who received therapy in the CRISIS study, including participants who disengaged. We were able to include one person who did not find the therapy helpful and one person who struggled to engage and highlight their experiences, which has been minimally done in qualitative research about experience of psychological interventions (Schermuly-Haupt, Linden, and Rush 2018). Another strength was that we have gathered patient perspectives on the delivery of a CBTp-informed intervention in acute crisis settings, which has not been done previously. Moreover, the coproduction group was involved in as much of the study as possible, including designing the interview schedule, undertaking some interviews, coding interviews, developing the final theme structure and preparing this manuscript. However, only 3 of the 10 interviews were conducted by a lived experience researcher due to the challenges of engaging the participants in the interviews. The research assistants made initial contact with participants and were tasked with arranging the interviews. Some participants struggled with the logistics of arranging a three-way MS teams interview (participant, research assistant and lived experience researcher) and consequently would be interviewed by the research assistant alone.

A limitation of the study was that we were only able to interview 10 of 26 participants who were allocated to the therapy arm as part of the CRISIS study. This sample is lower than what is usually recommended for a qualitative study using thematic synthesis (usually $n = 12–15$; Braun and Clarke 2006), and we are also missing the valuable perspective of others who were offered the intervention. We excluded people who did not speak English in our study, which meant this perspective is overlooked. It is best practice to adapt research methods to maximise inclusivity in research, and we aspire to do this in the future (NIHR-INCLUDE 2020). Our interviews were also relatively short (average length of 23 min) when qualitative interviews are typically recommended to be 45–60 min meaning less data was obtained; however, our interview length is in line with previous qualitative interview studies conducted in inpatient settings which may reflect the target population (e.g., Wood et al. 2019a, 2019b). Finally, the interview schedule included set questions regarding areas of acceptability relating to the intervention, such as the therapeutic relationship, which may have led to this being a pertinent theme in the analysis. However, we were following the acceptability framework (Sekhon, Cartwright, and Francis 2017), which guided our questions.

In conclusion, the CBTp-informed crisis intervention appeared to be acceptable to participants and the majority reported deriving benefits from taking part in the therapy. The study has identified the potential key beneficial components of the CBTp intervention and key barriers and facilitators of the intervention. Further large-scale RCT research is needed to determine the efficacy of the intervention.

Author Contributions

L.W. led the development of the study, analysis and write-up of this manuscript as part of her NIHR research fellowship supervised by N.M. and S.J. H.B., A.A. and P.N. undertook the qualitative interviews. All authors contributed to the analysis and write-up of the manuscript.

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Ethics Statement

Full Health Research Authority and NHS Research Ethics Committee (REC) approval has been granted (IRAS ID: 272043; 20/LO/0137/AM01), and the study is sponsored by University College London.

Consent

All patients gave written informed consent when taking part in this research. This included consent for their data to be written up anonymously for peer review publication.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data can be made available upon request to the corresponding author.

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