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A crisis-focused cognitive behavioural informed approach to formulating experiences of psychosis in acute mental health inpatient settings

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Abstract

Background: People experiencing psychosis in acute crisis should be offered cognitive behavioural therapy for psychosis (CBTp); however, there are few crisis-focused CBTp-informed models to underpin formulation development for people experiencing psychosis and receiving inpatient mental health care.

Aims: This paper draws on existing CBTp and crisis theories to conceptualise a psychotic crisis from a cognitive behavioural perspective to inform the delivery of therapy in inpatient settings.

Method: Previous literature is reviewed, critiqued, and synthesised. It draws upon relevant crisis and CBTp theories to outline how to best formulate a psychotic crisis.

Discussion: Drawing on existing research and theory, this paper outlines how a psychotic crisis can develop and be maintained. It highlights the importance of the person's context including the social, political, and cultural context, interpersonal context and trauma, and previous and current inpatient experience. It then outlines the key triggers, cognitive, behavioural, and emotional components of the crisis, and personal strengths, values and resources. A crisis-focused CBTp-informed approach is outlined, which can be used to underpin formulation and brief therapy strategies for people experiencing a psychotic crisis. More research is required to explore the efficacy of such therapies.

Keywords: acute psychosis; cognitive theory; inpatient CBT

Introduction

Understanding the development of a crisis

A mental health crisis has been described as an acute grief-like reaction which lasts approximately 4–6 weeks, which can happen to anyone who experiences an unexpected and significant obstacle or loss that derails them from their life goals and values, and leaves them feeling out of control (Lindemann, 1944; Dass-Brailsford, 2007). A mental health crisis can result in being admitted to crisis services, for example through the relapse of an existing mental health condition, which results in substantial impact on the life of the person and their social network (Joint Commissioning Panel for Mental Health, 2013). There is little literature on how a mental health crisis is conceptualised (Hudson *et al.*, 2024); however, there are some theories that have been applied to understand its development. Lazarus and Folkman's (1984)

transactional theory of stress and coping provides a framework for understanding how mental health crises develop (Matthieu and Ivanoff, 2006). Their model outlines that individuals are constantly appraising their surrounding environment, and difficulties arise when the environment is appraised as threatening or harmful, which results in emotional distress and coping strategy activation. The coping strategies produce an outcome which is then reappraised as favourable, unfavourable, or unresolved. When a perceived threat is left as unfavourable or unresolved, distress ensues and, if the distress is great enough and causes functional impairment, a crisis can occur (Matthieu and Ivanoff, 2006; Roberts and Ottens, 2005). In summary, a crisis develops, and is perpetuated by the individual's perception of the event as extremely distressing and upsetting, alongside an inability to resolve the crisis through normal coping mechanisms (Roberts and Ottens, 2005).

Whilst these conceptualisations provide an important foundation for understanding the underlying environmental, cognitive, behavioural and emotional mechanisms of crisis, they have also been criticised for being linear, simplistic, placing the problem in the individual and not capturing the social, cultural and political context of a mental health crisis (Dass-Brailsford, 2007). Moreover, there are limited crisis theoretical models which have been developed specifically for people with acute mental health problems, such as people who experience psychosis and are in receipt of psychiatric inpatient care, who arguably have a more complex trajectory to experiencing a crisis. People experiencing psychosis represent 50% of people admitted to inpatient and crisis care settings and there is a clear need to understand how psychotic crises develop (World Health Organisation, 2022). Cognitive behavioural theories have been applied to make sense of mental health crises. For example, Clarke (2009) has developed the Comprehend, Cope and Connect (CCC) transdiagnostic third-wave mode, which draws upon dialectical behavioural therapy (DBT) and compassion focused therapy (CFT), and postulates that when in crisis, an individual's 'emotional mind' takes over, and in connection with the body's threat system, vicious negative cycles of distress can occur (Bullock *et al.*, 2021). There is evidence of the usefulness of the model (Araci and Clark, 2017; Bullock *et al.*, 2021; Harris *et al.*, 2023), including with psychosis (Owen *et al.*, 2015). However, as it is a transdiagnostic model not informed by CBTp theory, which is recommended by clinical guidelines for people with psychosis in acute crisis (NICE, 2014), there is a need to outline a psychosis-specific approach.

A cognitive behavioural informed model of crisis for people experiencing psychosis

As outlined, the above theories demonstrate how threatening events, emotional distress, cognitions and coping behaviours play a role in the development and maintenance of a crisis (Lazarus and Folkman, 1984; Lindemann, 1944; Roberts and Ottens, 2005; Matthieu and Ivanoff, 2006), and provide an understanding of how a psychotic crisis develops and is maintained. By drawing upon the crisis and inpatient literature (Dass Brailsford, 2007; Clarke, 2009; Clarke, 2021) and utilising the CBTp model outlined by Morrison (2001, 2017), we describe a theoretically informed formulation model of a psychotic crisis from a cognitive behavioural perspective. We have utilised the Morrison model (2001, 2017), with some crisis adaptations, to specifically understand the development and maintenance of a psychotic crisis (Fig. 1). The crisis-focused formulation model outlines the importance of the person's social, cultural, and political context, interpersonal context and trauma, and current and past experiences of inpatient care, which inform the development and maintenance of their crisis. The model then outlines a maintenance model of the crisis including triggers, emotions and physiological changes, appraisals and cognitive processes, and behavioural and cognitive responses. It also outlines the importance of an individual's strengths, values and support. These are described in more detail in subsequent sections.

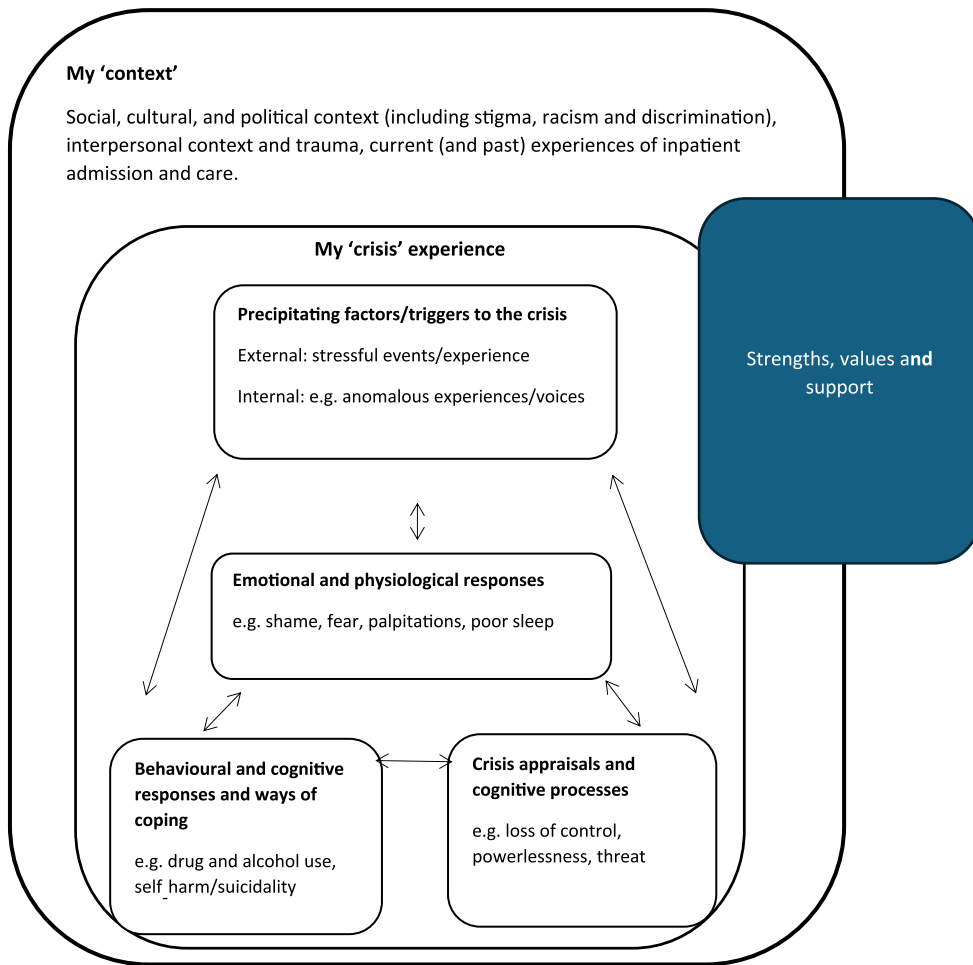


Figure 1. Crisis-focused CBTp theoretical framework.

The therapy protocol that was informed by this formulation model has been published and gives more detail about intervention strategies (Wood *et al.*, 2024).

Understanding a person's context

It is important to understand a crisis within an individual's personal context as this will significantly shape the development and maintenance of a mental health crisis, particularly their cognitive and behavioural responses (Dass-Brailsford, 2007). Important aspects are the individual's social, cultural, and political context, interpersonal relationships and trauma, and current and past experiences of inpatient care, which are described further below.

Social, cultural, and political context

Crises are idiosyncratic and culturally determined, and culturally specific beliefs and experiences will influence the development and maintenance of a crisis (Wood *et al.*, 2019; Phiri *et al.*, 2023). It is important to understand factors such as the person's religious and spiritual beliefs, culturally specific understandings of mental health issues and psychosis, gender and family roles/

expectations, experiences of racism and discrimination, and the role of individualism *vs* collectivism, as this will impact upon the crisis development (Rathod *et al.*, 2019; Phiri *et al.*, 2023). These factors will also shape the triggering events, emotional responses, cognitions, and coping strategies that a person will experience as part of their crisis. For example, if there is a cultural or family narrative that divorce is a shameful experience, then such an event is more likely to lead to a more distressing response (Dass-Brailsford, 2007).

The social, cultural, and political context is also important in understanding why people have been admitted to hospital. Understanding the context of admission can be extremely helpful in normalising the experience and empowering people. It is well-established that psychiatric inpatient services have over-representation of people from marginalised backgrounds who have high rates of social disadvantage, and interpersonal trauma (Karlsen *et al.*, 2005; Muskett, 2013). Chronic stressful conditions, such as ongoing social disadvantage, can contribute to the development and maintenance of a mental health crisis (Lipsitz and Markowitz, 2013). Experiences such as housing instability and financial difficulties are frequently reported stressors that contribute to crisis development (Wood *et al.*, 2019). Research has also demonstrated that those from ethnic minority backgrounds are over-represented and are more likely to be detained under the Mental Health Act (HM Government, 2007). In particular, people from Black African and Black Caribbean backgrounds are 3.5 times more likely to be detained under the Mental Health Act than their white counterparts, with those from mixed backgrounds being 3 times more likely, those from 'other' backgrounds being 2.5 times as likely, and those from Asian backgrounds being 1.5 times more likely (HM Government, 2024). It has been argued that a number of factors are causing ethnic minorities to be over-represented in this setting, including structural racism, stigma, immigration issues, challenges integrating conflicting social identities, difficulty accessing appropriate community mental health support, treatment non-compliance (taking into account that the dominant medical model may be at conflict with their personal/cultural beliefs), and being perceived as being a high risk of harm to self and others (which may relate to racial stereotypes) (Das-Munshi *et al.*, 2018; Barnett *et al.*, 2019; Vyas *et al.*, 2021).

Interpersonal context and trauma

Positive interpersonal relationships and intimate connections with others are a basic human need and important for our overall well-being and functioning (Lipsitz and Markowitz, 2013). Therefore, it is unsurprising that a mental health crisis often occurs as the result of interpersonal difficulties such as relational transitions or changes, attachment instability, interpersonal trauma, loneliness, isolation, loss, or conflict (Dass-Brailsford, 2007). Our relationships and interpersonal context shape how we appraise ourselves, the world and others (Fowler *et al.*, 2006; Young *et al.*, 2003), and will consequently influence appraisals in relation to the crisis and impact on any related behaviours. Therefore, making sense of interpersonal stress, change and loss is crucial to understanding the development and maintenance of a crisis (Lipsitz and Markowitz, 2013). The experiences of psychosis during a crisis almost always occurs within an interpersonal context, whether that be threatening interpersonal experiences (e.g. feeling that others are out to harm them), or internally with their relationship with voices (hearing commanding, omnipotent, derogatory voices that may reflect previous or current relationships with others).

There is extensive research demonstrating that interpersonal trauma can contribute to the development of psychosis and a crisis (Dass-Brailsford, 2007; Hardy, 2017; Varese *et al.*, 2012). Research has demonstrated that people experiencing psychosis have high rates of interpersonal childhood trauma such as physical abuse and sexual abuse, as well as other forms of abuse such as parental loss and separation, and bullying (Schafer and Fisher, 2011). Racial trauma is also a common experience in people experiencing psychosis who are hospitalised (Karlsen *et al.*, 2005). Research has demonstrated that a dose-response relationship has been identified between trauma,

discrimination, and psychosis (Pearce *et al.*, 2019), therefore people receiving inpatient care, may be more likely to have severe experiences of psychosis and have faced multiple traumas. Understanding an individual's interpersonal context and experiences of trauma is essential to understanding the presenting crisis.

Current and past experiences of inpatient admission and care

The impact of the inpatient treatment pathway itself is important to incorporate into the formulation model due to the potentially traumatic nature of the admission and inpatient care (Morrison *et al.*, 2003). We should attempt to understand the person's experience of the current and past admissions. Research has documented that an inpatient admission, particularly under the care of the Mental Health Act, can be distressing and traumatic (Solanki *et al.*, 2023). This is due to factors such as being admitted against one's will, being forcibly taken to hospital by police and/or emergency services, and being physically restrained (Solanki *et al.*, 2023; Wood *et al.*, 2019). Moreover, those from Black African and Black Caribbean, and mixed ethnic backgrounds are more likely to have police or criminal justice system involvement in their admission (Halvorsrud *et al.*, 2018), which increases the likelihood of the admission being distressing (Akther *et al.*, 2019). Being in receipt of inpatient care has also been identified as traumatic due to the confined and restrictive environment, potential witnessing or experience of verbal, physical and sexual harassment, use of physical restraint and rapid tranquilisation and a general lack of control and disempowerment regarding one's environment (Fenton *et al.*, 2014; Shaw *et al.*, 1977). Moreover, inpatient care has been shown to be retraumatising and can exacerbate a person's existing mental health distress, with some people reporting new post-traumatic stress symptoms as a result of admission (Morrison *et al.*, 2003). Dass-Brailsford (2007) highlighted that most crises develop into traumas and those from marginalised backgrounds are more likely to have a crisis experience which progresses into a longer, more trauma-based experiences. Inpatient care can also be a place where lower-level trauma takes place, such as microaggressions, being in receipt of inflexible and restrictive care and losing autonomy (e.g. rigid activity structures), and not having your basic needs met (e.g. not having appropriate access to food or a comfortable environment to sleep in), which can also maintain a person's crisis and escalate distress (Wood *et al.*, 2022).

In summary, the context of a person's crisis is crucial to ensure appropriate understanding of its development and maintenance, and this section of the formulation model has highlighted pertinent areas of consideration. Therapists should endeavour to enquire about such experiences in an assessment, and throughout the therapy experiences, and make appropriate adjustments, including cultural adaptations to the content and delivery of the therapy (Naeem *et al.*, 2019). The intervention should take into account current and past trauma, including trauma caused by the inpatient care system (Muskett, 2013; Clarke, 2021). Therefore, therapy should be underpinned by the values of safety, trustworthiness, choice, collaboration, empowerment and cultural competence (HM Government, 2022).

The 'crisis'

A person's crisis experience consists of crisis triggers, emotional and physiological responses, crisis appraisals and cognitive processes, and coping strategies and safety behaviours, which impact on one another to develop and maintain a crisis experience. The pathways to the development of a psychotic crisis are aligned to those already outlined in previous cognitive models of psychosis, i.e. that they can develop through cognitive and affective changes or through affective disturbance alone (Garety, 2001). However, in crisis, the affective change is likely to be prominent, more severe, and distressing (Clarke, 2021). The components and pathways to crisis will be described further below.

Crisis triggers

A crisis is caused by events or experiences which threaten an individual's equilibrium, are culturally meaningful, and leave a person feeling out of balance from their usual daily functioning, and cause disruption to cognitive and emotional processing (Garety, 2001; Roberts and Ottens, 2005). These can be external events that have occurred in a person's life or internal psychological events (e.g. a trauma memory or hearing a voice).

It has been postulated that events which cause a crisis are perceived by the person to impact upon at least one of four domains: physical safety (e.g. perceived or actual significant physical health problems such as receiving a cancer diagnosis, homelessness or long-term financial problems), psychological safety (e.g. events which impact on personal identity, and self-esteem), social safety (e.g. breakdown or loss of relationships with friends, family and spouses), and moral and spiritual domains (e.g. events which significantly challenge personal values, caused a questioning of their faith, or inhibited religious practice) (Myer, 2001; Hudson *et al.*, 2024). The more domains an event impacts, and the more the event is perceived as threatening, uncontrollable and unpredictable, the more likely it is to cause a crisis (e.g. interpersonal trauma) (Thoits, 1995; Myer, 2001). Triggers of a crisis, which can include stopping psychiatric medication, also cause disruption to daily functioning, an elevated risk of harm to self, others or from others, and heightened emotional distress (Tobitt and Kamboj, 2011). Hobbs (1984) describes two dominant types of crisis triggers: (i) *developmental situations*, which are inevitable life transitions such as childbirth and adulthood, and (ii) *accidental situations*, which are unexpected stressors such as financial hardship, loss of relationship, or trauma. Both developmental and accidental situations can act as both pre-disposing factors and immediate triggers to a crisis. Crisis triggers can further occur during the inpatient settings, for example the inpatient admission experiences and difficult interactions with staff (Wood *et al.*, 2019). Morrison (2017) highlights the importance of modifying triggers or the environment as part of a CBTp intervention, which would also be imperative in crisis.

It is also important to also identify internal events, intrusions into awareness, and anomalous experiences, which may be interpreted in a threatening way and also trigger a crisis (Morrison, 2001; Garety, 2001). Anomalous experiences can include anomalous self-experiences (distortions in how you experience yourself), anomalous perceptual experiences (hearing things that others cannot), and anomalous cognitive experiences (distortions in cognitive processes) (Wright *et al.*, 2018). It is well documented that internal triggers, intrusions, and anomalous experiences within psychosis usually occur from the exacerbation of life stressors/external triggers, which precipitate it (Ventura *et al.*, 2000). Therefore, an increase or shift in internal experiences are likely to occur within the context of heightened external triggers. In addition, it has been demonstrated that external triggers/stressors can also lead to heightened emotional distress and/or generation of novel trauma-related images (if there is a past history of trauma) which can result in anomalous experiences (Hardy, 2017). People in crisis are therefore likely to experience an increase or shift in anomalous experiences and other internal events due to an increase in external life stress, therefore leading to an exacerbation of psychotic experiences as a component of the crisis.

Role of emotions and related physiological responses

A crisis is usually characterised by strong distressing emotions along with difficulties self-regulating them (Dass-Brailsford, 2007; Sharp *et al.*, 2018). These emotional experiences are strongly linked to an individual's cognitive appraisals of the crisis, which can serve to maintain the crisis, and impact one another (Morrison, 2017). Emotional distress is often at the foreground of the crisis and should be a core part to any psychological intervention (Clarke and Wilson, 2009; Sharp *et al.*, 2018). Emotions are key to the development and maintenance of psychosis (Garety,

2001; Smith *et al.*, 2006), and a number of distressing emotions have been demonstrated to be associated with psychosis such as depression, anxiety, hopelessness, guilt and shame (Birchwood *et al.*, 2007; Kuipers *et al.*, 2006; Smith *et al.*, 2006). Emotional distress can occur before, during, and after a psychotic crisis and will change in accordance with an individual's cognitive appraisals of their situation (Dass-Brailsford, 2007; Freeman, 2016; Upthegrove *et al.*, 2017). Emotions such as defeat, humiliation and entrapment are also a key component in the development of crisis and related risk behaviours such as self-harm and suicidality, and should also be considered as part of the formulation (O'Connor and Kirtley, 2018). An array of emotions may be present and fluctuate throughout the crisis, but the therapist should be trying to identify key ones to be able to prioritise in the therapy work. Intervention strategies that focus on emotion regulation may be particularly helpful in crisis and have been described in several relevant papers (Rendle and Wilson, 2008; Sharp *et al.*, 2018).

Physiological responses coincide with emotional responses to mobilise individuals to behaviourally respond (Behnke *et al.*, 2022). The more heightened the emotional distress, the more intense physiological responses a person is likely to experience (Behnke *et al.*, 2022). These physiological responses can further perpetuate psychosis as they can lead to increased intrusions or anomalous experiences (Morrison, 2001). People from certain cultural backgrounds are more likely to report physiological responses over cognitive or emotional ones when in crisis as they may perceive their difficulties to have a physical cause (Department of Health and Human Services, 2001; Rathod *et al.*, 2019). Poor sleep or insomnia is also a recognised problem for people experiencing psychosis in crisis, and can be exacerbated in those receiving care from inpatient settings due to the noisy ward environment (Sheaves *et al.*, 2017).

Crisis appraisals and cognitive processes

A key component of understanding the development and maintenance of a psychotic crisis is the appraisals relating to the experience. These will maintain emotional distress and influence behavioural responses and coping strategies, including risk behaviours (Morrison, 2017). Appraisals of the crisis triggers are usually emotionally distressing and negative in content, which cause the crisis to develop and perpetuate. Myer and Conte (2006), drawing on evolutionary psychological processes, describe three types of crisis appraisals: transgression appraisals (e.g. 'they have wronged me'), threat appraisals (e.g. 'I/my family are in danger') and loss appraisals (e.g. 'my relationship is over'). For people experiencing psychosis, these same types of appraisals will apply but the content of their appraisals may also be 'culturally unacceptable' to those around them and thus conceptualised as psychotic (Morrison, 2017). For example, it may be an external trigger, voice or other anomalous experience, which is appraised as a transgression (e.g. 'the witchcraft has made me a bad person', 'the voices are telling me I am a terrible mother'), threat (e.g. 'I am being followed by MI5', 'the staff are trying to try to kill me') or loss (e.g. 'the voices are right, all my family are going to abandon me'). Additional appraisals, which have been highlighted to be associated with high risk crisis behaviours relate to themes of loss of control (e.g. 'I have no control over my experiences'), loss of power (e.g. 'the voice can read my mind'), defeat (e.g. 'I cannot fight this anymore'), entrapment (e.g. 'I cannot escape this situation'), and hopelessness (e.g. 'things will never get better for me – I will be ill forever') (Haddock *et al.*, 2019). Individuals may perceive a permanence to their experience and have little hope that things will be able to change, which may lead to appraisals of harming themselves or others (Haddock *et al.*, 2019). The frequency, intensity, conviction, and levels of negative content of appraisals can increase when in crisis (Wood *et al.*, 2024). Dysfunctional meta-cognitive beliefs can also cause and maintain psychosis and emotional distress (Kuhne *et al.*, 2017), and these beliefs can be heightened in an acute mental health crisis (Aghotor *et al.*, 2010). Metacognitive beliefs have been demonstrated to be associated with risk, including suicidal ideation (Hutton *et al.*, 2019).

It has been established that people experiencing psychosis and in crisis, respectively, are at increased likelihood of having cognitive and attentional difficulties and therefore people experiencing a psychotic crisis are highly likely to be experiencing transient or long-standing cognitive difficulties which may act to perpetuate the crisis (Millan *et al.*, 2012). Cognitive difficulties in attention, working memory and executive functioning are well documented in people experiencing a crisis (Trivedi, 2006), with factors such as emotional distress, and medication side-effects being contributory factors (Maloney *et al.*, 2014; Moncrieff *et al.*, 2009). Moreover, extensive research has demonstrated that interpersonal trauma and heightened levels of emotional distress can lead to cognitive processing biases such as jumping to conclusions, belief inflexibility and external attribution bias (i.e. are more likely to associate experiences to an external cause) which cause symptoms of psychosis to develop and be maintained (Ho-Wai So *et al.*, 2016; Ward and Garety, 2018). The crisis literature also outlines that difficulties in problem solving can be present in those experiencing an acute mental health crisis, as well as with those presenting with self-harm and suicidality, and may be an area to prioritise in therapy (Roberts and Ottens, 2005; O'Connor, 2018). Problem-solving difficulties, particularly social problem solving, have been identified in people experiencing psychosis and particularly prevalent in those experiencing co-morbid depression (Vorontsova *et al.*, 2013). It is well documented that people experiencing psychosis can have difficulties generating solutions to problems, evaluating the efficacy of solutions, and can lack the ability to implement problem solving (Bellack *et al.*, 1994). Problem-solving difficulties, particularly social problem solving, are also present in those with risk of harm such as suicide, self-harm and violence and aggression (Pollock and Williams, 2004).

Behavioural and cognitive responses and ways of coping

As outlined in the literature, a crisis can occur due to the individual not being able to find ways of coping with the crisis, and consequently feeling out of control (Roberts and Ottens, 2005). People in inpatient settings are more likely to have a multitude of difficult experiences or adversities which have led to admission (Lipsitz and Markowitz, 2013), and these are usually so severe and debilitating that the person understandably does not have the coping strategies required to manage the situation and may respond in unhelpful ways. These responses may serve to maintain the problem and perpetuate distressing emotions and appraisals. Therefore, coping strategy development is often an area which requires focus, which should be personally meaningful and culturally relevant.

Responses to a crisis have been identified to fall within three key domains of immobility, avoidance, and approach (Myer and Conte, 2006). Immobility describes being unable to resolve the crisis and becoming stuck/trapped/impotent in resolving the crisis (e.g. self-neglect); avoidance outlines attempts to escape or evade the crisis event to try and manage what is happening (e.g. evading friends and family members, not talking about issues, attempting suicide) and approach strategies are attempts to try and manage the crisis (e.g. an unsuccessful attempt at reconciling a recently ended relationship and perseverative processing strategies), which are not effective. Some of these responses may be forms safety behaviours, which are defined as overt or covert behaviours to avoid feared outcomes, and are carried out within a specific situation (Salkovskis, 1991). Safety behaviours will provide temporary relief but are likely to act to reinforce or perpetuate the crisis. Safety behaviours and coping behaviours are often a challenge to distinguish and their classification is dependent on its function and the individual's context (Tully *et al.*, 2017).

Behavioural responses to crisis that put the individual at risk of harm to themselves or others are what often lead people into acute mental health services. Due to overwhelming distress,

hopelessness, defeat, entrapment, shame, and related appraisals, people often respond with behaviours such as self-neglect, self-harm and suicide attempts (Sheehy *et al.*, 2019); whereas if people are feeling angry and frustrated, and have related appraisals, they are more likely to demonstrate a risk of harm to others through violence and aggression.

One of the other main factors which contributes to and maintains a mental health crisis is drug and alcohol use, which been identified as one of the main influential factors in precipitating an admission (Graham *et al.*, 2019). Drug and alcohol use is often a key coping strategy for acute mental health inpatients who regularly present to the wards. In a cross-sectional study, Flovig *et al.* (2009) found that 81.9% of people who had been admitted to a psychiatric hospital had used illicit substances prior to admission. Graham *et al.* (2019) talk about mental health admissions being a 'teachable moment' and an opportunity to provide a therapeutic space to discuss their substance misuse.

As outlined, responses to a crisis are comprehensive and diverse and intervention should be tailored to idiosyncratic response. However, potentially helpful approaches include coping strategy development, behavioural activation, crisis plans, and self-management strategies for self-harm (Durrant *et al.*, 2007; Clarke and Wilson, 2009; Heriot-Maitland *et al.*, 2014; Morrison, 2017; Wood *et al.*, 2024).

Strengths, values, and social support

It is important to identify the individual's strengths, values and sources of social support when developing an understanding of their crisis experiences as these will act as strategies to potentially target triggers, cognitions, emotions and behaviours that are maintaining the crisis. Working from a perspective that an individual is the expert in their own crisis and has the required strengths and resources to overcome the crisis is key (Slawinski, 2006). The therapist should be there to support the individual to develop their own skills to manage their crisis experiences, which is line with CBTp values (Brabban *et al.*, 2016). Moreover, all work should be underpinned by the person's values to ensure that the therapy is prioritising goals and ways of coping that are personally and culturally meaningful to the individual (Slawinski, 2006). Recent research has shown the frequent goals for crisis-focused inpatient therapy are discharge from hospital, a return to everyday life, and to prevent crisis and readmission. Goals for therapy could be identified by utilising q-sort cards, which have been specifically developed for inpatient settings (Douglas *et al.*, 2022).

Family, friends, and carers play an important role in supporting the person to access support for a crisis and are often cited as the ones who make the initial contact with crisis services (Wood *et al.*, 2019). Moreover, extensive research has demonstrated that family support and involvement play a significant role in the prevention of relapse and rehospitalisation (Bird *et al.*, 2010; Eassom *et al.*, 2014). It has been demonstrated that if family members are involved in the delivery of treatments or therapies, the impact of these therapies appear to be longer-lasting (Bird *et al.*, 2010). Many ethnic minority individuals may come from a collectivist culture and involving family may be essential to the therapy being successful (Naeem *et al.*, 2019). Therefore, collaboratively agreeing when and how to involve the person's social network in any therapy is key.

Clinical example

To demonstrate the application of this formulation model, a case example is presented with a brief treatment plan.

Matthew (pseudonym), a young Black British single man of African descent with a first episode of psychosis, was admitted to an acute mental health inpatient hospital after an attempt to end his life. He was taken into hospital by police as he was found in a public place. He was in hospital for three weeks, which is where we began brief crisis-focused CBTp for eight sessions (three were on

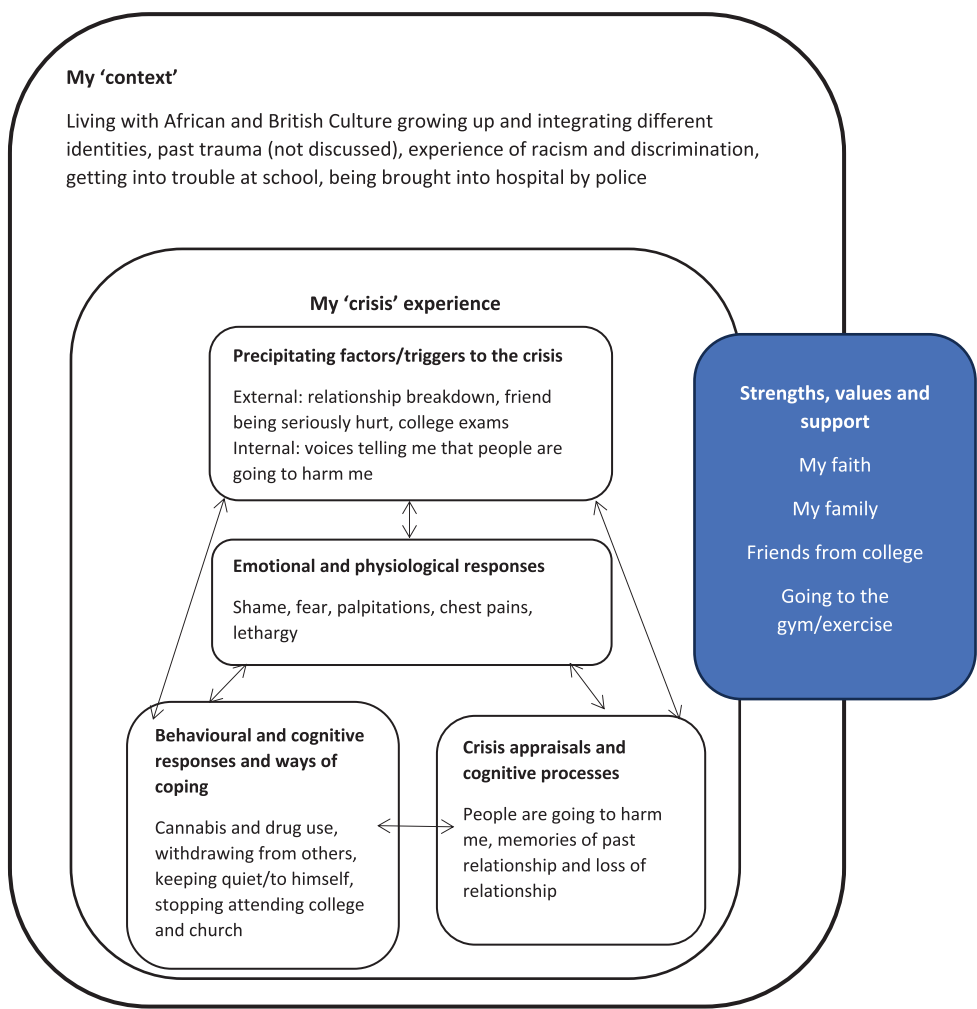


Figure 2. Matthew's formulation.

the ward, and five post-discharge). He lived in London with his family and was studying at college. He had a large social circle and would go out regularly with friends where he would smoke cannabis socially. He was religious and attended church regularly prior to his crisis. His admission was precipitated by a breakdown in a relationship, and a close friend being badly hurt in a fight, as well as an increase in cannabis use to cope with these situations. Matthew started experiencing voices and paranoid beliefs, which led to feelings of extreme fear and anxiety. He would have strong somatic feelings such as chest pains and palpitations, as well as poor sleep and lethargy. To cope he would smoke cannabis, drink alcohol, withdraw from others, and keep a look-out for danger. A more detailed formulation can be found in Fig. 2. Our goal for therapy was to facilitate discharge and improve Matthew's preparedness for being back at home in the community. This involved helping to manage his experiences of psychosis and crisis planning, which we hoped would empower him and give him a sense of control. Specifically, we did work on coping strategy development (e.g. prayer, and speaking to pastor, coping with voices work), behavioural activation (going back to church, exercising, spending time with friends who don't smoke weed), exploring alternative explanations to him being a bad person by bringing in perspective of pastor, and parents, and putting thing we have done together into a crisis plan for the future.

Summary

In summary, this paper presented a crisis-focused cognitive behavioural formulation model drawing upon relevant theories and literature from both CBTp and crisis research fields. It draws upon both an understanding of the person's context as well as their crisis to understand the development and maintenance of a crisis experience. This is the first paper that we are aware of to summarise the key crisis and CBTp literature to understand the development and maintenance of a psychotic crisis, which is specifically adapted for acute mental health inpatient settings. This approach can be used to inform CBTp delivered to this population to help people manage their crisis experiences. Initial research has been undertaken to assess the feasibility of a crisis intervention based on this model (Wood *et al.*, 2025), but further trials are required to test the efficacy of this model and its proposed mechanisms of change. This model has the potential to be applied transdiagnostically due to several aspects pertaining to understanding and managing crisis; however, further research would be needed to determine this given that the development work has been undertaken solely with psychosis populations (Wood *et al.*, 2025).

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Competing interests. The authors declare none.

Ethical standards. The authors of this manuscript have abided by the Ethical Principles of psychologists and Code of Conduct as set out by the BABCP and BPS. This theoretical model was developed as part of a body of research aim to adapt CBTp for use in inpatient settings with crisis. This body of research has received full Health Research Authority (HRA) and NHS Research Ethics Committee (REC) approval has been granted (IRAS ID: 272043; 20/LO/0137/AM01) and the study is sponsored by the University College London. The case example was a participant in this trial who gave informed consent for his anonymised data to be used in publications arising from this research. A pseudonym was used and all identifying information has been changed.

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