Participant perspectives on cognitive remediation and social recovery in early psychosis (CReSt-R): an acceptability study

Frawley, Emma, Heary, Caroline, Berry, Clio, Cella, Matteo, Fowler, David, Wykes, Til and Donohoe, Gary (2023) Participant perspectives on cognitive remediation and social recovery in early psychosis (CReSt-R): an acceptability study. Early Intervention in Psychiatry. pp. 1-8. ISSN 1751-7885

This version is available from Sussex Research Online: http://sro.sussex.ac.uk/id/eprint/112426/

This document is made available in accordance with publisher policies and may differ from the published version or from the version of record. If you wish to cite this item you are advised to consult the publisher's version. Please see the URL above for details on accessing the published version.

Copyright and reuse:
Sussex Research Online is a digital repository of the research output of the University.

Copyright and all moral rights to the version of the paper presented here belong to the individual author(s) and/or other copyright owners. To the extent reasonable and practicable, the material made available in SRO has been checked for eligibility before being made available.

Copies of full text items generally can be reproduced, displayed or performed and given to third parties in any format or medium for personal research or study, educational, or not-for-profit purposes without prior permission or charge, provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way.

http://sro.sussex.ac.uk
Participant perspectives on cognitive remediation and social recovery in early psychosis (CReSt-R): An acceptability study

Emma Frawley | Caroline Heary | Clio Berry | Matteo Cella | David Fowler | Til Wykes | Gary Donohoe

Centre for Neuroimaging, Cognition & Genomics (NICOG), School of Psychology, University of Galway, Galway, Ireland
School of Psychology, University of Galway, Galway, Ireland
Primary Care and Public Health, Brighton and Sussex Medical School, Brighton, UK
Institute of Psychiatry, Psychology & Neuroscience, King's College, London, UK
School of Psychology, University of Sussex, Brighton, UK

Correspondence
Gary Donohoe, Centre for Neuroimaging, Cognition & Genomics (NICOG), School of Psychology, University of Galway, University Road, Galway, Ireland. Email: gary.donohoe@nuigalway.ie

Funding Information
Irish Health Research Board (HRB), Grant/Award Number: CDA-2018-001

Abstract

Aim: Psychosis spectrum disorders continue to rank highly among causes of disability. This has resulted in efforts to expand the range of treatment targets beyond symptom remission to include other recovery markers, including social and occupational function and quality of life. Although the efficacy of psychosocial interventions in early psychosis has been widely reported, the acceptability of these interventions is less well-known. This study explores the participant perspective on a novel, psychosocial intervention combining cognitive remediation and social recovery therapy.

Methods: We employed a qualitative research design, based on semi-structured interviews and reflexive thematic analysis. Six participants with early psychosis were recruited from the intervention arm of a randomized pilot study, three women and three men, aged between 22 and 27 years.

Results: Four themes were developed through the analytical process, namely, (1) a solid therapeutic foundation, (2) multi-directional flow of knowledge, (3) a tailored toolset, and (4) an individual pathway to recovery. Participants also provided pragmatic feedback about how to improve the delivery of the therapy assessments and intervention. Both the themes and pragmatic feedback are described.

Conclusions: People with early psychosis described the intervention as acceptable, engaging, helpful and person-centred, suggesting its potential role in a multicomponent therapy model of early intervention in psychosis services. Participants in this study also highlight the importance of an individualized approach to therapy, the vital role of the therapeutic relationship and the ecological validity and value of adopting an assertive outreach delivery, providing therapy outside a conventional clinic setting.

Keywords
acceptability, cognitive remediation, early psychosis, feasibility, occupational function, psychosocial intervention, social function, social recovery
1 | INTRODUCTION

Psychosis spectrum disorders continue to rank highly among causes of disability in people aged 18-to-30-years-old (World Health Organization, 2017). Although anti-psychotic medications are effective in targeting clinical symptoms, less than half of all patients are able to achieve functional recovery (Green, 2016). Residual impairments, even after successful pharmacological intervention, have a significant impact on functioning and disability in those living with psychosis (Fett et al., 2011; Horan & Green, 2019). Targeted psychosocial treatments embedded in early intervention in psychosis (EIP) are associated with significant gains in function, particularly when provided as part of a multicomponent model of care as operationalized in EIP services (Frawley et al., 2021). Although studies reported a variety of outcomes of psychosocial intervention, data on the acceptability are underreported.

This qualitative study addresses this gap by exploring the acceptability of the Cognitive Remediation and Social Recovery in Early Psychosis (CReSt-R) intervention for participants taking part in a trial. Feedback from these participants can improve the trial and will be integral in further development of this multicomponent intervention to optimize clinical utility. Designing, implementing, and evaluating psychosocial interventions in early psychosis is complex and now encompasses additional components such as acceptability, cost-effectiveness, scalability, and transferability across contexts (Skivington et al., 2021). Engaging stakeholders is a core element with acceptability highlighted as a fundamental element in the design and reporting of feasibility trials (O’Cathain et al., 2015). Acceptability is defined as the perception that a given treatment, service or practice is agreeable, palatable, or satisfactory (Proctor et al., 2010).

The CReSt-R study investigates the feasibility of a novel, multicomponent intervention. This intervention combines cognitive remediation training (CRT) and social recovery therapy (SRT), delivered in a 10-session programme. Sessions were primarily delivered at a therapeutic space at the University of Galway campus, and other community locations dependent on participant preference (e.g., some participants opted to have sessions in their home or other community locations). E.F. was the primary therapist with clinical supervision provided by G.D. Briefly, the CRT programme used in this study is the Computerized Interactive Remediation of Cognition-Training for Schizophrenia (CIRCuits). CIRCuits is a web-based CRT programme which targets metacognition, specifically strategy use, in addition to massed practice of cognitive functions (attention, memory, and executive functioning) and follows the protocol of a previous randomized controlled trial (Reeder & Wykes, 2010; Reeder et al., 2017).

The SRT component is a cognitive behavioural therapy intervention that focuses on addressing barriers to individuals interacting in their social environment, e.g., social anxiety. It is informed by cognitive behavioural theory and addresses individual goals. SRT also follows an established protocol (Fowler et al., 2009; Fowler et al., 2013; Fowler et al., 2019) and has been the subject of a randomized trial in its own right (Fowler et al., 2018). The individual therapy components, primary and secondary outcome measures, and key feasibility indicators are outlined in the study protocol (Frawley et al., 2022) and trial registry (ClinicalTrials.gov Identifier NCT04273685).

Participants were recruited from the outpatient department of Galway University Hospital Adult Mental Health Service (AMHS) and Galway Child and Adolescent Mental Health Services (CAMHS). Inclusion criteria were broad in nature for this study with a pragmatic approach operationalized. Inclusion criteria included being aged between 16 and 35 years of age, within the first 5 years of a diagnosed psychotic illness (based on time since first contact with a clinical service), community based, clinically stable and having the ability to give consent. Exclusion criteria were having a history of organic impairment, history of a head injury with loss of consciousness >5-min duration and drug abuse in the preceding month. While all participants met the inclusion criterion of having early-stage psychosis, there is currently no specialist early intervention in psychosis service available in this geographical location. Therefore, treatment as usual varied across participants.

In summary, participants received a 10-week therapy intervention with assessments completed at three time points throughout the study- at baseline prior to beginning the intervention, 2 weeks post-intervention and a follow-up time point at 3 months post-intervention. The purpose of this qualitative study is to explore the acceptability of the combined, multicomponent intervention to people aged 16–35 years in the early psychosis population.

2 | METHOD

An interview schedule was developed with a focus on eliciting participant feedback on: their general experience of participating in the intervention, intervention components, mechanisms of change, communication with the research therapist, experience of assessment sessions, and perceived benefits and challenges of participating in the intervention (see supplementary material). The interview schedule builds upon previous acceptability studies of each therapy component (Gee et al., 2018; Reeder et al., 2016) with additional emphasis on people’s experience of the bridging of therapies, and general experience of participating in the trial. There was no public patient involvement (PPI), reflecting lived and living experience perspectives, in the design of the study and interview schedule. This is acknowledged as a limitation of the study in the discussion below.

Participants were recruited through purposive sampling of the intervention arm of the randomized pilot study. All intervention participants (16 in total: those who completed the therapy protocol (13) and those who left therapy early (3)) were invited to participate in the qualitative study via email with information regarding the purpose of the qualitative study, data management, and the format of the planned semi-structured interviews. Of the 16 invitees, five declined to participate for a variety of reasons, for example, some participants did not want to be recorded, others cited other personal time demands such as study and work commitments as barriers to participation. Five invitees did not respond to the invite.

In total, six participants consented to participate: three women and three men aged between 22 and 27 years. All six participants...
completed the intervention protocol in its entirety, including the 10-week therapy intervention, baseline assessment, and two follow-up assessment sessions. All participants were within the first 5 years of a diagnosed psychotic disorder and were not receiving other psychosocial intervention at the time of the study. Participants opted in and provided written consent via responding to the email and were contacted by a member of the research team (E.F.) to schedule an interview date thereafter. In-depth semi-structured interviews were completed online via a secure platform with a member of the research team not directly involved in delivery of the intervention (G.D.). Interviews, undertaken from July to November 2021, varied in duration from 40 to 60 min (Mdn = 44, range = 20). All interviews were recorded and transcribed verbatim. Transcribed interviews were uploaded to NVivo software (released in March 2020) for analysis.

A reflexive thematic analysis was undertaken (Braun & Clarke, 2006; Braun & Clarke, 2022; Notley et al., 2014). A reflexive approach to thematic analysis was used, as opposed to alternative models such as coding reliability or codebook approaches to thematic analysis, due to the robust process guidelines and theoretical flexibility it offers (Braun & Clarke, 2022; Byrne, 2021). The process guidelines (six phases of reflexive thematic analysis) provided a clear and efficient work plan for the research team to follow. The guidelines were followed in an iterative manner and not necessarily in a linear fashion as the data was explored, and codes and themes developed, reviewed, and refined. Fundamentally, the reflexive approach to thematic analysis also highlights the researcher’s active role in knowledge production. In this regard, researcher subjectivity is seen as a primary tool in making meaning of the data set and the development of codes and themes (Braun & Clarke, 2022). Given the proximity of the researchers to the CReSt-R intervention, reflexivity and use of a reflexive journal was considered an advantage in adopting this approach and interpreting the data set.

When analysing the data, a critical realist epistemological approach was adopted, attempting to make meaning of participants’ realities through exploring their perspectives and expressed language of their experiences (Danermark et al., 2002). Analysis involved deep familiarization with the data in both aural and transcribed formats with ongoing, active reflection on both the content and process by the researchers. E.F. completed a reflective journal throughout the research process. Coding of all transcripts was completed by E.F. NVivo software was used for efficiency of organizing and visualizing data and recording decision making processes for quality control purposes. Independent coding of a sample of transcripts was also undertaken by C.H. and C.B. Congruent with a reflexive thematic analysis approach, the aim was not to reach a consensus on coding, but rather to enrich the understanding and interpretation of the data and fuel discussion at coding meetings with E.F., C.H., C.B., and G.D. Themes were generated, reviewed, and developed in an iterative process.

3 | RESULTS

In general, the CReSt-R intervention was described as acceptable by all participants and all participants stated they would recommend the intervention to others. The four themes developed during the reflexive thematic analysis traverse individual participant perspectives and interconnect to form a model of acceptability as conveyed in Figure 1.
3.1 | A solid therapeutic foundation

The relationship with the therapist was consistently described as central to the participants’ experience of the intervention. This reflects findings from a recent paper highlighting facilitation by a therapist as a core feature of cognitive remediation training (Bowie et al., 2020). Participants described feeling apprehensive about taking part in the study; however, once they met the therapist and began to develop a rapport, this fostered a sense of security and promoted active engagement with the therapy process. Participants mentioned the value of feeling heard, active listening, and a sense of affirmation from the interactions in therapy sessions, as the following quote illustrates: ‘But when I was talking, she was very good at helping me to express myself. You know when I’d say something she’d nod her head and smile at me, and that sort of affirmation was very helpful for me that I knew that she was taking everything in and listening and that what I was saying was relevant’ (woman, aged 26).

The continuity of therapy sessions (a regular meeting time, regular and predictable contact from the therapist and a regular meeting place) was also described as a source of reassurance and support in the context of individual recovery. Participants described a sense of safety in terms of the cognitive and emotional demands of therapy and also in the physical space, outside a conventional clinic setting. Having a regular meeting time and receiving ongoing feedback from the therapist was described as a source of extrinsic motivation. This therapeutic relationship was described as forming a solid foundation from which the therapy process could develop and was fundamental in the perception of acceptability of the intervention. The structure of the intervention, combining cognitive remediation training and social recovery therapy, allowed continuity of feedback to the young person. Selection of goals, strategies, space to reflect on cognitive strengths and challenges and progress made towards collaborative goals were described by participants as strengths of the intervention: ‘It was very structured you know and I suppose we could see as the weeks went on how well I was doing in it and how I was improving and that kind of thing. So that was helpful’ (man, aged 26).

3.2 | Multi-directional flow of knowledge

Central to the acceptability of the intervention was the transfer of knowledge between participant and therapist. Participants described sharing their previous experiences with mental health services, fears, and expectations of therapy: ‘Yeah, I suppose I was afraid that you know the therapist would be disappointed with me that I wouldn’t talk enough. And I was also afraid that I might be put under pressure to think positively or do things that I felt were overwhelming’ (woman, aged 26).

This allowed for an open discussion on how they may best be supported throughout the therapeutic process: ‘If it wasn’t flexible, I don’t think I would have been able to do it, or if it was too intensive’ (woman, aged 22). ‘I need help with understanding information, I find it kind of overwhelming. I need space and a bit of time for it to soak in’ (man, aged 23).

This shared knowledge was described as strengthening the therapeutic relationship and was pivotal in creating a flow of knowledge. This flow of knowledge was not only between participant and therapist but also intrinsic to the individual participant, allowing for self-reflection and development of self-awareness: ‘We did a mind map looking at my behaviours in the centre of it and my thoughts and emotions and that. I found it very helpful that sometimes she’d put words on things and other times she got me to put words on the things and it emerged that one of my behaviours was avoidance that I was avoiding meeting people and talking to people. And just to identify that behaviour was very clarifying for me and then we could begin to challenge it a bit’ (woman, aged 22).

This multi-directional flow of knowledge was described as empowering in terms of informing collaborative goals, selection and application of therapy strategies and the focus of individual therapy sessions in the context of individual recovery and developing a ‘tool-set’ to reach their goals: ‘I know that my values and goals have changed since the study. It did help me gain like confidence in kickstarting or like springboard into what I’m kind of doing now, to take the next steps myself’ (woman, aged 22).

3.3 | A tailored toolset

Participants described being experts in their own lived experience and recovery, contributing to a collaborative formulation whilst also describing the therapist as a source of knowledge, feedback, and affirmation. Participants also described a sense of individualism and autonomy in the therapy intervention. Rather than a ‘one size fits all’ approach, they were active agents in guiding the sessions and focus of therapy: ‘Yeah my sessions now would be completely different to another person’s you know what I mean, it was tailored to me, it was spot on’ (man, aged 27). ‘We were setting goals as to what I wanted to do in the future and stuff like that you know, goals important for me, stuff I have control over’ (woman, aged 26).

Goal setting and strategy use were highlighted by participants as strengths of the intervention. Whilst setting goals was an important source of motivation for participants, it was also described as a challenging process: ‘Initially I was sceptical and I thought you know we’ll set goals and I’ll never be able to reach them. But as we went on through the therapy, I was able to see you know it clarifies in your mind you know what you’re trying to do and then you can begin to work it out and do something about it. And I feel like my goals were reached quite well at the end of the therapy so I was happy about that’ (man, aged 26).

A strategy that stands out is writing things down, that I’d remember things better if I write them down. And I suppose even writing things down just to express myself as well and reduce anxiety I’ve still used that since the therapy. That would be the main thing (woman, aged 22).

Thinking about thinking or metacognition were used interchangeably by participants to describe both therapy components and how this was tailored to them. They described developing an awareness of...
their cognitive strengths and challenges and working alongside the therapist to identify strategies specific to their daily life and selected goals. Similar to goal setting, metacognition was also described as a concept that was challenging to articulate at first, however, one they became familiar with by the end of the intervention: ‘I’d describe it as becoming more aware of your thoughts and emotions and learning how to challenge your thinking. Yeah being able to manage on your own with thoughts and emotions a bit better and reduce your anxiety levels’ (woman, aged 26).

The sense of tailoring the intervention to meet individual needs was described as appealing to participants, again strengthening engagement, and facilitating a flow of knowledge that allowed them to ‘try out’ strategies in ‘real life’ and discuss these experiences in the safety of the therapy intervention. This tailored toolset traversed both therapy intervention components (CRT and SRT).

3.4 | An individual pathway to recovery

All participants interviewed stated they would recommend the intervention to others. However, participants highlighted the importance of the timing of the intervention and proximity to an acute episode of psychosis and where an individual may be on their personal recovery journey. This provides an interesting perspective on when to offer this intervention to participants: ‘I suppose I think every individual has a different journey to make. And if the program had been offered to me a year ago, I probably wouldn’t have even gone on it. So it depends on the frame of mind that you’re in to be even open to the program. It just got me at a very good time’ (woman, aged 26).

While feedback on the intervention was positive, participants did describe both enjoyable and challenging aspects, again each perspective was unique to the young person in the context of their individual pathway to recovery. Participants particularly reported at times finding the at-home cognitive remediation training component as challenging without the external motivation and feedback from the therapist: ‘I suppose I found it difficult sometimes to complete the circuits every week you know and it got a bit repetitive at times. So that would have been one thing that might have needed changed’ (man, aged 23). This varied between participants, suggesting that support for at-home cognitive remediation training should be tailored to the individual and integrated into individual recovery plans.

All participants reported personal improvements or achieved goals at the end of the therapy intervention. Whilst not all goals were met, the process of setting goals was described as something which could be carried forward to future endeavours: ‘I’ve achieved the goals like the long-term goals. I was talking a lot about trying to get back into work and I’m working now. And I was talking about moving out and I’ve moved out of the home house so now I’m in the town. So the goals actually came around full circle you know’ (man, aged 26).

The ending of therapy was described by participants as both a positive and challenging experience. Whilst progress towards goals was described, there was a natural sense of uncertainty but also hopefulness about the next step, independent of therapy sessions: ‘And the therapy had basically given me the way to not because I’m not looking at myself so negatively or I’m not looking at my life as being unmanageable that I can take the progress you know towards making these steps and having the confidence to do so’ (woman, aged 26).

3.5 | Pragmatic feedback

Study participants also provided feedback on the delivery of the multicomponent intervention and experience of assessments completed at three time points. While this pragmatic feedback is not included in the thematic model of acceptability (Figure 1), it is included to provide additional context to the individual experience of the therapy process. The therapy intervention was delivered both in-person and online during the COVID-19 pandemic. All participants stated online sessions were acceptable, however, there was a consensus that in-person sessions (for assessment and therapy) were preferable: ‘I preferred in-person ones better when you’re talking about kind of personal things to do with being personal’ (man, aged 27). Participants also stated a preference for therapy to be held outside of a traditional clinic setting, e.g. on a university campus or other community location: ‘Hospitals I don’t particularly like. Yeah I just find it’s easier to focus in a different setting’ (woman, aged 22).

Two of the six participants stated they would have preferred if the therapy intervention lasted longer than 10 weeks, whilst the remaining participants were satisfied with the duration of the intervention in its current form. Regardless of duration, receiving feedback, planning for after therapy and being kept up to date with study progress were highlighted as important by all participants.

Assessment sessions were described as quite long and challenging with participants describing the need to split the assessment sessions in two. Participants described the assessments as abstract and were unsure if the outcomes used captured the progress they made in therapy: ‘But I thought maybe the clinical assessment focused an awful lot on sort of abstract things like what we’d cover in circuits and that. And there were a few questions about mood and maybe sort of different activities I might do but I’m not sure that it fully captured the progress I had made. Maybe if there were more questions around how you feel around other people or you know how your interactions with other people have changed it might capture the progress a bit better’ (woman, aged 26).

It was also apparent from participant interviews that more detailed information about the intervention at the point of recruitment may be beneficial for participants. Also, further emphasis on the rationale for both therapy components and the bridge between the two components should be considered in future intervention delivery with some ambivalence described: ‘Maybe if there was a better link between circuits and the cognitive behavioural therapy if I could see more of a connection between the two... well I mean it made sense that they were together. Like kind of the goal to recover from psychosis and cognition is a big part of that and CBT is a big part of that too so I presume yeah they did kind of. They were very different but they did work for what they did. Yeah they worked’ (man, aged 27).
DISCUSSION

In summary, this qualitative study indicated that the specific intervention assessed was broadly acceptable to those who took part in the study. More generally, the acceptability model developed as part of the data analysis has the potential for transferability to other therapies in this cohort. The participants with psychosis interviewed here particularly described goal setting, selection of strategies that may be applied to everyday life, and the concept of ‘thinking about thinking’ or metacognition as core elements of the combined intervention they found helpful and engaging. It was especially important that these core elements were tailored to the young person in the context of their individual recovery. From a clinical perspective, this can also be considered in the context of a clinical staging model (McGorry et al., 2007), highlighting the significance of when, and to whom this type of intervention is offered.

The foundation upon which the intervention sits is the therapeutic relationship and a sense of being seen, heard, involved, and valued in the therapy process, allowed for a multi-directional flow of knowledge between the young person and the therapist. The importance of the presence of an active and trained therapist has previously been identified as a core element of CRT (Bowie et al., 2020), demonstrating a positive impact on cognitive outcomes, but not on a proxy of acceptability namely drop-out rates (Vita et al., 2021; Vita et al., 2022). The importance of the therapeutic relationship in the combined therapy intervention was highlighted by the people in this study.

A limitation of this study is that the research team were unable to recruit any participants who left the trial early. Three participants left the trial before session five, when social recovery therapy begins. Feedback from these participants at the point of leaving the study was that they felt not ready for ‘this type of therapy’; this feedback reflected the theme of the individual pathway to recovery and individual timing of when an intervention such as this is appropriate for and acceptable to a young person. It also emphasizes the feedback from participants to strengthen the ‘bridge’ between the two therapy components. Some found it difficult to make the connection between CIR-CuTS and their social recovery, without the extrinsic support from the therapist. This is an important consideration for future therapy delivery. The drop-out rate will be considered as a proxy of acceptability along with the findings of this qualitative study in the overall feasibility trial.

Participants emphasized a preference for in-person therapy sessions, specifically located in the community, outside conventional clinic settings. They describe this as important in promoting active engagement with the intervention. Feedback on mode of delivery of the intervention will be integrated with other feasibility considerations for implementation of the intervention in the future.

Sample size for this qualitative study, embedded in the context of a randomized pilot study, is congruent with a reflexive thematic analysis approach with data viewed through a lens of richness rather than saturation (Braun & Clarke, 2019) Vasileiou et al. (2018) caution against decontextualised sample size numerical guidelines in qualitative research but rather emphasize the context of the individual study itself. We highlight the proximity of the participants to the CReSt-R intervention and the richness of their described experiences in providing invaluable insights to the acceptability and feasibility of the intervention.

This qualitative study provides important data for further developing the CReSt-R intervention. Acceptability themes described by participants in this study are a solid therapeutic foundation; knowledge exchange between the young person and therapist; consideration of the timing of this intervention for a young person in their recovery process; and the importance of active, autonomous therapy ‘tools’ to promote individual engagement and recovery. Pragmatic feedback also highlights the importance of reviewing the setting and duration of the therapy intervention and assessment sessions in a future definitive trial. Development of public patient involvement (PPI) in the design, delivery, analysis and dissemination of future qualitative studies of the intervention is also highlighted as a priority by the authors.

Early intervention in psychosis (EIP) is recognized as providing multicomponent, targeted interventions that benefit individuals living with psychosis in terms of remission, recovery, and functional trajectory (Cornell et al., 2018; Hodgekins et al., 2015; Kane et al., 2016). Current clinical guidelines focus on the provision of pharmacological intervention in conjunction with several specific psychosocial interventions (namely, cognitive behavioural therapy for psychosis (CBTp), family-based interventions and supported employment) (National Institute for Health and Care Excellence (NICE), 2014 , 2015). Despite this, however, impairment in cognitive performance persists, is not effectively targeted by current interventions, and continue to have a significant impact on function and the rate of disability in those living with psychosis (Cowman et al., 2021; Fett et al., 2011; Horan & Green, 2019). Given the evidence that cognition and particularly social cognition may be relevant to improving social function, it is possible that better managing cognitive difficulties as part of psychosocial trials may result in improved effectiveness of psychosocial therapies.

For example, CBTp seeks to target dysfunctional beliefs by identifying and examining the evidence for and against those beliefs and replace faulty beliefs with more adaptive beliefs. Doing so is highly cognitively demanding, particularly when evidence gathering, and testing depends on social cognitive processes (e.g., attributing meaning to social interactions). Meeting the demands of a cognitively challenging intervention like CBTp has the potential to be greatly facilitated by also targeting cognitive function either alongside or as a prequel to targeting clinical symptoms. The potential benefit of doing so would be to increase patients’ abilities to engage in psychosocial intervention in the context of a multicomponent early intervention service. The CReSt-R study, in a feasibility phase, does not yet report on the efficacy of the intervention. This study however, reports from an acceptability perspective, an intervention that is described as not only acceptable but engaging, helpful and person-centred, and continues to suggest that it may have a potential role in a multicomponent therapy model in EIP.
ACKNOWLEDGEMENTS
The authors would like to acknowledge the contribution of all public and patient involvement contributors to the CRESt-R study to date including patients, clinicians, and the Youlead Youth Advisory Panel (YAP). Thank you to the participants who took part in this qualitative study- we appreciate you. We are grateful to the CIRCuits and SRT program developers and to the funders of this study. Open access funding provided by IReL.

FUNDING INFORMATION
This work was funded by the Irish Health Research Board as part of the collaborative doctoral award in Youth Mental Health [YOULEAD] (HRB grant number: CDA-2018-001).

DATA AVAILABILITY STATEMENT
Data sharing is not applicable to this article as no new data were created or analyzed in this study.

TRIAL REGISTRATION
Cognitive Remediation & Social Recovery in Early Psychosis (CRESt-R); ClinicalTrials.gov Identifier NCT04273685. Trial registered Feb 18th, 2020. Last updated October 28th, 2022.

ORCID
Emma Frawley https://orcid.org/0000-0002-1709-2429
Caroline Heary https://orcid.org/0000-0001-8732-0856
Clio Berry https://orcid.org/0000-0003-1164-9836
Matteo Cella https://orcid.org/0000-0002-5701-0336
David Fowler https://orcid.org/0000-0001-5806-2659
Til Wykes https://orcid.org/0000-0002-5881-8003
Gary Donohoe https://orcid.org/0000-0003-3037-7426

REFERENCES
Green, M. (2016). Impact of cognitive and social cognitive impairment on functional outcomes in patients with schizophrenia. The Journal of Clinical Psychology, 72(Suppl 2), 8–11. https://doi.org/10.1008/jcp.14074s1c0.02


SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.