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Intensive Home Treatment in Mental Health: A Qualitative Exploration of Carers' Experiences

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ABSTRACT

Intensive Home Treatment for acute mental health crises has expanded internationally as a community-based alternative to inpatient admission. Despite its growing use, little is known about how informal carers experience supporting a relative during acute psychiatric decompensation at home—an emotionally demanding context marked by intensified responsibility and disruption of daily life. The aim of this study is to explore the lived experiences of informal caregivers providing support to a family member admitted to mental health Intensive Home Treatment using a reflexive thematic analysis within a constructivist orientation. The study adhered to the COREQ guidelines for qualitative research reporting. Data were collected using individual semi-structured interviews ($n = 30$) and one focus group ($n = 8$). The Stress Process Model informed the interview guide and acted as a sensitising lens; however, coding and theme development remained inductive. Three overarching themes and seven sub-themes captured the caregiving experience. Carers reported substantial physical, emotional, occupational and social consequences, including exhaustion, anxiety and marked disruption of daily routines. Their experiences combined distress with positive meaning making: strengthened bonds, feelings of usefulness and increased closeness coexisted with uncertainty, fear of relapse and difficulty managing unpredictable behaviours. Coping strategies included personal practices and external supports. All these findings suggest that caring during acute Intensive Home Treatment is meaningful yet highly demanding. Mental health professionals should systematically assess caregiver burden, support needs and coping resources, offering targeted interventions to enhance emotional well-being and sustain effective home-based psychiatric care.

1 | Introduction

Since the early 21st century, Intensive Home Treatment (IHT) teams have been established in many Western countries. These multidisciplinary teams provide intensive, short-term care in the home for individuals experiencing an acute mental health crisis. In Spain, such teams have been implemented unevenly across

the territory, with considerable variation over time (Megías del Rosal et al. 2004; Massa Domínguez 2017).

IHT teams are defined as a resource capable of delivering a range of hospital-level medical and nursing interventions in the patient's home during an acute psychopathological decompensation. They have proven to be a viable and cost-effective

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alternative to conventional psychiatric hospitalisation (Johnson et al. 2005; Stulz et al. 2020; Martín-Blanco et al. 2022). At the same time, they are considered community-based services, as they promote the provision of care within the community itself, reintegration into the community and continuity of care within the mental health network.

These IHT teams serve a dual purpose: to provide an alternative to inpatient admission and to facilitate early discharge for inpatients in partial remission. For this reason, IHT interventions are brief (with an average duration of around 1 month) but intensive, involving daily home visits and frequent contact with family members. The inclusion of relatives and other informal caregivers as partners in the care process is a core component of this model, but also a potential source of emotional strain and burden that remains understudied.

2 | Background

An informal caregiver is defined as a person who provides unpaid care and attention to an individual with health problems, usually a close family member. While caregiving for a person with a severe mental illness can bring personal meaning and a sense of fulfilment (Bauer et al. 2012), it is often accompanied by significant burden (Fadden et al. 1987).

Since the mid-20th century, following the shift towards community-based psychiatric care, researchers have observed that many informal caregivers experience high levels of strain and psychological distress, with up to 60% reporting severe burden (Grad and Sainsbury 1963). This burden may manifest as emotional exhaustion, anxiety, depressive symptoms and impaired overall wellbeing (Shah et al. 2010).

Early theoretical and empirical work distinguished between objective and subjective burden (Hoenig and Hamilton 1966; Schene 1990; Reine et al. 2003). Objective burden refers to the observable disruptions in family life, work, or social activities caused by the patient's symptoms and behaviours, whereas subjective burden encompasses the caregiver's emotional and psychological reactions to these demands, including stress, guilt, or hopelessness.

However, most caregiver burden studies and measurement instruments were designed for those supporting individuals in stable or subacute phases of illness (Crespo and Rivas 2015) and without a genuine and meaningful input from carers themselves (Cham et al. 2022). With the expansion of IHT, families increasingly assume the caregiving role during acute psychiatric crises, a situation that is potentially more disruptive and emotionally taxing. Evidence suggests that caregiver overload is one of the leading causes of transfer from IHT to inpatient psychiatric care (Martín-Blanco et al. 2024), a finding consistent with previous UK experiences (Morant et al. 2017). Moreover, several studies have highlighted that the crisis phase of illness is strongly associated with higher levels of caregiver burden (Awad and Voruganti 2008; Pompili et al. 2014; Souza et al. 2017).

To conceptualise this complex experience, the present study is grounded in the Stress Process Model (SPM) proposed by Pearlin

et al. (1990), one of the most influential frameworks for understanding caregiver burden. This model conceptualises caregiving stress as a dynamic process influenced by multiple domains (Awad and Voruganti 2008): background and context (sociodemographic characteristics, relationship with the care recipient and social environment) (Bauer et al. 2012); primary stressors, directly linked to the patient's symptoms, behavioural problems, or care needs (Bauer et al. 2013); secondary stressors, which arise from the spillover of caregiving demands into other areas of life such as work, finances, or social relationships (Brennan et al. 2016); mediators, including coping strategies, social support and a sense of mastery; and (Cham et al. 2022) outcomes, such as psychological distress, perceived burden, or quality of life. The SPM has recently been revisited and expanded to incorporate new realities of caregiving, such as the intensity of care, employment demands and the possibility of positive outcomes like resilience or growth (Han 2023; Park et al. 2024). These updates emphasise that caregiving experiences are multifaceted and shaped by broader contextual factors.

Within the context of IHT, this model provides a useful conceptual tool to interpret caregivers' experiences during acute mental health crises. The acute phase of illness amplifies primary stressors (such as severe symptoms and behavioural changes) and secondary stressors (such as disruption of daily life), while simultaneously testing the effectiveness of available mediators. Exploring caregivers' narratives through this lens allows for a deeper understanding of how they interpret and manage the psychological demands of home-based acute care. Therefore, the aim of this study is to explore the lived experience of being an informal caregiver for a person undergoing an acute psychiatric episode and receiving IHT, using a qualitative approach.

3 | Methods

A multicentre qualitative study using reflexive thematic analysis within a constructivist orientation was conducted to explore informal carers' experiences. Data were generated through individual semi-structured interviews and one focus group and analysed to develop themes reflecting shared patterns of meaning.

Four IHT teams located in the metropolitan region of Barcelona (Catalonia, Spain), each serving areas with distinct sociodemographic characteristics (these differences included variations in socioeconomic status, urban density and access to mental health services, which were considered relevant to capture a range of caregiving experiences), participated in the study: CPB Serveis de Salut Mental—Hospital de la Santa Creu i Sant Pau, Parc Salut Mar, Fundació Sanitària Mollet and Corporació Sanitària Parc Taulí.

3.1 | Setting and Participants

The study population consisted of informal caregivers of patients experiencing an acute episode who received care in one of the participating IHT teams between January and December 2023. A convenience sampling strategy was employed to recruit participants and data collection continued until sufficient depth, richness and diversity of accounts had

been achieved to address the research aim. Inclusion criteria required that participants were informal caregivers, able to understand Spanish and willing to provide written informed consent. No additional exclusion criteria were applied. Focus group participants were different from those who took part in the individual interviews.

3.2 | Data Collection and Ethical Considerations

The study received approval from the ethics and clinical research committees of the hospitals or health centres to which each IHT team is linked. All participants received the same participant information sheet and signed the same informed consent form, both approved by the clinical research committees. The document explicitly stated that participants could be invited either to an individual interview or to a focus group. However, although general confidentiality information was provided, the limits of anonymity inherent to focus group participation were not explicitly differentiated in the participant information sheet. This limitation is acknowledged here, as anonymity cannot be fully guaranteed in focus group settings, as participants are known to each other.

Interviews and the focus group were conducted during the mid-to-late phase of the IHT admission (approximately weeks 2–4), once acute symptoms had improved. Participant selection was conducted by a designated researcher at each IHT team. As part of standard clinical procedures, clinical staff identify the patient's primary informal caregiver at the start of the admission. Drawing on this routinely collected information, the site researcher consulted the clinical teams to determine whether any identified caregivers met the study's inclusion criteria and whether they agreed to be contacted by the researcher. Service users were present when the clinical team introduced the possibility of their caregiver being contacted and none expressed any objections. Eligible caregivers were then approached by the researcher and invited to participate. A total of 30 informal caregivers took part in the individual interviews and the focus group included 8 participants. No one else was present during the interviews apart from the participant and the researcher. No participant declined to take part.

Given the acute crisis context, interviewers monitored distress, paused interviews if needed and offered referral to the IHT team for support. Carers could stop their participation at any point without consequences. During the focus group, particular attention was paid to the potential emergence of emotional distress given the group-based nature of the discussion. The moderator, an experienced mental health professional, actively monitored participants' verbal and non-verbal cues and ensured a supportive and respectful environment. Participants were reminded at the beginning of the session that they could refrain from answering any question or withdraw at any time without consequences. In cases of visible distress, the discussion was paused and the participant was offered the opportunity to take a break or discontinue participation. After the focus group, all participants were offered the possibility of individual follow-up contact with the research team and, if needed, referral to the corresponding IHT team for additional support.

3.3 | Research Instruments

A brief sociodemographic questionnaire was used to collect demographic information from participants. Qualitative data were gathered through semi-structured, face-to-face interviews based on a topic guide developed collaboratively by the research team. The Stress Process Model was used as a sensitising framework to inform the development of the topic guide, allowing the research team to explore domains previously identified as relevant in caregiving research (e.g., stressors, mediators and outcomes), while maintaining openness to participants' own meanings and experiences. All interviews were audio-recorded and transcribed verbatim and had a mean duration of 23 min.

To complement and contrast the interview data, a focus group was conducted after preliminary analysis of the interviews, with the aim of exploring, refining and deepening emerging themes through group interaction. The focus group was conducted using a structured discussion guide aligned with the main interview topics. The session, held online due to participants being located across different cities, was audio-recorded, transcribed and lasted approximately 70 min.

3.4 | Data Analysis

Reflexive thematic analysis was conducted following Braun and Clarke's (2006) six-phase framework. Two female researchers independently completed the first five phases—familiarisation, coding, initial theme generation, theme review and refinement—and subsequently met to compare and consolidate their analyses. A qualitative male research specialist contributed to the final refinement of themes.

Although the SPM informed the development of the interview guide and was used as a sensitising framework during interpretation, coding and theme construction were carried out inductively. A deductive application of the model was intentionally not pursued in order to avoid constraining the emergence of novel or context-specific meanings related to caregiving during IHT. Data management and coding were performed using ATLAS.ti v.25.01. A total of 186 codes were generated across the dataset, from which three overarching themes and seven sub-themes were developed (see Table 1). Participant quotations used in reporting the findings are identified only by participant number to preserve confidentiality.

TABLE 1 | Themes and sub-themes of carer's experience during Intensive Home Treatment (IHT).

Themes	Sub-themes
Repercussions of caregiving	About health
	About daily routines
	About the family
Lived experiences of caregiving	General aspects
	Caregiver reactions
Coping strategies for difficult situations	Own strategies
	External strategies

TABLE 2 | Sociodemographic data of the interview participants ($n = 30$).

	Mean	Range	<i>n</i>	%
IHT team				
CPB-Hospital de la Santa Creu i Sant Pau			17	56.6%
Parc Salut Mar			5	16.6%
Fundació Sanitària Mollet			8	26.6%
Age (years)	59.39	22–87		
Sex (female)			13	43.3%
Caregiving (years)	10.2	0–38		
Acute episode length (weeks)	15.66	3–52		
Relationship				
Father, mother			12	40.0%
Brother, sister			4	13.3%
Son, daughter			3	10.0%
Couple			10	33.3%
Friend			1	3.3%
Highest educational level				
Middle school			8	26.7%
High school			9	30.0%
University or postgraduate degree			13	43.3%
Work status				
Employee			14	46.7%
Retired			2	6.67%
Pensioner			11	36.7%
Unemployed			3	10.0%
Cohabiting during IHT				
Yes			26	86.7%
Only during this episode			1	3.3%
Relative's main diagnosis				
Depressive disorder			15	50.0%
Psychotic disorder			11	36.7%
Manic episode			2	6.67%
Anxiety disorder			1	3.3%
Borderline personality disorder			1	3.3%

Focus group data were analysed using the same reflexive thematic approach and software. Analysis considered both individual contributions and group dynamics, including areas of convergence, divergence and collective meaning-making. While the focus group did not generate additional themes, it enriched the interpretation of the data and contributed to the refinement and validation of the thematic framework derived from the interview data.

Descriptive statistics were used to summarise the sociodemographic characteristics of the sample.

3.5 | Trustworthiness and Rigour

To ensure methodological rigour, the study adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (Tong et al. 2007) and followed an explicitly reflexive, interpretive stance throughout the research process. All interviews were conducted by mental health professionals working in IHT, with experience in acute and community care but without direct involvement in the participants' relatives' treatment teams, thereby minimising role-related influence. Researchers maintained reflexive journals to document assumptions related to caregiving and crisis contexts and regularly discussed these preconceptions to examine their potential impact on data interpretation. An audit trail—including coding memos, evolving theme-development documents and records of analytical decisions—was maintained to enhance transparency and dependability.

Credibility was strengthened through systematic peer debriefing at key analytic stages and through triangulation of data sources. The focus group was used to triangulate themes emerging from the individual interviews, providing complementary insights and enhancing the robustness of the final thematic structure. Divergences in interpretation were resolved through consensus-based analytic meetings, ensuring coherence across the dataset and supporting the overall trustworthiness of the findings.

4 | Results

Sociodemographic characteristics of the two samples (individual interviews and focus group) are shown in Tables 2 and 3. The following results offer an overview of the construct of the caregiving experience during IHT, along with the various elements that shape and influence it.

4.1 | Theme 1: Repercussions of Caregiving

This theme explores the impact on health and life of providing care to a person undergoing an acute episode while receiving treatment at home. Three key dimensions were particularly affected during the IHT: health, daily routines and family life, corresponding to the sub-themes outlined in Table 1.

TABLE 3 | Sociodemographic data of the focus group participants (*n* = 8).

	Mean	Range	<i>n</i>	%
IHT team				
CPB-Hospital de la Santa Creu i Sant Pau			3	37.5%
Parc Salut Mar			2	25.0%
Fundació Sanitària Mollet			2	25.0%
Parc Taulí			1	12.5%
Age (years)	54.62	30–80		
Sex (female)			5	62.5%
Relationship				
Father, mother			4	50.0%
Brother, sister			1	12.5%
Couple			3	37.5%
Highest educational level				
High school			2	25.0%
University or postgraduate degree			6	75.0%
Work status				
Employee			6	75.0%
Retired			1	12.5%
Unemployed			1	12.5%
Cohabiting during IHT				
Yes			8	100.0%
Relative's main diagnosis				
Depressive disorder			2	25.0%
Psychotic disorder			3	37.5%
Manic episode			3	37.5%

4.1.1 | About Health

Numerous caregivers reported experiencing negative effects on their physical and/or mental health. With regard to physical health, exhaustion and fatigue were the most frequently cited issues across participants' narratives.

Yes, I think so, in the sense that I feel much more tired. Before, I could handle everything better and didn't feel this level of exhaustion (...) now I feel really, really tired. Very much so. And I struggle

with the day-to-day, just getting up in the morning is hard. (p. 17)

Several caregivers also expressed concern about the potential development of somatic illnesses or the exacerbation of pre-existing conditions because of the physical and emotional strain associated with caregiving.

There were nights... during the acute phase of their psychosis when I felt something in my heart, like movements and I thought it might have some effect on me, you know? And then I also thought that maybe, in the long run, being so, so worried could lead to something like cancer or something like that—I've thought about that too. (p. 10)

Regarding mental health, the most frequently reported symptoms across interviews were anxiety and nervousness, sadness, sleep disturbances, irritability, apathy and difficulty concentrating.

I had this feeling of being overwhelmed, like struggling to take a deep breath. There was definitely a sense of nervousness, you know? About how everything would go, emotionally. You really feel like everything depends on you and there's that nervous feeling in your stomach—like when you're young and have an exam, that kind of thing. (p. 1)

4.1.2 | About Daily Routines

Of the thirty participants interviewed, all but three reported that their daily routines had been disrupted because of their relative's IHT. A reduction in social life emerged as the most frequently discussed and prominent impact across participants' accounts.

Yes, I completely adapted to him. I totally adjusted my free time—I was at home with him almost all the time when he was in bed (...). So yes, it really disrupted my private life because I stopped going out, I stopped doing the things that made me feel good. (p. 10)

Nevertheless, daily routines were reported to be affected across various domains, including the loss of leisure activities, an increase in domestic responsibilities and significant workplace impacts—such as shift changes, absences from work, job resignation, or abandoning the search for employment. Economic repercussions were also noted because of these changes.

Yes, it does affect you because, well, there are days when she's worse and you have to call work to say

you won't be going in or something like that. In terms of free time, of course—whether you like it or not—you're thinking about her health, so sometimes you're about to do something and then maybe you don't... because you don't want her to worry. Or just to stay at home with her.

(p. 14)

4.1.3 | About Family

Finally, the repercussions on the wider family were also highlighted, particularly in relation to shifting roles among family members and the potential impact on the care of others. Several caregivers reported having less time to attend to other dependents or partially dependent relatives—such as elderly parents or young children—due to the demands of IHT. As a result, they were often required to delegate these responsibilities to others.

Yes, the role of son now has more of a caregiver side to it—like saying, 'Dad, clear the table', or helping him with all the things he used to do but doesn't anymore. So now he's telling him, 'Dad, sit up straight, mind your posture, don't get so close to the plate'. He's taken on the role of carer and adult—and in this case, he's just a teenager.

(p. 2)

4.2 | Theme 2: Lived Experiences of Caregiving

This theme reflects caregivers' perceptions and the meanings they attribute to the act of caring for a relative undergoing IHT. It encompasses both the positive and negative dimensions of caregiving, as well as the role that mental health stigma may play in shaping the caregiver's experience and engagement.

4.2.1 | General Aspects

A recurring theme among participants was the strain related to the level of time and attention required. Many caregivers identified 'dedication' as one of the most burdensome aspects—referring to the need to allocate significantly more hours to supporting their relative, with some explicitly describing the experience as one of 'total dedication'.

Well, it's the feeling that I'm on 24 h a day, you know? (...) On alert, 24 h on alert. Constantly watching for any change, whether the medication is working... a bit like being on call, as if we were on call 24/7.

(p. 29)

Despite the challenges described, most carers identified positive aspects in their caregiving experience—particularly in relation to the quality of the relationship with their relative. Many reported that the act of caring had strengthened their emotional bond and brought them closer together. Furthermore,

notwithstanding the difficulties and personal repercussions outlined above, a significant number of carers expressed a sense of fulfilment and purpose, stating that caregiving made them feel useful and valued.

The relationship changes. It becomes much closer with the patient—who in this case is my partner—the bond is much stronger. Because you feel that this person depends on you, a kind of positive dependence. It's not something that overwhelms me—the bond has grown.

(p. 1)

Of the 30 family members interviewed, only nine reported having concealed their relative's mental health condition due to the stigma associated with mental illness. In some cases, this concealment occurred solely because the relative had explicitly requested it.

No, because I don't think depression—or anything like that—is something to hide these days. Why should I hide the fact that my husband is ill? It's depression. I'd actually like it to be seen more.

(p. 3)

4.2.2 | Caregiver Reactions

When examining carers' emotional responses, many expressed feelings of pity regarding their relative's illness, identifying the need to witness their loved one's suffering as one of the most distressing aspects of the caregiving experience. Some caregivers reported experiencing fear or apprehension about how the patient might react when receiving instructions or suggestions, particularly during moments of heightened vulnerability and as a result, were unsure how to respond and even questioned whether their actions were appropriate.

I'm afraid to ask him for anything because I know he'll get angry, but if I don't ask... well, things about living together just get worse.

(p. 6)

On the other hand, they share a sense of uncertainty about what the future holds for their family members, whether they will be able to make a full recovery after the episode or whether there will be future relapses.

Negative aspects include the fear of not understanding what's happening, the uncertainty, facing something you just don't get... Not knowing how things will evolve or whether she'll fully recover. And that feeling of worry or even anger because you don't know why it's happening. At first, you just can't make sense of it—what happened to get to this point? Is it something you did? Is it your fault, or did something happen that...?

(p. 28)

4.3 | Theme 3: Coping Strategies for Difficult Situations

This theme refers to the strategies employed by caregivers to manage the demands of supporting a person undergoing an acute decompensation during IHT. These coping mechanisms may be internal—such as attitudes, behaviours, or personal actions—or external, involving help-seeking behaviours directed towards professionals or informal support networks.

4.3.1 | Own Strategies

The most frequently reported internal strategies among participants included meeting up with friends and going for walks. Several caregivers also mentioned using breathing techniques or meditation to alleviate anxiety. Physical exercise and leisure activities—such as listening to music, cooking, or watching television—were likewise cited as useful approaches for managing emotionally challenging situations.

In addition, many of the caregivers chose not to address certain issues that they knew could affect their family member as a method of preventing uncomfortable or conflictive situations, always trying to show a positive and caring attitude towards their family member. In particular, one participant reported increasing alcohol consumption as a method to cope with the challenges and/or the burden of his relative's IHT.

What I do is call my circle of friends and I also try to go out for half an hour or an hour every day for a walk. Sometimes I go to watch my team's football match and have a beer. I usually do it in the evenings when she is at her best. I started to do it after she got a bit better.

(p. 28)

4.3.2 | External Strategies

On the other hand, two relatives mentioned that it helped them a lot to go to a group of relatives of people with a mental illness and other carers referred that it would be a strategy that could be good for them although they had never tried it. Asking for professional help to manage distress is an option that many carers contemplate, but very few do. The support offered by the professionals who cared for their relative during the home admission was very useful for them to deal with the distress, although many participants verbalised that they would have liked to have had an individual space alone with the professionals to express their doubts and discomfort.

For me in particular it was very good to talk in a group, because it helps to hear what is happening to others and to know that you are not the only one.

(p. 26)

5 | Discussion

Previous literature has consistently highlighted, through systematic reviews, the significant impact that caring for a relative with mental illness has on the lives of informal carers (Phillips et al. 2021), as well as the levels of burden they experience (Cham et al. 2022), most often quantified using standardised measures such as the Zarit Burden Interview (Zarit et al. 1980). This instrument has also been used in studies examining carer burden within IHT (León-Caballero et al. 2022). While these tools provide valuable insights into the magnitude of carer strain, they may not fully capture the specificity and complexity of caring during an acute mental health episode in the home context—a situation characterised by short, intense periods of heightened responsibility and emotional demand compared with everyday care.

This study represents the first qualitative exploration of how carers experience this process since the implementation of IHT. By attending to the meanings and lived experiences articulated by participants, our findings reveal the profound emotional and practical impact of supporting a loved one through an acute psychiatric episode, while also illuminating the diverse strategies families employ to navigate these challenges.

Within the theme 'Repercussions of care', participants described experiences that resonate with the classic conceptualisation of objective and subjective burden (Hoenig and Hamilton 1966; Schene 1990). Objectively, carers reported a substantial reduction in time for self-care, leisure, or employment, as their daily routines became centred around supervision and emotional support. Subjectively, they spoke of exhaustion, anxiety and physical strain, which tended to intensify during acute episodes and diminish in more stable phases. These accounts underscore the dynamic nature of burden, suggesting it fluctuates in parallel with the relative's clinical condition.

Many of these experiences mirror those described in previous research involving carers of people with mental disorders in stable phases (Awad and Voruganti 2008; Ogilvie et al. 2005; Silaule et al. 2024) and during conventional hospitalisation (Mokwena and Ngoveni 2020). This continuity suggests that caring is not confined to discrete moments of crisis or stability but rather unfolds as an ongoing process in which boundaries between phases become blurred. Future quantitative studies could further examine whether the intensity of burden indeed peaks during IHT, which might help tailor support interventions to carers' specific needs in these contexts.

In relation to 'Lived Experiences of Caregiving', our findings indicate that the emotional and practical impact of acute symptoms affects carers regardless of their relative's diagnosis, echoing the conclusions of Hadryś et al. (2011). What appeared most distressing for family members was not the specific symptom, but the suffering it provoked in their loved one. Communication difficulties and challenges in managing unpredictable or tense situations—particularly those marked by uncertainty about how the relative might react—were commonly described, consistent with prior reports (Sharif et al. 2020; Mokwena and

Ngoveni 2020; Brennan et al. 2016). Bauer et al. (2012) similarly found that all carers in their sample reported communication-related conflicts, highlighting this as a central dimension of the caring experience.

Yet, a particularly striking aspect of our findings concerns the positive dimensions of caring. Several participants reflected that sharing moments of vulnerability had deepened their emotional connection and fostered greater empathy and closeness. These experiences align with Bauer et al. (2013), who reported that over half of carers perceived their relationship as strengthened through caring. Positive emotions—such as gratitude, fulfilment and a sense of usefulness—have been consistently documented across different contexts (Hinrichsen et al. 1992; Veltman et al. 2002; Cohen et al. 2002). Our findings extend this literature by suggesting that such positive experiences may persist regardless of the clinical stage, coexisting with strain and burden in complex and dynamic ways.

Interpreting our findings through the lens of the SPM helps to situate carers' experiences within a broader theoretical framework. Acute IHT appears to intensify primary stressors (e.g., symptom severity and behavioural unpredictability) and secondary stressors (e.g., disruption of work and family roles), while simultaneously placing considerable demands on mediating resources such as coping strategies and social support. Consistent with recent extensions of the model (Han 2023; Park et al. 2024), our findings also highlight the coexistence of burden and positive meaning-making, suggesting that caregiving during acute crises is not solely detrimental but involves complex and dynamic processes.

Our findings within the 'coping strategies' theme align closely with Lazarus and Folkman's (1984) transactional model of stress and coping. Consistent with this framework, most strategies identified were emotion-focused, which is theoretically congruent with the acute and largely uncontrollable context experienced by caregivers during IHT. Furthermore, participants' descriptions paralleled several dimensions captured within the Ways of Coping (WOC) instrument (Folkman and Lazarus 1985), including distancing, self-controlling, escape-avoidance and seeking social support.

While some of the strategies identified overlap with those reported in earlier research (Speirs et al. 2023; Bauer et al. 2012; Kartalova-O'Doherty and Doherty 2008), none of the carers in our study mentioned religion as a resource—a divergence from findings in other cultural contexts (Sharif et al. 2020; Kartalova-O'Doherty and Doherty 2008; Silaule et al. 2024). This absence may reflect broader socio-cultural trends in Spain, where religious practice has declined in recent decades (Gil-Gimeno and Asua 2025), as well as the particular composition of our sample. Although participants were recruited from socio-demographically diverse settings, the absence of detailed variables such as ethnicity limits the extent to which sample diversity can be fully characterised. This limits a more comprehensive understanding of how cultural or religious backgrounds may shape coping strategies. It is also possible that the clinical interview setting influenced participants' responses, prompting them to emphasise psychological rather than spiritual coping mechanisms. Future studies should incorporate

more comprehensive sociodemographic data, adopt recruitment strategies that enhance the inclusion of underrepresented groups and explore how personal beliefs and spirituality shape coping during home-based psychiatric care, particularly in more diverse and representative samples.

Previous studies have shown that carer-focused interventions can reduce burden and related psychological distress (Gutiérrez-Maldonado and Caqueo-Urizar 2007; Hansen et al. 2022; Yesufu-Udechuku et al. 2015). An important implication emerging from our findings is the need to create dedicated spaces for carers within IHT interventions. Participants expressed a clear need for opportunities to communicate with professionals independently of the service user, suggesting that carer-focused time should be systematically incorporated into IHT teams. Such spaces may facilitate emotional expression, improve understanding of the illness and enhance carers' capacity to manage complex situations.

5.1 | Strengths and Limitations of the Study

This study represents the first in-depth exploration of the experience of caregiving for a person undergoing an acute exacerbation of mental illness during IHT. Achieving theoretical saturation and the use of multiple analytic perspectives constitute key strengths of the study, supporting the credibility of the findings. As detailed in the Trustworthiness and Rigour section, independent coding and comparative analytic discussions contributed to a robust interpretative process. However, despite emphasising the specific period of interest during the interviews, some participants may have found it difficult to focus exclusively on the IHT period and their accounts may have been influenced by the broader trajectory of their relative's illness. Ethnicity was not systematically collected, which limits the ability to explore how cultural background may shape caregiving experiences.

6 | Conclusion

Being the primary carer for a relative experiencing an acute decompensation of mental illness within the context of IHT involves a set of experiences that carers often describe as highly meaningful. Many perceive that the process strengthens their relationship with their family member and fosters a sense of usefulness and gratification. However, it also entails challenges and negative consequences that may affect carers' physical and emotional health, influence the course of the treatment episode and even generate reluctance towards future IHT interventions.

Based on the findings of this study—the first to qualitatively explore carers' experiences within psychiatric IHT—it is crucial to ensure that carers are provided with adequate resources and professional support to develop effective coping strategies, manage the demands of home-based care and mitigate potential negative consequences. To enable standardised assessment of carers' experience of IHT and facilitate timely intervention, we plan to pursue the development of a specific questionnaire designed to evaluate carers' experiences during mental health IHT episodes, drawing directly on the insights generated by this research.

The findings of this study underline the importance of providing targeted support to carers during mental health IHT. Healthcare professionals should systematically assess the repercussions and lived experiences of caregiving, as well as the coping strategies employed, to identify needs early and deliver appropriate interventions that promote carers' well-being and sustain the effectiveness of home-based psychiatric care.

Author Contributions

Alba González-Fernández: conceptualization, methodology, formal analysis, investigation, resources, data curation, writing – original draft. Ana Martín-Blanco: conceptualization, methodology, formal analysis, investigation, resources, data curation, writing – review and editing, supervision. Francesc Casanovas, Alba Luque Tintó and Denise Cid Matamoras: investigation, resources. Joan Trujols and Maria J Portella: methodology, writing – review and editing, supervision. David Giménez-Díez: investigation, methodology, formal analysis, writing – review and editing, supervision.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Due to the sensitive and identifiable nature of the qualitative data, interview and focus group transcripts cannot be shared publicly. Data are available from the corresponding author upon reasonable request and subject to institutional ethical approval.

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