The lifeline in narrative exposure therapy: the experience of therapists

Jayde M. Dix

D.Clin.Psy Thesis (Volume 1) 2021
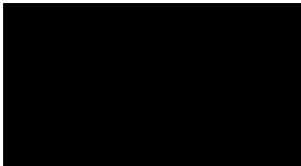
University College London

UCL Doctorate in Clinical Psychology

Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:

Name: Jayde Dix

Date: 31st May 2021

Overview

Psychological interventions for PTSD and complex PTSD can be effective in reducing distress and improving wellbeing. The majority of the evidence base is quantitative in nature, meaning relatively little is known about clinician and service user views on the benefits and challenges of these interventions. This thesis uses qualitative methods to explore several questions about the experience of trauma-focussed therapies.

Part 1 is a thematic synthesis. Twenty-one qualitative studies which explored the service user experience of evidence-based trauma therapies were reviewed and synthesised. The findings suggest that these interventions can be very beneficial, but can also be distressing and difficult. The findings also suggest a range of factors which may support initial and continued engagement with the therapies.

Part 2 is a qualitative study exploring the therapist experience of the lifeline component of narrative exposure therapy (NET). In NET, a lifeline is constructed using physical materials to depict the chronology of a person's life. Sixteen therapists were interviewed about their experience of this component of NET and their responses were analysed using thematic analysis. The findings suggest that the lifeline is a valued part of the therapy, and a range of suggested functions, challenges, and processes therapists felt were associated with the lifeline are detailed.

Part 3 of this thesis is a critical appraisal of the process of the research. Through the chronology of the project from proposal to submission, a range of issues are reflected on, including the challenges of conducting research in clinical settings and the experience of adapting to qualitative methodology.

Impact statement

Despite a growing literature in the area, there has not to date been a synthesis of research exploring the service user experience of trauma-focussed interventions. The findings of Part 1, therefore, add usefully to the evidence base as well as highlighting valuable areas for clinicians and services to consider further. For example, the finding that a sense of safety and trust in the therapeutic relationship was vital to service users may prompt reflection on how to promote the development of these strong relationships, and how to facilitate enough time for this process in stretched services. Findings pertaining to the aspects of therapy most valued by service users should be held in mind alongside findings pertaining to the challenges of therapy and accounts of times it was not helpful. It is rare for clinicians to have access to such detailed feedback from service users, and thus this review can provide useful material for reflection and refinement of practice.

Researchers should take note of a key quality problem found across many of the studies: they did not intentionally recruit from people who dropped out of therapy. This is important to highlight, particularly in trauma-focussed interventions research where drop-out rates are high. A key message of Part 1 is that future research in the area must aim to recruit people who did not complete their course of therapy, or for whom it was not helpful.

The empirical paper is a qualitative account of how therapists experience the delivery of the lifeline in NET. The lifeline is a unique part of the therapy and has not received a great deal of research attention, and so this detailed account of the therapist experience is valuable for its richness and novelty. For clinicians, this study might be particularly useful in supporting training and supervision. For example, important points were raised about the cultural sensitivity of the lifeline, and a key message of Part 2 is that consideration of this must be integrated into ongoing training and supervision of new NET therapists. Many therapists spoke of the value of using physical materials in the therapy; something which is

relatively unusual in adult mental health. This finding might suggest that therapists working with people with PTSD could consider how they can utilise physical materials more creatively to support the therapeutic process.

A clear research aim from this study is to complete an analogous study exploring the service user experience of the lifeline. This would give the opportunity to explore similarities and differences in the accounts of service user and therapist, and would no doubt provide its own important implications for research and practice. From here, a detailed qualitative account of the lifeline could be developed, which would be of benefit to the NET literature and the NET community more broadly. More generally, this study shows the richness of information one can achieve using a qualitative methodology with therapists, and how research of this kind can produce detailed suggestions for clinical practice.

Table of Contents

Part 1: Literature Review

The service user experience of trauma-focussed interventions: a thematic synthesis of

the qualitative literature.

Abstract

Aim: This review systematically summarises and synthesises qualitative studies exploring the experience of service users receiving trauma-focussed interventions with a memory work component. The review aimed to draw on literature from a wide range of settings and populations.

Method: The studies included in this review were identified through a systematic search of the literature using PsycINFO, Web of Science, and Embase databases; this search resulted in 21 studies that met inclusion criteria. The 21 studies identified were rated for methodological quality using an adapted version of the Critical Appraisal Skills Programme checklist, and then analysed using a thematic synthesis approach. A sensitivity analysis was also conducted.

Results: The thematic synthesis resulted in four analytical themes pertaining to key areas identified across the studies. These findings firstly highlighted factors contributing to the successful initiation of, and continued engagement with trauma-focused interventions, which was often experiences as a deeply challenging process throughout. Secondly, the synthesis emphasised that safety in the therapeutic relationship is integral to the success of therapy. The analysis also indicated that therapy can be beneficial in many domains, but is not a complete 'cure', and that outcomes can be impacted or influenced by a range of extra-therapeutic factors.

Conclusion: This paper offers a detailed overview of core aspects of the experience of trauma-focused interventions. A number of potential clinical recommendations and areas for future qualitative study are identified.

Introduction

Since the first recognition of a common psychological response following traumatic experiences in the 1970s, there has been a vast amount of research investigating post-traumatic stress disorder (PTSD) and its treatments (van der Kolk, 2015). There are now decades of strong quantitative evidence that such trauma-focussed interventions can support the reduction of PTSD symptoms, and improve people's wellbeing (Bisson et al., 2007; Watts et al., 2013; Lewis, Roberts, Andrew, Starling & Bisson, 2020).

One of the key 'active ingredients' common across most modern trauma-focussed interventions is exposure to and/or processing of the trauma memories (Schnyder et al., 2015). The nature of this component varies across therapies, as do the precise theorised mechanisms of action that underpin it, but it is considered to be an important part of any evidence-based, trauma-focussed intervention (Schnyder et al., 2015). Intrusions in PTSD are proposed to reflect retrieval of decontextualised trauma memories, with detailed sensory-perceptual elements. This means they are easily triggered, experienced as happening 'here and now' with associated distressing emotions, and they are not updated with new information (Ehlers & Clark, 2000; Hackmann & Holmes, 2004; Brewin, Gregory, Lipton & Burgess, 2010). Exposure aims to ameliorate the intrusive symptoms of PTSD through activating the memory and processing it in a way that was not possible at the time of the trauma, as well as to give the opportunity to work with associated cognitions (Sripada, Rauch & Liberzon, 2016).

Being exposed to deeply distressing, and much avoided, memories is understandably a challenge for service users. Like much modern therapy, it conflicts with the natural human urge to avoid that which makes us anxious, uncomfortable, or afraid (Kashdan, Barrios, Forsyth & Steger, 2006). The same can apply to therapists, who report hesitancy and avoidance of exposure with service users with PTSD because of fear of symptom

exacerbation, suicidality, or drop-out (van Minnen, Henriks, & Olff, 2010; Becker, Zayfert & Anderson, 2004; Ruzek et al., 2014).

Data on drop-out from trauma-focussed interventions also seems to support this narrative of therapy being a particularly difficult process. Precise estimates and measurements vary, but much literature supports the notion that around 1 in 5 service users who commence a trauma-focussed intervention will not continue until its intended endpoint, especially where the intervention is focussed on the trauma material itself (Lewis, Roberts, Gibson & Bisson, 2020; Varker et al., 2021). A great deal of research has sought to highlight service user, therapist, and therapy factors which might contribute to people dropping out of therapy (see Najavits, 2015 for an overview), and some studies have aimed to address this qualitatively (Hundt et al., 2018).

Relatively high drop-out rates call attention to potential challenges of trauma-focussed interventions for PTSD, and qualitative methods may be a useful means to bring to light the personal lived experience of such interventions. Qualitative and quantitative methods are conceptualised as complementary (Pope & Mays, 1995), given that qualitative methods offer the opportunity to explore the sense people make of their experiences and the meanings they construct about the healthcare interventions they participate in (Al-Busaidi, 2008).

There is now a significant body of qualitative work on the topic of trauma-focussed interventions that requires synthesising. The Centre for Reviews and Dissemination (2009, chapter 6.1, para. 1,) suggest that qualitative synthesis can be useful for "understanding the what, how, and why"; to identify factors impacting on the delivery of an intervention; and to provide detailed accounts of how the outcomes of treatments are experienced. While it is now very well-established that trauma-focussed interventions 'work', there is as yet no unified understanding of how this 'effective therapy' is experienced by is users, or what factors support retention in therapy. More generally, it may be useful to explore any overarching

themes that seem prevalent across individual studies, as well as diverging accounts of similar phenomena.

This review will summarise and synthesise qualitative literature investigating the lived experience of receiving trauma-focussed interventions, using a thematic synthesis approach. The review aims to answer the broad question 'What is known about the service user experience of trauma-focussed interventions?' and to critically evaluate the quality of literature in this area.

Methods

Researcher background and epistemological positions

The author is a currently employed as a trainee clinical psychologist who had little experience of delivering trauma-focussed interventions at the time of writing. She was keenly aware when thinking about the focus of the review that trauma-focussed interventions can be a difficult process for service users. As such, she was concerned about the potential paucity of literature regarding people who found therapy too difficult or ultimately ineffective. This was balanced with the acknowledgment that the perspectives of those who completed therapy and found it helpful are also valid, and a rich source of information that may be used to the benefit the former group too.

The author is also a White British woman. She is aware of how psychological research and practice is used in ways which oppress, ignore, and disadvantage minoritised communities, and was keen to ensure this synthesis did not re-enact this. Noting in particular the needs of asylum seeking and refugee populations, and racial disparities in accessing psychological therapies (e.g., Spoont et al., 2015) she aimed to pay intentional consideration to these issues throughout the process to ensure they were not side-lined through her White, Western lens.

The methodology used for this review was thematic synthesis (Thomas & Harden, 2008), which takes a critical realist perspective. Critical realism supposes that the 'real world' exists but cannot be directly observed, and that our experience of this world is filtered through our beliefs, experiences, and perspectives. It is the latter that is documented in qualitative research. This epistemological position fit with the research question; the researcher here assumes that the data extracted is a reflection of the objective world as it is experienced through the multiple lenses of the participants and authors.

Data collection

Inclusion and exclusion criteria

In defining the inclusion criteria for this review, it was important to have a clear idea of what a 'trauma-focussed intervention' is. A key aim of trauma-focussed interventions is to reduce symptoms such as nightmares or flashbacks, which originate from the way the traumatic experience was encoded in memory at the time of the event (Brewin, 2015). Given this proposed aetiology, a common element of many evidence-based treatments for PTSD, or PTSD-like difficulties, is work with the traumatic memories themselves (Schnyder et al., 2015). This takes different forms across therapies, for example reliving in trauma-focussed CBT (Ehlers & Clark, 2000) or narrative exposure in narrative exposure therapy (Schauer, Schauer, Neuner & Elbert, 2011). As such, the aim was to identify research using trauma-focussed interventions which included a memory exposure component. Practically, this meant therapies recommended by the National Institute for Health and Care Excellence (NICE, 2018) are well represented in this review.

Similarly, it is important to note the breadth of populations included in this review. In clinical practice, PTSD is frequently comorbid with other difficulties (Brady, Killeen, Breweron & Lucerini, 2000), and the label does not always fully encapsulate the post-

traumatic difficulties observed in some service users (Courtois, 2004). As such, any study where a trauma-focussed intervention was being delivered, regardless of the formal diagnostic status of the service user, was included.

Studies were included if:

1) The intervention participants were being interviewed about was a trauma-focussed psychological intervention which involved some element of exposure to the trauma memories

2) At the time of taking part, participants were currently receiving, had completed, or had attended at least one session and then dropped out of this intervention.

3) The population were receiving, or had received this intervention due to a diagnosis of PTSD, or other mental health difficulties that followed exposure to traumatic event/s

4) The study explored any aspect of the lived experience of receiving this therapy

5) Qualitative data collection and analysis methods were used

In criteria 2) above, the phrase 'exposure to the trauma memories' is defined as any component of therapy that involves the service user intentionally recalling or bringing to mind the memories of the trauma. This includes therapy components such as reliving, imaginal exposure, narrative exposure and in vivo exposure.

Studies were excluded if they:

1) Were not written or available in English

2) Reported insufficient detail of their qualitative analysis for re-analysis in the thematic synthesis (e.g., no supportive quotations, or limited elaboration of themes)

3) Were books or book chapters

4) Were case studies where there was no presentation or analysis of the service user experience of the intervention

Search terms

There were four main areas of search term: population, focus of the study, intervention, and qualitative methodology. The search terms used can be seen in Table 1 below. The terms were devised through informally surveying different types of language and terminology commonly used in the research area. For the 'Intervention' search terms specifically, the selection was guided by which of the named, evidence-based trauma-focussed intervention models typically involve an exposure component. These were then added to the search terms by name, alongside more general terms such as 'trauma therapy' or 'trauma work', to ensure the broadest range of literature was accessed.

Table 1. *Search terms used*

Population	AND	Focus of study	AND	Intervention	AND	Qualitative methodology
patient* OR "service user*" OR client* OR outpatient* OR inpatient* OR "trauma survivor*" OR "trauma victim*" OR veteran* or "post?traumatic stress disorder" OR PTSD OR traumati?ed OR refugee* OR "asylum seek*" OR "low?resource" OR "torture victim*" OR "torture survivor*"		experience* OR feedback OR view* OR understanding* OR subjective* OR testimon*		"trauma therap*" OR "trauma work" OR "trauma?focu*ed therap*" OR "trauma?focu*ed work" OR "CBT for PTSD" OR "cognitive?behavio*ral therap* for PTSD" OR "trauma?focu*ed CBT" OR "trauma?focu*ed cognitive?behavio*ral therap*" OR "TF?CBT" OR "prolonged exposure" OR PE OR "cognitive processing therap*" OR CPT OR "eye movement desensiti*ation reprocessing therap*" OR EMDR OR "narrative exposure therap*" OR NET		qualitative* OR interview* OR "thematic analysis" OR "interpretive phenomenological analysis" OR IPA or "grounded theory" OR "discourse analysis" OR "narrative analysis" OR "Foucauldian discourse analysis" OR exploratory OR "focus group*" OR survey* OR descriptive OR perspective* OR acceptability OR narrative* OR perception* OR inquiry or theme* or thematic*

These search terms were used to conduct systematic searches in the PsycINFO, Web of Science, and Embase databases. These databases were chosen in order to gain a good overview of psychology, psychiatry, and mental health research. The searches were completed on 4th September 2020 and were set to search from the beginning of the database history up to 30th August 2020.

Procedure

The PRISMA guidelines for systematic reviewing (Moher et al., 2015) was used to identify relevant papers from the initial output of the database searching (see Figure 1 for the PRISMA flow diagram). First, all studies from the three database searches were exported into Endnote (Endnote X9, 2013). Repeated entries were removed using the 'remove duplicates' tool. The resultant 5951 papers were imported into Rayyan (Ouzzani, Hammady, Fedorowicz & Elmafarmid, 2016), an online platform for systematic reviewing. The titles and abstracts of these records were screened, and any that warranted full-text review were retained. The full text of ten of these papers could not be accessed online or via library services. On further assessment of their abstracts, it seemed very unlikely that they would pass the full-text review stage, and so obtaining them via emailing the authors was not pursued.

The 249 records for full-text review were read and those not meeting inclusion criteria were excluded. Hand searches of the remaining studies' reference lists returned a further 62 papers to review. From this list, a further 2 eligible papers were identified, bringing the total of papers for the thematic synthesis to 21. Support and consultation with the thesis supervisor were sought throughout to resolve any conflict about papers' inclusion or exclusion.

Figure 1. *PRISMA flowchart*

```
┌─────────────────────────────┐      ┌─────────────────────────────┐
│ Records identified through  │      │ Additional records identified│
│ database searching          │      │ through other sources        │
│ (n = 7045)                  │      │ (n = 64)                     │
└──────────────┬──────────────┘      └──────────────┬──────────────┘
               │                                     │
               └──────────────┬──────────────────────┘
                              ▼
              ┌─────────────────────────────┐
              │ Records after duplicates    │
              │ removed                     │
              │ (n = 5951)                  │
              └──────────────┬──────────────┘
                             ▼
              ┌─────────────────────────────┐        ┌─────────────────────────────┐
              │ Records screened            │───────▶│ Records excluded            │
              │ (n = 5951)                  │        │ (n = 5702)                  │
              └──────────────┬──────────────┘        └─────────────────────────────┘
                             ▼
              ┌─────────────────────────────┐        ┌─────────────────────────────┐
              │ Full-text articles assessed │───────▶│ Full-text articles excluded │
              │ for eligibility             │        │ (n = 228)                   │
              │ (n = 249)                   │        │                             │
              └──────────────┬──────────────┘        │ Exclusion reasons:          │
                             ▼                        │ No qualitative component    │
              ┌─────────────────────────────┐        │ (n = 104)                   │
              │ Studies included in         │        │ Not focussed on exploring   │
              │ qualitative synthesis       │        │ patient experience of       │
              │ (n = 21)                    │        │ trauma therapy (n = 50)     │
              └─────────────────────────────┘        │ Case study (n = 23)         │
                                                      │ Not in English (n = 10)     │
                                                      │ Not able to access (n = 10) │
                                                      │ Opinion, theory, or review  │
                                                      │ piece (n = 9)               │
                                                      │ Insufficient detail on      │
                                                      │ results (n = 8)             │
                                                      │ Study protocol (n = 8)      │
                                                      │ Book or chapter (n = 6)     │
                                                      └─────────────────────────────┘
```

Data extraction

Key information on the study aims, population, intervention, qualitative method, and country were extracted (see Table 2). This provided an overview of the literature and allowed for initial assessment of the scope of the included studies.

There is some debate about what is to be considered "data" in qualitative syntheses of evidence (Noyes et al., 2018). For the purposes of this review, any text in the results or

findings section (including that in tables, quotes, and diagrams) was considered as "data" and was extracted. Where there was relevant information in the discussion, e.g., further interpretations of the primary analysis, this was also extracted. In cases of mixed methods studies, or those which included perspectives not relevant to the review (e.g., studies using both service user and therapist interviews) only the text directly relevant to the review question was extracted. The resulting dataset was imported into NVivo (QSR International Pty Ltd, 2020) for analysis.

Analysis

Quality assessment

The methodological quality of the included studies was assessed using an adapted version of the Critical Appraisal Skills Programme (CASP) checklist (CASP, 2017). The original CASP is a 10-item checklist covering the research aims; appropriateness of a qualitative methodology; the study design, recruitment, data collection, and analysis; the presentation of the findings; consideration of ethical issues; and the broader value of the research. The CASP is a commonly used instrument in qualitative health research, including that similar to the current review (e.g., McPherson, Wicks & Tercelli, 2020).

In the present review, two other factors were considered important and were incorporated into the CASP. Given that drop-out from PTSD treatment is a significant issue in real-world clinical practice (Najavits, 2015), it felt pertinent to assess which of the studies included service users who had dropped out of therapy. This is important as capturing only the experience of service users who were able to remain in therapy to completion excludes the voices of those who may have found therapy ineffective or intolerable. As such, an additional item was added to the CASP, asking "was the recruitment strategy inclusive of accessing participants who had dropped out of therapy?"

The second area incorporated into the CASP was that of reporting demographics; the additional question asked: "was there any description of the demographics of participants, and/or the impact this might have on the results?" This question was added for a number of reasons. First, it has long been advised that reporting some demographic information helps to 'situate the sample', giving social context to the results (Elliott, Fischer & Rennie, 1999). This was important to this review, especially considering the broad range of studies included. Secondly, there are some demographic differences in people's experience of trauma-focussed therapies noted in the literature (e.g., race and drop-out rates: Lester, Artz & Resick, 2010). As such, this review specifically assesses the reporting of demographics, and whether participant characteristics had been considered elsewhere by the study authors. The 'minimum criteria' to score 'yes' on this item was reporting of age, gender, and ethnicity; chosen to balance pragmatism with acknowledgment of the importance of reporting at least some key characteristics. The amended version of the CASP used for this review can be found in Appendix A.

The CASP was completed for all of the studies by the author, and a randomly selected 25% (n = 5) of the studies were rated by another researcher. The initial inter-rater agreement was substantial (Cohen's kappa = 0.69), and discrepancies between ratings were then discussed between the author and secondary researcher, and the thesis supervisor was consulted to achieve consensus.

Thematic synthesis methodology

There are a range of analysis methods that can be used to summarise and synthesise qualitative research (see Barnett-Page & Thomas, 2009, for a review). A thematic synthesis approach was used for the current review (Thomas & Harden, 2008). This was chosen for its ability to "draw conclusions based on common elements across otherwise heterogenous

studies" (Lucas, Baird, Arai, Law & Roberts, 2007), as well as for its ability to result in a synthesis which can directly inform real-world clinical practice (Barnett-Page & Thomas, 2009).

The three-stage process detailed in Barnett-Page & Thomas (2009) was followed. First, all the data imported to NVivo from the included studies was coded line-by-line. The researcher coded the text according to the ideas, themes, or concepts that were being identified during reading. When data was read that was not encapsulated by existing codes, new codes were added. Once this initial process was complete there was a large bank of codes and virtually all of the data had been coded, with many sections assigned to more than one code.

In the final stage of the synthesis, researchers must 'go beyond' the simple description of themes and begin to generate new ideas about or conceptualisations of the summarised data: analytical themes. In this stage, descriptive themes were reviewed and key elements or ideas that were shared or conflicting between them were used to inform the production of analytical themes. The result of this process was a theme structure of 20 descriptive themes grouped under four overarching analytical themes.

Results

Study summary

Key information about each study was extracted and presented in Table 2 below. The studies predominantly came from the USA ($n = 9$) and UK ($n = 6$), but there were also studies conducted in Australia ($n = 2$), Canada ($n = 2$), South Africa ($n = 2$) and Norway ($n = 1$). Of the 291 participants across the studies, gender was reported for 227 (78%) of them. 47.42% ($n = 138$) of these participants were female, 30.58% ($n = 89$) of them were male, and gender was not reported for the remaining 22% of participants ($n = 64$).

The studies were from a range of countries, and ethnicity was reported differently across studies. To avoid unhelpfully grouping together disparate cultures and communities, ethnicity here is reported as in the original studies. Ethnicity was reported for just 39.18% of the overall number of participants (n = 114). Of these 114 people, 44.74% were White (n = 51); 23.68% were African American (n = 27); 5.26% were Hispanic (n = 6); and 4.39% were Sub-Saharan African (n = 5). A further 3.50% were Black British (n = 4) and 2.63% were Afro-Caribbean British (n = 3). 2.63% of the 114 participants for whom ethnicity was reported were South Asian (n = 3), 0.88% were South East Asian (n = 1) or East Asian (n = 1), and 1.75% were Asian (n = 2). One participant was Central American (0.88%), one was Native American (0.88%), and three were Middle Eastern (2.63%). Two further participants were Burundian (1.75%), and Sudanese (1.75%). Finally, 0.88% of the participants for whom ethnicity was reported were Zimbabwean (n= 1); Eastern European (n= 1); Afghan (n= 1); Iraqi (n= 1); and Black (n= 1). The remaining participants did not have a reported ethnicity (n = 174), which is 60.82% of the overall sample.

Although specific aims varied, all included studies explored the service user experience of trauma-focussed interventions. There were some studies which cited a more specific aim (e.g., Ashwick, Turgoose & Murphy, 2019 exploring therapy delivered via Skype specifically). It was assumed (and often directly stated) that all of the studies' participants had difficulties consistent with PTSD due to the types of therapy they were receiving. Some studies recruited from specific populations (e.g., veterans, or asylum seekers), or people with a specific trauma history (e.g., survivors of childhood sexual abuse, or of sexual or domestic violence). Studies that recruited from groups with comorbidities were not excluded, and therefore one study's sample presented with comorbid PTSD and addiction, and a further three were conducted with people who had psychosis and PTSD. There was no age limit built into the search terms, and this resulted in a number of studies with children and young people

being included. The remaining studies drew on more general populations with PTSD or

complex PTSD or did not specify the population.

Table 2. *Summary of studies included in thematic synthesis*

Study	Main aim	Sample	Intervention	Data collection and analysis method
Ashwick, Turgoose & Murphy, 2019 UK	To explore the acceptability of using tele-therapy for treating PTSD in a sample of UK veterans.	$n = 16$ (1 female, 15 male, 27-58 years old, White ($n = 15$), Black ($n = 1$)) UK veterans	Cognitive processing therapy	Semi-structured interviews Thematic analysis
Chouliara et al., 2011 UK	To elicit perceptions and experiences of talking therapy services for adult survivors of childhood sexual abuse.	$n = 13$ (13 female; no age or ethnicity reported) Adult survivors of childhood sexual abuse	A range of trauma-focussed therapies	Semi-structured interviews Interpretive phenomenological analysis
Cicconi, 2018 UK	To explore the experience of asylum seekers with narrative exposure therapy	$n = 11$ (7 female, 4 male, 27-62 years old, Sub-Saharan African ($n = 5$), Middle Eastern ($n = 2$), Eastern European ($n = 1$), Central American ($n = 1$), East Asian ($n = 1$), South-East Asian ($n = 1$). Asylum seekers who have received NET for PTSD	Narrative exposure therapy	Semi-structured interviews Thematic analysis
Dittman & Jensen, 2014 Norway	To explore traumatised youths' experiences of receiving trauma-focussed CBT.	$n = 30$ (23 female, 7 male, 11-17 years old, no ethnicity reported) Young people who had received TF-CBT	Trauma-focussed CBT	Semi-structured interviews Thematic analysis

Study	Main aim	Sample	Intervention	Data collection and analysis method
Edmond, Sloan & McCarty, 2004 USA	To examine what women who have experienced trauma due to sexual abuse think about the effectiveness of prolonged exposure or eclectic therapy	$n = 38$. Demographics for prolonged exposure group only not reported. (Full sample: 59 female, 0 male, 18-51 years old, White ($n = 50$), African American ($n = 2$), Hispanic ($n = 1$), Asian ($n = 1$), Pacific Islander ($n = 1$), Finno-Ugaric ($n = 1$), Russian Jewish ($n = 1$), Lebanese ($n = 1$), Racially Mixed ($n = 1$)) Adult survivors of childhood sexual abuse	Prolonged exposure	Semi-structured individual interviews Analysis method not stated
Grubaugh, Veronee, Ellis, Brown & Knapp, 2017 USA	To explore service users' reactions and responses to prolonged exposure through feasibility indices, including post-intervention interviews	$n = 9$ (no demographics available) (Full sample: $n = 14$, 1 female, 13 male, mean age = 47 years old, African American ($n = 7$), Caucasian ($n = 7$)) Veterans with psychosis spectrum disorder	Prolonged exposure	Semi-structured interviews Constructivist grounded theory

Study	Main aim	Sample	Intervention	Data collection and analysis method
Hundt et al., 2015 USA	To explore veteran's experiences of initiating an evidence-based psychotherapy for PTSD.	$n = 23$ (6 female, 17 male, mean age = 54, African American ($n = 10$), Non-Hispanic White ($n = 8$), Hispanic ($n = 2$), Asian ($n = 2$), Native American ($n = 1$)) USA veterans	Prolonged exposure or cognitive processing therapy	Semi-structured interviews Grounded theory
Hundt, Barrera, Arney & Stanley, 2017 USA	To elicit first-hand accounts of veterans who had completed prolonged exposure or cognitive processing therapy	$n = 23$ (6 female, 17 male, mean age = 54 years old, African American ($n = 10$), Non-Hispanic White ($n = 8$), Hispanic ($n = 2$), Asian ($n = 2$), Native American ($n = 1$)) USA veterans	Prolonged exposure or cognitive processing therapy	Semi-structured interviews Grounded theory
Hundt, Ecker, Thompson, Helm, Smith & Stanley, 2018 USA	To examine veteran's reasons for dropping out of prolonged exposure or cognitive processing therapy	$n = 28$ (11 female, 17 male, mean age = 45 years old, African American ($n = 17$), Non-Hispanic White ($n = 7$), Hispanic/Latino ($n = 4$)) USA veterans	Prolonged exposure or cognitive processing therapy	Semi-structured interviews Grounded theory
Mead, 2019 USA	To explore the experiences of military sexual trauma survivors in cognitive processing therapy, including changes in their	$n = 21$ (21 female, 0 male, early 20s – late 60s, sample included White, Black, Latino, and American Indian people; no n reported for ethnicity)	Cognitive processing therapy	Written questionnaires Thematic analysis

Study	Main aim	Sample	Intervention	Data collection and analysis method
	symptoms, social lives, and relationships	USA veterans		
Murray, Merritt & Grey, 2015 UK	To ascertain whether people find site visits as a part of PTSD therapy useful, and whether the function of site visits in participant's narratives confirm/not the cognitive model of them	$n = 25$ (9 female, 16 male, 28-65 years old, White British ($n = 15$), Black British ($n = 4$), South Asian ($n = 3$), White Other ($n = 2$), Middle Eastern ($n = 1$)) Service users receiving TF-CBT for PTSD	Trauma-focussed CBT	Written questionnaires Grounded theory
Naccarato, 2008 USA	To examine how service users experienced the EMDR process	$n = 15$ (11 female, 4 male, 22-55 years old, no ethnicity reported) Diagnosed with PTSD or DESNOS	EMDR	Semi-structured interviews Grounded theory
Schwarz, Baber, Barter & Dorfman, 2020 USA	To assess, using a mixed methods design, the efficacy of EMDR for women who experienced trauma due to sexual or domestic violence.	$n = 12$ (12 female, 0 male, no age or ethnicity reported) (Full sample: $n = 21$, 21 female 0, male, 20-60 years old, White ($n = 12$), Latina ($n = 4$), African American ($n = 3$), Asian ($n = 1$), and biracial ($n = 1$)) Women who have experienced trauma due to sexual or domestic violence	EMDR	Semi-structured interviews Constant comparative method

Study	Main aim	Sample	Intervention	Data collection and analysis method
Sharpe-Lohrasbe, 2012 Canada	To explore the resourcing experience of children and young people in triphasic trauma treatment	$n = 10$ (no gender reported, 13-17 years old, no ethnicity reported) Children and young people receiving trauma-focussed interventions	EMDR	Semi-structured interviews Descriptive phenomenological psychological method
Shearing, Lee & Clohessy, 2011 UK	To explore service users' experience of reliving in trauma-focussed CBT for PTSD	$n = 7$ (6 female, 1 male, 20-50 years old, White British ($n = 4$), Afro-Caribbean British ($n = 3$)) PTSD resulting from type 1 traumatic event	Trauma-focussed CBT	Semi-structured interviews Interpretive phenomenological analysis
Tong, Simpson, Alvarez-Jiminez & Bendall, 2017 Australia	To explore young people with first episode psychosis' reactions to trauma-focussed PTSD therapy	$n = 8$ (7 female, 1 male, 19-25 years old, no ethnicity reported) Young people with first episode psychosis and PTSD/sub-threshold PTSD	Trauma-focussed treatment adapted for people with first-episode psychosis	Semi-structured interviews Interpretive phenomenological analysis
Tong, Simpson, Alvarez-Jiminez & Bendall, 2018 Australia	To explore the experience of young people with first episode psychosis of talking about trauma in therapy	$n = 11$ (9 female, 2 male, 18-27 years old, no ethnicity reported) Young people with first episode psychosis and PTSD/sub-threshold PTSD	Trauma-focussed treatment adapted for people with first-episode psychosis	Semi-structured interviews Interpretive phenomenological analysis

Study	Main aim	Sample	Intervention	Data collection and analysis method
van de Water, Rossouw, Yadin & Seedat, 2018a South Africa	To explore the experiences of adolescents accessing psychotherapy for PTSD in a school setting	*n* = 10 (demographics unclear) Adolescents with PTSD or sub-threshold PTSD	Prolonged exposure for adolescents	Semi-structed interviews and focus groups Thematic content analysis
van de Water, Rossouw, van der Watt, Yadin & Seedat, 2018b South Africa	To explore the experiences of adolescents accessing psychotherapy for PTSD in a school setting	*n* = 10 (demographics unclear) Adolescents with PTSD or sub-threshold PTSD	Prolonged exposure for adolescents	Semi-structed interviews and focus groups Thematic analysis
Vincent, Jenkins, Larkin & Clohessy, 2013 UK	To examine the acceptability of trauma-focussed CBT for PTSD to asylum seekers by exploring their experience of treatment	*n* = 7 (3 female, 4 male, 19-42 years old, Burundian (*n* = 2), Sudanese (*n* = 2), Zimbabwean (*n* = 1), Afghan (*n* = 1), Iraqi (*n* = 1)) Asylum seekers with PTSD	Trauma-focussed CBT	Semi-structured interviews Interpretive phenomenological analysis
Wise & Marich, 2016 USA	To explore the lived experience of people with co-occurring PTSD and substance misuse disorders in standard and addiction-specific EMDR programmes.	*n* = 9 (6 female, 3 male, 28-60 years old, no ethnicity reported) Co-occurring PTSD and addiction disorder	EMDR	Semi-structured interviews Creswell's system for interpreting meaning

Quality assessment

Each of the studies was rated using the amended CASP checklist. The full results of this are found in Table 3 below. It is of note that four of the included studies were PhD theses (Cicconi, 2018; Mead, 2019; Naccarato, 2008; and Sharpe-Lohrasbe, 2012). While these would not have been peer-reviewed, they were deemed suitable to include as all would have been examined and the CASP-rated quality of them did not appear to differ from the rest of the sample.

All of the included studies stated their aims clearly, and both a qualitative methodology and the particular research design chosen was deemed appropriate to address these aims (CASP questions 1-3). Similarly, the data collection strategy used in all of the studies was felt to be appropriate (question 5). All but one (Grubaugh et al., 2017) of the studies described a rigorous analysis method, and all of the studies were found to clearly state and detail their findings (questions 8-9). Every study's findings were thought to be of value to clinical practice, future research, or both (question 10).

The recruitment strategies used were largely appropriate to the questions each study hoped to answer, although there were three studies where the recruitment process was not described clearly enough to establish this (question 4. 14.29%: Edmond et al., 2004; Murray et al., 2015; Naccarato, 2008). Fifteen of the studies (71.43%) either did not include people who had dropped out of therapy, did not make clear if they did, or employed recruitment strategies that would have implicitly excluded such clients. Only six of the 21 studies (28.57%) gave detail sufficient to ascertain that they did recruit from both completer and non-completer groups (question 4a. Ashwick et al., 2019; Dittman & Jensen, 2014; Grubaugh et al., 2017; Hundt et al., 2017; van der Water et al., 2018a; van der Water et al., 2018b). For the purposes of the amended CASP, the minimum reporting requirements were of age, gender and ethnicity (be these reported at an individual or group level; question 4b). Eight of the

studies (38.09%) did not report these basic demographics (Chouliara et al., 2011; Dittman & Jensen, 2014; Edmond et al., 2004; Naccarato, 2008; Sharpe-Lohrasbe, 2012; Tong et al., 2017; Tong et al., 2018; Wise & Marich, 2016).

Seven of the 21 studies (33.33%) described paying adequate attention to the relationship between researcher and participants (defined as critical examination of the researcher's role, potential bias, and influence across each stage of the research; Ashwick et al., 2019; Chouliara et al., 2011; Cicconi, 2018; Mead, 2019; Schwarz et al., 2020; Sharpe-Lohrasbe, 2012; Wise & Marich, 2016). Where it was mentioned, it was often brief and pertaining to professional roles or being separate to the participants' clinical team, rather than any in-depth exploration of other aspects of identity difference or similarity that might influence what a participant shares in interview. A majority of the studies referred in some way to ethical issues, often by describing the process of informed consent or their ethical approval. Six studies (28.57%) did not make any reference to ethical issues (Edmond et al., 2014; Murray et al., 2015; Shearing et al., 2011; van der Water et al., 2018a; Vincent et al., 2013; Wise & Marich, 2016).

Sensitivity analysis and qualitative assessment of contribution to analysis

Following quality rating, any studies which scored less than 9/12 (75% compliant) on the CASP were removed from the analysis. This resulted in the removal of the three lowest scoring studies from the analysis: Edmond et al., (2004); Naccarato (2008); and Murray et al., (2015), which scored 6/12, 8/12, and 8/12 on the amended CASP, respectively. When reviewing the themes following this removal, they remained largely unchanged. Before removal, 15 of the 20 themes were supported by 50% or more of the studies, and following removal of the poorest quality studies, 13 themes were still supported by over half of the literature. This indicated that the final analysis was not overly reliant on the poorest quality

papers. Indeed, the support for the final analysis was spread fairly comprehensively across the body of literature. Because these lowest scoring studies did not appear to have disproportionately contributed to the analysis, they were not excluded from the final analysis. The thematic synthesis presented here, therefore, is inclusive of all the papers regardless of their quality.

The frequency of themes coded per paper was also explored. There were six studies which supported less than half of the themes: Tong et al., (2017); Wise & Marich (2016); Ashwick et al., (2019); Hundt et al., (2015); Murray et al., (2015) and van der Water et al., (2018a). On further assessment, this is likely because some studies were asking more narrow, specific research questions than that of this review, some were mixed methods in design, and some included a comparison group receiving a treatment other than a trauma-focussed intervention. There were no striking differences between how much different studies contributed to the analysis based on their methodology, the therapy being studied, or population, though there were some potential patterns which are discussed in the results.

Table 3. *Summary of CASP ratings for each study*

Amended CASP items	Ashwick et al., 2019	Chouliara et al., 2011	Cicconi, 2018	Dittman & Jensen, 2014	Edmond et al., 2004	Grubaugh et al., 2017	Hundt et al., 2015	Hundt et al., 2017	Hundt et al., 2018	Mead, 2019	Murray et al., 2015	Naccarato, 2008	Schwarz et al., 2020	Sharpe-Lohrasbe, 2012	Shearing et al., 2011	Tong et al., 2017	Tong et al., 2018	van der Water et al., 2018a	van der Water et al., 2018b	Vincent et al., 2013	Wise & Marich, 2016
1) Statement of aims	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2) Appropriateness of qualitative method	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3) Appropriateness of design	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4) Appropriateness of recruitment strategy	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✗	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓
4a) Inclusion of people who dropped out	✓	✗	✗	✓	✗	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✓	✗	✗
4b) Inclusion of minimum demographics	✓	✗	✓	✗	✗	✓	✓	✓	✓	✓	✓	✗	✓	✗	✓	✗	✗	✓	✓	✓	✗
5) Appropriateness of data collected to research issue	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
6) Consideration of relationship between researcher and participants	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓	✗	✗	✓	✓	✗	✗	✗	✗	✗	✗	✓
7) Consideration of ethical issues	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✗	✓	✓	✓	✗	✓	✓	✗	✓	✗	✗
8) Rigor of data analysis	✓		✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
9) Clear statement of findings	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
10) Value of research	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Thematic synthesis

The data extracted from the 21 studies was analysed using thematic synthesis (Thomas & Harden, 2008). This synthesis generated four overarching analytical themes, which encompassed 20 descriptive themes. The analytical themes are presented in Table 4, and the full theme structure is depicted in Figures 2-5 below.

Table 4. *Analytical theme summary*

Theme number	Analytical theme	Number of studies supporting theme (n)
1	What helps people to begin therapy, and to persist through its challenges?	$n = 18$
2	Safety makes or breaks the therapeutic relationship, and therefore the therapy.	$n = 19$
3	Therapy as a transformative experience	$n = 21$
4	Therapy as a profoundly challenging, and not always curative, process	$n = 20$

Analytical theme 1: What helps people to begin therapy, and to persist through its challenges?

The first analytical theme encompassed three descriptive themes pertaining to both intra- and extra-therapeutic factors which participants felt had helped them to commence therapy in the first instance, and to continue their engagement with therapy when challenges or obstacles arose. It is important to note that this account of what helped people to commence therapy does not include the perspectives of those who found even this too difficult; and similarly, the account of what supported people to continue with therapy is largely exclusive of those who later dropped out. The structure of this theme is depicted in Figure 2.

Figure 2. *Analytical theme 1.*
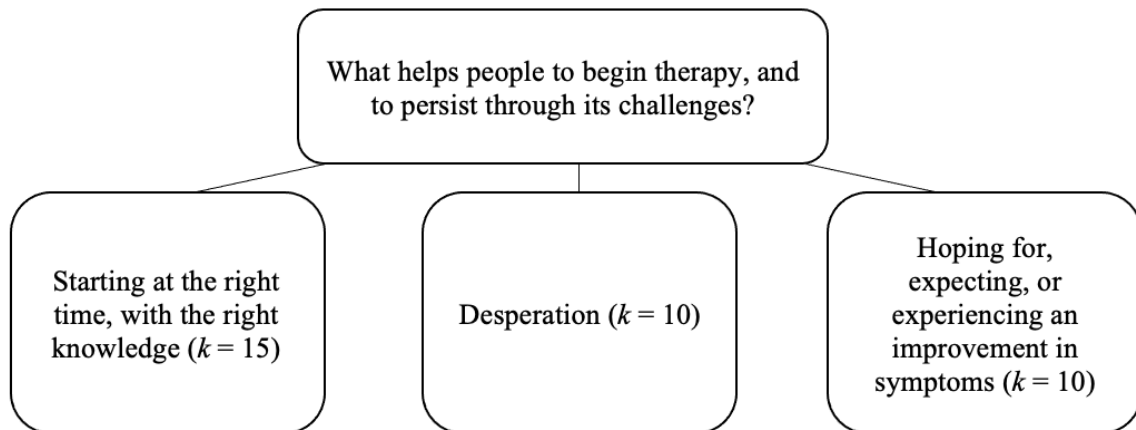
Starting at the right time, with the right knowledge

The timing, or mistiming, of therapy was an important factor for some participants. Being able to commence at the "right" time supported engagement, while being pressured to start when service users did not feel ready was detrimental to engagement. Similarly, many studies described feeling prepared for what therapy would involve as an important initial step toward them engaging, though some spoke about it not being possible to be truly prepared. There were specific comments pertaining to the usefulness of a thorough understanding of the rationale for the tasks of therapy, at the beginning but also throughout the process of the intervention. Of note, in Hundt et al., (2018), a lack of understanding of or buy-in to the rationale contributed to service users dropping out of treatment. It seemed that together, being able to begin therapy at the right time and being in receipt of good information about what therapy would entail were important factors in facilitating initial and continued engagement.

Desperation

Throughout the accounts, there was a sense that being desperate for change, or having "hit rock bottom" was a significant motivator for participants when it came to engaging in therapy. There was a sense in some of the studies that this desperation provided motivation

even when the participants did not have a clear idea of how therapy could work or if they could be helped.

Hoping for, expecting, or experiencing, an improvement

Many participants spoke about a hope or expectation that therapy would make them feel better, and this helped them to begin therapy. Once therapy had begun, participants described how early improvements in symptoms helped to motivate them further and keep them attending sessions.

Illustrative quotes for the three descriptive themes detailed above are available in Table 5 below.

Table 5. *Illustrative quotes for descriptive themes under analytical theme 1*

Descriptive theme	Illustrative quote	N
Starting therapy at the right time, with the right knowledge	Participant: "I felt pressured to talk about it when I didn't feel ready. I wished we could have done it another time when I was more ready and that I could have decided when, but I felt that I couldn't. . . that I had to say it right away." (Dittman & Jensen, 2013) Participant: "…because it was explain[ed], I knew what was up. If someone said do that…I'd probably be like, no, why don't you do that…like tell me why first – so it's better just to not be thrown into something" (Sharpe-Lohrasbe, 2012).	$n =$ 15
Desperation	Participant: "I done tried everything and that (expletive) don't work. […] I know what's next after this. What's next is the penitentiary or the graveyard for me." (Hundt et al., 2015)	$n =$ 10
Hoping for, expecting, or experiencing, an improvement	Author: Participants were encouraged by "seeing signs of progress" […]. These changes helped them to persevere with therapy. (Vincent, Jenkins, Larkin & Clohessy, 2013) Participant: "I was hoping that "Maybe this will be the time that was going to be the turnaround and my anxiety and everything would be lessened." (Hundt et al., 2015)	$n =$ 10

Analytical theme 2: Safety makes or breaks the therapeutic relationship, and therefore the therapy

The second analytical theme covered four descriptive themes which describe a range of therapist qualities and behaviours that engender a fundamental sense of safety in the relationship which facilitates the work of therapy itself. The structure of this theme is depicted in Figure 3.

Figure 3. *Analytical theme 2*
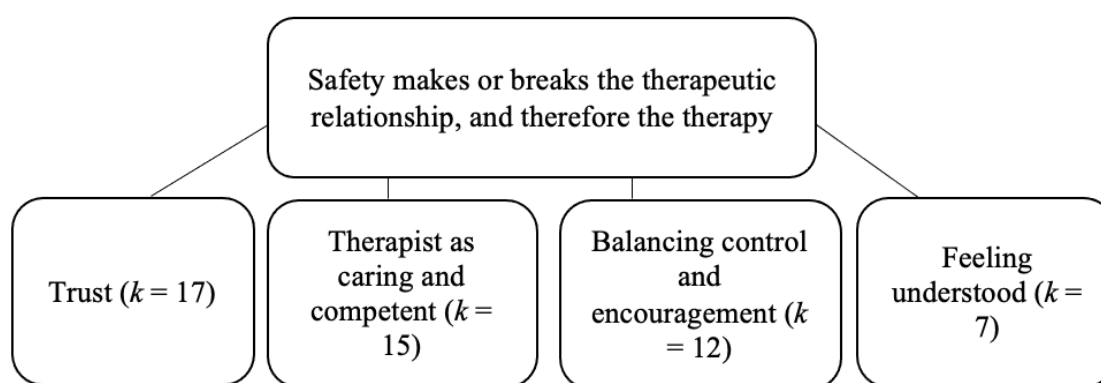
Trust

Trust was the most prevalent theme in this group. Many participants commented on being able to trust their therapist as being a core, essential condition to therapy progressing. There were specific behaviours noted in some accounts as things that supported the development of a trusting relationship. Some participants commented on how if trust had not been present, the therapy would have been futile and ineffective. There was also a number of references to being able to trust the therapist with information because of their commitment to confidentiality.

Therapist as caring and competent

Many participants commented both on how warm and kind their therapist was, as well as on them being knowledgeable and skilled. This seemed to allow for a sense of being in "safe hands". While a lot of participants mentioned the therapist as being caring and competent, some studies seemed to highlight one more than the other.

Balancing control and encouragement

To retain safety in the therapy, a careful balance between being encouraged to move forward while having ample control was important to a number of participants. Where this was not well-managed, it seemed to disrupt the progress of therapy. There was a range of comments on this duality.

Feeling understood

A sense of feeling heard and understood emerged from a smaller number of studies. This sense of being understood seemed to lead to feeling held and contained which was valuable for participants.

Quotes to illustrate each of the above four descriptive themes are presented in Table 6 below.

Table 6. *Illustrative quotes for analytical theme 2's descriptive themes*

Descriptive theme	Illustrative quote	*n*
Trust	Author/participant: The ability to share trauma memories with their case manager was a sign of the level of trust attained in the therapeutic relationship. "I did trust her so I told her what had happened". Author: using techniques such as asking for permission to continue talking about a certain topic and regularly monitoring participant distress (Tong, Simpson, Alvarez-Jiminez & Bendall, 2018) Participant: "If you don't trust your therapist you don't tell everything. If you don't tell everything, it's you you can't, you can't, you can't get any better I think." (Cicconi, 2018)	*n* = 17

Descriptive theme	Illustrative quote	*n*
Therapist as caring and competent	Participant: "She knew it [EMDR] very well. I think she is an advanced EMDR specialist or something like that. She is good because if one angle wouldn't work she'd try a different angle." (Edmond, Sloan & McCarty, 2004) Author/participant: It was a surprise to find "someone out there that really cares." (van de Water, Rossouw, Yadin & Seedat, 2018a)	*n* = 15
Balancing control and encouragement	Participant: "I didn't feel like I was pushed into it and I was given lots of warning, and umm, I was given enough time to talk about all my fears. But they also didn't allow me to procrastinate" (Shearing, Lee & Clohessy, 2011) Author/participant: Being pushed whilst respected […] appeared to encourage participants' engagement in difficult therapeutic processes: "Sometimes I tell him, 'No, I don't want to speak any more' He will, sometimes he will push me to speak..." (Vincent, Jenkins, Larkin & Clohessy, 2013)	*n* = 12
Feeling understood	Participant: "She really listened but as well as listening she heard me and for me there is a huge difference between listening and hearing" (Chouliara et al., 2011)	*n* = 7

Analytical theme 3: Therapy as a transformative experience

The third analytical theme encompassed a group of eight descriptive themes,

describing the various ways participants felt trauma-focussed interventions helped them.

Many positive outcomes were reported across studies, the summary of which is presented in

Figure 4 below. As the largest of the analytical themes, the descriptive themes will be

discussed here together, with illustrative quotes for each collated in Table 7.

Figure 4. *Analytical theme*

```
                    ┌─────────────────────────────────┐
                    │ Therapy as a transformative      │
                    │ experience                       │
                    └─────────────────────────────────┘
```

Improved symptoms (k = 18)	Improved coping and functioning (k = 17)	Memory changes (k = 14)	Improved relationship with self (k = 14)
Moving on, closure (k = 14)	Therapy as life-changing, life-saving (k = 12)	Improved understanding (k = 12)	Relief (k = 10)
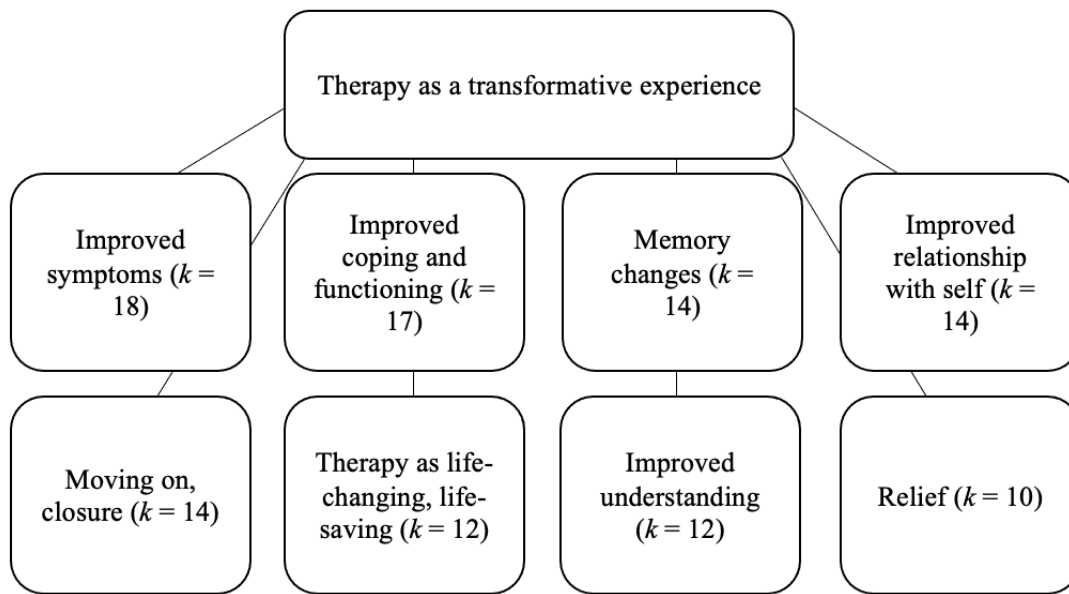
Many studies described how trauma-focussed interventions were successful in their aim to reduce PTSD symptoms, as well as facilitating changes in the quality of the trauma memories clinicians would expect to see following exposure or reprocessing (Improved symptoms; Memory changes). Participants also spoke of an improved understanding of PTSD, how it arises, and how it can be overcome (Improved understanding).

Following therapy, many participants described functioning better in a number of domains and being better able to cope with symptoms or difficulties when they arose, sometimes specifically referring to grounding or other techniques they learned in therapy (Improved coping and functioning). A range of studies mentioned ways in which therapy seemed to improve the participant's relationship with themselves, including a reduction in self-blame, clarification of their identity, or improvements in self-esteem (Improved relationship with self).

Some participants described a powerful sense of relief, sometimes when beginning to process their traumas, and sometimes just on the commencement of therapy itself. Some of

these participants commented on the healing power of being able to simply share their story

with another person and verbalise the traumatic experiences they had been through (Relief). A

number of studies spoke to the benefit of therapy enabling people to move on from their pasts

or gain some form of closure regarding what had happened to them (Moving on, closure).

There was a range of data that related to the experience of therapy as life-changing, life-

saving, or otherwise transformative in more abstract or hard to categorise way (Therapy as

life-changing, life-saving).

Table 7. *Illustrative quotes for analytical theme 3's descriptive themes*

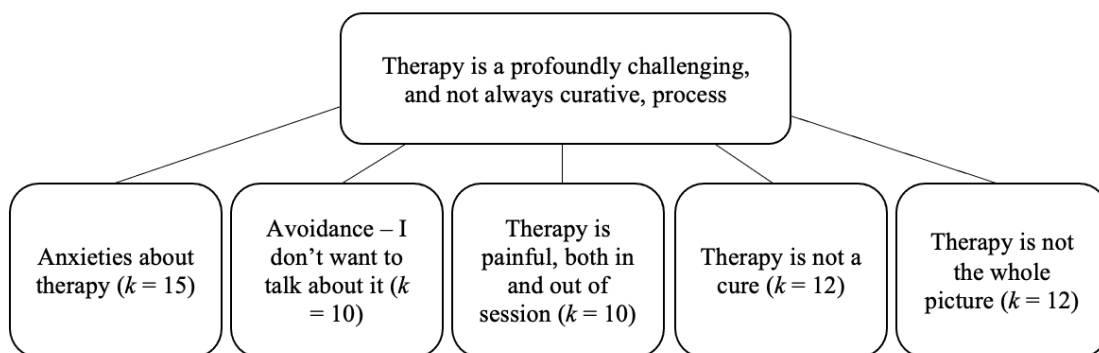| Descriptive theme	Illustrative quote	*n*
Improved symptoms	Participant: "It's like I said, once I'm here, I can be in here, and talk with her (therapist). She will speak to me and I can go home that day and feel less symptoms" (Grubaugh et al., 2017) Participant: "before CPT, I had bad PTSD and depression. I didn't go anywhere or trust anyone. Today, I don't often have any symptoms. I still get triggered, but I have the tools to handle it" (Mead, 2019)	*n* = 18
Improved coping and functioning	Author: Many of the youths (9) said that it was helpful to learn techniques such as breathing exercises that they could use to deal with difficult emotions. (Dittman & Jensen, 2013) Author: Many were now engaging in more activities including exercise, attending religious services, playing more with their children, and doing things they used to enjoy but had lost interest in. (Cicconi, 2018)	*n* = 17
Memory changes	Participant: "Like at first when we started, like it was really difficult to tell the story. It made me upset and made me feel as if I was reliving it as I told it. . . and as I got to the end, it was almost boring." (Grubaugh, Veronee, Ellis, Brown & Knapp, 2017) Participant: "I can get distance on it, and it doesn't feel like I'm in it any more, you know" (Naccarato, 2008)	*n* = 14

Descriptive theme	Illustrative quote	n
Improved relationship with self	Participant: "The something that shifted is a more concrete sense of self […] It is actually the ability to perceive that there is a difference between what's being done to me and who I am." (Edmond, Sloan & McCarty, 2004)	$n = 14$
Moving on and closure	Author/participant: Eight (32%) commented that the result of the visit was a sense of moving on and putting the event in the past, leading to a sense of peace and release. One participant likened the site visit to "closing a big book I had been reading for a long time." (Murray, Merritt & Grey, 2015)	$n = 14$
Therapy as life-changing, life-saving	Participant: "the world is more colorful and worthwhile now. I am not isolating or having suicidal thoughts anymore. Now I feel human and I love life." (Mead, 2019)	$n = 12$
Increased understanding	Author: Although they typically entered EBP knowing the symptoms of PTSD, EBP helped them understand how these were triggered and how automatic thoughts influenced their reactions. This greater understanding was comforting in that it provided a greater sense of predictability and control. (Hundt, Barrer, Arney & Stanley, 2017)	$n = 12$
Relief	Participant: "each night after it [reliving] I felt very much relieved when I was at work. Very much relieved. […] a weight being lifted off your shoulders". (Shearing, Lee & Clohessy, 2011)	$n = 10$

Analytical theme 4: Therapy as a profoundly challenging, and not always curative, process

The fourth analytical theme encapsulates the intensely challenging nature of therapy, alongside the fact that therapy does not always work, nor is therapy itself the only important determinant of outcome. The six studies which had included in recruitment people who had dropped out from therapy were well represented across this analytical theme, with all endorsing at least three of the five and often all of the descriptive themes in this group. Indeed, it is interesting to note that two of these six papers were also two of the papers which were found to contribute least to the overall analysis as a whole (Ashwick et al., 2019; van

der Water et al. 2018a), yet they were well represented in this specific analytical theme. This may indicate that the inclusion of people who are not able to complete therapy gives a more nuanced view of both the positive and negative experiences of trauma-focussed interventions. This is depicted in Figure 5 below.

Figure 5. *Analytical theme 4.*

Therapy is a profoundly challenging, and not always curative, process

Anxieties about therapy (k = 15) — *Avoidance – I don't want to talk about it (k = 10)* — *Therapy is painful, both in and out of session (k = 10)* — *Therapy is not a cure (k = 12)* — *Therapy is not the whole picture (k = 12)*

Anxieties about therapy

This descriptive theme detailed a variety of anxieties service users had before starting, or during, therapy. These included specific fears, for example about therapy making their symptoms worse or whether they would feel comfortable with their therapist, as well as more general anxieties about what the process of therapy would involve or feel like.

Avoidance – I don't want to talk about it

Many studies included specific reference to wanting to avoid talking about the traumatic material. For some, this was due to a belief that avoidance was a good way of coping with trauma, and for others it was because of how painful this material was to revisit. In many cases, this desire to avoid was a significant challenge in being able to continue to engage in the work.

Therapy is painful, both in and out of session

This descriptive theme described how painful the process of therapy can be, both during the sessions, but also in the emotional and psychological impact of the sessions on the

rest of service users' lives. Some service users described the intense distress they felt,

particularly during exposure sessions, and how this distress persisted in the days following

therapy.

Therapy is not a cure

While many service users reported positive outcomes from therapy, others referred to

leaving therapy with some remaining difficulties, or in some cases feeling worse than before.

For some service users, this seemed to be an acknowledgement that therapy had helped, but

not totally 'cured' them. For others, there was a sense that therapy had been minimally, or not

at all helpful.

Therapy isn't the whole picture

The final descriptive theme described ways in which therapy alone was considered to

be lacking, or where the perceived effectiveness of it was influenced by external factors. In

some cases this was positive, for example references to using Skype for therapy as facilitating

engagement, or the importance of family encouragement and support. Conversely, some

service users' progress was felt to be impeded by factors like pending immigration claims,

and others felt non-therapy support had been more useful to them.

Illustrative quotes for these four descriptive themes are presented in table 8.

Table 8. *Illustrative quotes for descriptive themes under analytical theme 4.*

Descriptive theme	Illustrative quote	*n*
Anxieties about therapy	Participant: "I was very hesitant- scared honestly. I was afraid of what would come out- too much pain and anger!" (Mead, 2019) Author/participant: Some admitted that they were scared to see the counselor because "maybe she's not interested . . . will judge me," the counselor may not "believe" her, and "she is going to speak about it with . . . other counselors." (van der Water et al., 2018a)	*n =* 15
Avoidance – I don't want	Participant: "Leave it alone. "Don't trouble trouble, trouble won't trouble you." One of my mother's greatest sayings."	*n =* 10

Descriptive theme	Illustrative quote	n
to talk about it	(Hundt et al., 2015) Participant: "I was ashamed. I was ashamed of what had happened and I hadn't told anyone. I'd just, it's embarrassing. Especially from young. You don't feel like telling anyone. Just disgusting." (Tong et al., 2018)	
Therapy is painful, both in and out of session	Author/participant: Others described experiences which might indicate that their high level of distress during the narration lead to dissociation: "I was um…um…losing myself like…I wasn't aware of where I am." (P1) "Sometimes my spirit would leave my body." (P2) (Cicconi, 2018) Author/participant: The researcher observed that many participants described feeling consumed by reliving during the process. Jamie: 'it took over my life for a couple of weeks'. Participants spoke about the emotional exhaustion after reliving. […] Participants spoke about experiencing a temporary increase in PTSD symptoms immediately after undertaking reliving, particularly with regard to nightmares (Shearing et al., 2011)	$n =$ 10
Therapy is not a cure	Author/participant: Nevertheless, participants stressed that although their symptoms had reduced, the therapy was not a cure: "I mean, sometimes it's good, sometimes it's bad. But I would say that it has helped me but not all." (Ashwick et al., 2019) Author/participant: Although not common among this sample of treatment completers, it is important to note that some veterans had this experience: "Well, I wasn't feeling better at the end; I was feeling worse... the more I talked about it the worse that I felt about it". (Hundt et al., 2017)	$n =$ 12
Therapy isn't the whole picture	Author: 'Siyoli's' individual interview suggested that it was not the counselling that enabled her to change, but rather the birth of her child which made her stay at home and try and rebuild a new life. (van der Water et al., 2018b)	$n =$ 11

Discussion

This review aimed to summarise what is known about the service user experience of trauma-focussed interventions. Data from 21 qualitative studies exploring the service user experience of trauma-focussed interventions was collated and analysed using thematic synthesis. The synthesis resulted in four overarching analytical themes encompassing 20 descriptive subthemes relating to a very broad range of perspectives on the therapy process. These analytical themes were: 1) What helps people to begin therapy, and to persist through its challenges?, 2) Safety makes or breaks the therapeutic relationship, and therefore the therapy, 3) Therapy as a transformative experience, and 4) Therapy as a profoundly challenging, and not always curative, process.

The review also aimed to critically evaluate the quality of the literature in this area. As detailed in the results, most of the literature was of acceptable quality in most domains. Notably, all of the studies appeared to be well-designed to address the questions they asked, and all seemed to be of great use to future clinical practice or research. Some potentially important omissions or areas of poorer quality are highlighted in this discussion.

Trauma-focussed interventions can help, but are extremely challenging

The first key finding is that while trauma-focussed interventions were clearly helpful for those who had been able to access them, the entire process from initiation to completion or drop out was extremely challenging for many service users. This is especially stark considering that only six of the 21 studies explicitly recruited people who had dropped out of therapy: the majority of participants across the studies were those who had been able to access and complete therapy, and even they reported profound challenges throughout the process. Future qualitative research of this type would benefit from specifically targeting recruitment towards service users who were not able to complete therapy or who dropped out.

47

This would allow for a more nuanced exploration to the balance between the challenging nature of therapy and the potential positive outcomes it can offer, which might be expected to be different for therapy completers versus those who dropped out.

Even with the sampling bias towards 'completers', there are clear statements in this review about the challenges therapy that may be relevant more broadly. There is a wealth of research assessing drop-out, what contributes to it, and how to prevent it (Najavits, 2015). This review provides some ideas about particular factors (service user, therapist, relational, and external) which may support or inhibit a service user's ability or desire to remain in therapy. These factors can be considered as potential routes for addressing drop-out clinically, for example considering how to maximise early gains in therapy, or the importance of addressing external social issues that might disrupt engagement. Some specific themes relating to trauma-focussed interventions being ineffective or a negative experience also highlight the importance of research that looks at the less positive effects of therapy. Given how frequently therapy was described as extraordinarily hard by participants, it would seem very pertinent for future research to investigate the potential for iatrogenic harm specifically.

Despite the weight of data considering the challenges of therapy, there were also many statements of the ways trauma-focussed interventions had helped people and improved various aspects of their lives. Firstly, many service users reported that therapy had helped to improve their symptoms, ability to cope, and their functioning. This is consistent with, and further bolsters, existing data that reliably finds trauma-focussed interventions to be an effective treatment (Bisson et al., 2007; Watts et al., 2013; Lewis, Roberts, Andrew, Starling & Bisson, 2020). Some of this review's findings even detail outcomes from the service user perspective which are consistent with the memory theory (i.e., that after therapy, the trauma memory should change to feel like a 'normal' memory) that underlies most modern trauma therapies. This adds further validity to the theory itself. With that said, this review also found

a range of reported outcomes which are not traditionally key outcomes in effectiveness research, such as the value of feeling understood, or an improved relationship with the self after therapy. More routinely reporting outcomes which capture these kinds of changes in trauma-focussed interventions research may help to give a more nuanced and holistic conceptualisation of the effects of therapy. While these positive outcomes are heartening, as detailed above, it is difficult to know to what extent this message would hold in a broader sample.

Safety in the therapeutic relationship as core to trauma-focussed interventions

The second key 'message' of this review pertains to the importance of safety in trauma-focussed interventions. Participants described a range of factors that contributed to feeling safe with the therapist and in the therapy, for example the therapist appearing competent, and there being a sense of strong trust between therapist and service user. A common, though much debated, criticism levied at the more cognitively focussed therapy models is that they do not pay adequate attention to the therapeutic relationship (Leahy, 2008). It could be the case that in trauma-focussed interventions, where there is much focus on the 'technical' aspects of therapy, this is paid more attention to than the therapeutic relationship. The findings of this review would suggest that the relational aspects of therapy are important to, and noticed by, service users, and feature frequently in their accounts of therapy.

This is particularly pertinent when considering the needs of people with complex PTSD (CPTSD) presentations. Preliminary evidence suggests that CPTSD is common in clinical samples, and indeed is potentially more prevalent than PTSD itself (Karatzias et al., 2017; Karatzias et al., 2019). Given this, we might expect a reasonable proportion of those seeking trauma therapies to present with the additional disturbances in relational functioning

that the CPTSD diagnosis encapsulates. The UK Psychological Trauma Society guidelines for treating CPTSD (McFetridge, Hauenstein Swan, Heke & Karatzias, 2017) highlight the need to attend to safety and the therapeutic relationship carefully and intentionally at various points in treatment. The findings of this review would reinforce this guidance. It seemed from the service user accounts that their relationship with the therapist and how safe they felt was in many ways key to being able to successfully complete a trauma treatment.

A further implication of this finding relates to the focus of research in the area of trauma-focussed interventions. Clinical guidelines and the findings of this review suggest that therapy is more than just the tasks of stabilising and processing trauma memories. It would therefore be useful for there to be further research conducted into the relational aspects of trauma-focussed interventions that are identified as important by service users. This research could take the form of further qualitative work exploring the experience of service users and therapists with the interpersonal and relational tasks of therapy, or involve the quantitative measurement of the therapeutic alliance and how this impacts on outcomes. While there is some important work pertaining to this (e.g., Cloitre, Stovall-McClough, Miranda & Chemtob, 2004; Keller, Zoellner & Feeny, 2010), this review would suggest more focussed exploration could be useful and may be in line with service user opinion on important areas to consider.

Qualitative trauma-focussed interventions research: omissions and oversights

This review highlights several important, broader issues for consideration in future qualitative work in this area, that extend beyond the insights specific to the service user experience of trauma-focussed interventions. These issues were highlighted through the detailed quality assessment of the papers that was undertaken.

In qualitative research, where the aim is not necessarily to achieve generalizable findings, it is important to be able to contextualise the results of a study with information about the participants they were generated from. The reporting of demographics, particularly ethnicity, across the studies was a relative weakness. Gender was reported for 78% of participants, and ethnicity was only reported for 39.18% of participants. This means that for many of the studies, it was not possible to consider the intersecting identities of participants (nor how these might converge or differ from the researchers) when reading the results. This is important for myriad reasons. For example, when safety is found to be of central importance in this review, it is worth considering the broader context for some groups of participants. The experience of a sense of safety for refugees and asylum seekers might be quite different to that of indigenous populations. Likewise, developing a safe, trusting therapeutic relationship may be different as a person of colour with a White therapist, than in a racially matched dyad. Without even basic demographics, the richness of conclusions that can be drawn are limited. Future qualitative research in this area would benefit from careful consideration of the range of demographic variables that may be relevant to the topic of interview, and clear reporting of these so as to adequately situate the study sample.

Similarly, only in a third of the studies was there evidence of adequate attention to the role and influence of the researcher themselves on the design, interviewing, and analysis of the study. This is pertinent, as there is a range of areas where bias can be introduced in qualitative research due to the inherently interpersonal nature of interview data collection (Norris, 1997). This lack of information makes it more difficult to interpret the results; for example: were the interviewers strongly allied to the model they were interviewing service users about? Were veterans interviewed by civilian staff? Was the gender of the interviewer considered when interviewing survivors of sexual violence? Without comprehensive exploration of how these issues were considered, mitigated and used as a lens through which

to understand the data and analysis, it is difficult to draw definitive conclusions on the validity of any individual study, especially regarding potential clinical implications.

Limitations

There are a number of key limitations to this review. Firstly, a broad approach was taken to study inclusion. This means that the results of this review are drawn from the experiences of a range of service users, with different trauma histories, being treated using different models. Due to this, the level of nuance available in the conclusions is limited. Specific issues pertaining to different populations or therapies have not been explored, as this review did not stratify the data in this way. It may be helpful in future to conduct more focussed work, for example on the experience of veterans, or the experience of EMDR specifically.

A further limitation to note relates to the conceptualisation of PTSD and trauma-focussed interventions in this review, and the studies it draws on. It is acknowledged that the conceptualisation of PTSD as presented here originates largely from Western theory and research, as does the resulting assumption that trauma-focussed interventions need to contain a memory processing element. While there is significant data supporting the cross-cultural validity of PTSD and the efficacy of trauma therapies in different cultural contexts (e.g., Hinton & Lewis-Fernández, 2011; Robjant & Fazel, 2010), it is important to note that there may be different conceptualisations of post-traumatic reactions and useful means of therapy that exist beyond the lens used here. While this review addresses in detail the service user experience of common trauma-focussed interventions, there may have been valuable service user accounts beyond this perspective that were not included due to the Westernised lens that was used in the question and search terms.

A final key limitation pertains to the literature searched and included in this review. While no efforts were made to exclude this kind of work, the grey literature is poorly represented in the included studies. Anecdotally, much small-scale qualitative research takes place in MSc and DClinPsy projects or similar, meaning some of this literature may not have been accessible via traditional database searching. Similarly, many important service user accounts of trauma-focussed interventions are likely to exist outside of the traditional academic literature entirely. In particular "Web 2.0" sources such as blogs, forums, and Twitter (Banks, 2010) are places where service users share their lived experience, though the ethics of accessing this kind of data are incredibly complex. Future research may consider how to intentionally integrate the broader grey literature, so as to ensure the widest range of accounts are able to be integrated.

Conclusion

This review presents a synthesis of a variety of qualitative studies exploring the service user experience of trauma-focussed interventions. It provides a detailed answer to the question of what is known about the service user experience of trauma-focussed interventions. The results provide a range of useful insights into what service users find helpful, therapeutic, difficult, and supportive during the process of therapy. This review also provides rich information when considering what adaptations to clinical practice or future research directions might be fruitful, and can be considered a rich resource for considering potential clinical applications or directions for future research.

References

Al-Busaidi, Z. Q. (2008). Qualitative research and its uses in health care. Sultan Qaboos University Medical Journal, 8(1), 11.

Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: a critical review. BMC medical research methodology, 9(1), 1-11.

Banks, M. (2010). Blog posts and tweets: the next frontier for grey literature. In Grey literature in library and information studies (pp. 217-226). KG Saur.

Becker, C. B., Zayfert, C., & Anderson, E. (2004). A survey of psychologists' attitudes towards and utilization of exposure therapy for PTSD. Behaviour research and therapy, 42(3), 277-292.

Bisson, J. I., Ehlers, A., Matthews, R., Pilling, S., Richards, D., & Turner, S. (2007). Psychological treatments for chronic post-traumatic stress disorder: Systematic review and meta-analysis. The British journal of psychiatry, 190(2), 97-104.

Brady, K. T., Killeen, T. K., Brewerton, T., & Lucerini, S. (2000). Comorbidity of psychiatric disorders and posttraumatic stress disorder. *The Journal of clinical psychiatry*.

Brewin, C. R., Gregory, J. D., Lipton, M., & Burgess, N. (2010). Intrusive images in psychological disorders: characteristics, neural mechanisms, and treatment implications. Psychological review, 117(1), 210.

Brewin, C. R. (2015). Re-experiencing traumatic events in PTSD: New avenues in research on intrusive memories and flashbacks. European journal of psychotraumatology, 6(1), 27180.

Centre for Reviews and Dissemination. (2009). Systematic Reviews: The Centre for Reviews and Disseminations' guidance for undertaking reviews in health care. Retrieved on 1st June 2018 from https://www.york.ac.uk/crd/guidance/.

Cloitre, M., Chase Stovall-McClough, K., Miranda, R., & Chemtob, C. M. (2004). Therapeutic alliance, negative mood regulation, and treatment outcome in child abuse-related posttraumatic stress disorder. Journal of consulting and clinical psychology, 72(3), 411.

Critical Appraisal Skills Programme (CASP). (2017). Qualitative Research Checklist: 10 questions to help you make sense of qualitative research. National CASP Collaboration for Qualitative Methodologies. Oxford: Public Health Research Unit.

Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. Psychotherapy: Theory, research, practice, training, 41(4), 412.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. Behaviour research and therapy, 38(4), 319-345.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. British journal of clinical psychology, 38(3), 215-229.

Endnote X9 [Computer software]. (2013) Retrieved from https://swdb.ucl.ac.uk.

Hinton, D. E., & Lewis-Fernández, R. (2011). The cross-cultural validity of posttraumatic stress disorder: implications for DSM-5. Depression and anxiety, 28(9), 783-801.

Karatzias, T., Cloitre, M., Maercker, A., Kazlauskas, E., Shevlin, M., Hyland, P., ... & Brewin, C. R. (2017). PTSD and Complex PTSD: ICD-11 updates on concept and measurement in the UK, USA, Germany and Lithuania. European Journal of Psychotraumatology, 8(sup7), 1418103.

Karatzias, T., Hyland, P., Bradley, A., Cloitre, M., Roberts, N. P., Bisson, J. I., & Shevlin, M. (2019). Risk factors and comorbidity of ICD-11 PTSD and complex PTSD: Findings from a trauma-exposed population based sample of adults in the United Kingdom. Depression and anxiety, 36(9), 887-894.

Kashdan, T. B., Barrios, V., Forsyth, J. P., & Steger, M. F. (2006). Experiential avoidance as a generalized psychological vulnerability: Comparisons with coping and emotion regulation strategies. Behaviour research and therapy, 44(9), 1301-1320.

Keller, S. M., Zoellner, L. A., & Feeny, N. C. (2010). Understanding factors associated with early therapeutic alliance in PTSD treatment: Adherence, childhood sexual abuse history, and social support. Journal of consulting and clinical psychology, 78(6), 974.

Leahy, R. L. (2008). The therapeutic relationship in cognitive-behavioral therapy. Behavioural and Cognitive Psychotherapy, 36(6), 769-777.

Lester, K., Artz, C., Resick, P. A., & Young-Xu, Y. (2010). Impact of race on early treatment termination and outcomes in posttraumatic stress disorder treatment. Journal of consulting and clinical psychology, 78(4), 480.

Lewis, C., Roberts, N. P., Andrew, M., Starling, E., & Bisson, J. I. (2020). Psychological therapies for post-traumatic stress disorder in adults: Systematic review and meta-analysis. European Journal of Psychotraumatology, 11(1), 1729633

Lewis, C., Roberts, N. P., Gibson, S., & Bisson, J. I. (2020). Dropout from psychological therapies for post-traumatic stress disorder (PTSD) in adults: systematic review and meta-analysis. European journal of psychotraumatology, 11(1), 1709709.

Lucas, P. J., Baird, J., Arai, L., Law, C., & Roberts, H. M. (2007). Worked examples of alternative methods for the synthesis of qualitative and quantitative research in systematic reviews. BMC medical research methodology, 7(1), 4.

McFetridge, M., Hauenstein Swan, A., Heke, S., & Karatzias, T. (2017). UK Psychological Trauma Society (UKPTS) Guideline for the treatment and planning of services for Complex Post-Traumatic Stress Disorder in adults. UKPTS (United Kingdom Post Traumatic Stress Society).

McPherson, S., Wicks, C., & Tercelli, I. (2020). Patient experiences of psychological therapy for depression: a qualitative metasynthesis. BMC psychiatry, 20(1), 1-18.

Moher, D., Shamseer, L., Clarke, M., Ghersi, D., Liberati, A., Petticrew, M., ... & Stewart, L. A. (2015). Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. Systematic reviews, 4(1), 1.

Najavits, L. M. (2015). The problem of dropout from "gold standard" PTSD therapies. F1000prime reports, 7.

National Institute for Health and Care Excellence. (2013) Post-traumatic stress disorder. Retrieved from https://www.nice.org.uk/guidance/ng116

Norris, N. (1997). Error, bias and validity in qualitative research. Educational action research, 5(1), 172-176.

Noyes, J., Booth, A., Flemming, K., Garside, R., Harden, A., Lewin, S., ... Thomas, J. (2018). Cochrane Qualitative and Implementation Methods Group guidance series—paper 3: methods for assessing methodological limitations, data extraction and synthesis, and confidence in synthesized qualitative findings. Journal of Clinical Epidemiology, 97, 49-58.

Ouzzani, M., Hammady, H., Fedorowicz, Z., & Elmagarmid, A. (2016). Rayyan – a web and mobile app for systematic reviews. Accessed at https://rayyan.qcri.org/welcome

Pope, C., & Mays, N. (1995). Qualitative research: reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. Bmj, 311(6996), 42-45.

QSR International Pty Ltd. (2020) NVivo [Computer software]. (2020). Retrieved from https://swdb.ucl.ac.uk.

Robjant, K., & Fazel, M. (2010). The emerging evidence for narrative exposure therapy: A review. Clinical psychology review, 30(8), 1030-1039.

Ruzek, J. I., Eftekhari, A., Rosen, C. S., Crowley, J. J., Kuhn, E., Foa, E. B., ... & Karlin, B. E. (2014). Factors related to clinician attitudes toward prolonged exposure therapy for PTSD. Journal of Traumatic Stress, 27(4), 423-429.

Schauer, M., Schauer, M., Neuner, F., & Elbert, T. (2011). Narrative exposure therapy: A short-term treatment for traumatic stress disorders. Hogrefe Publishing.

Schnyder, U., Ehlers, A., Elbert, T., Foa, E. B., Gersons, B. P., Resick, P. A., ... & Cloitre, M. (2015). Psychotherapies for PTSD: what do they have in common?. *European Journal of Psychotraumatology*, *6*(1), 28186.

Spoont, M. R., Nelson, D. B., Murdoch, M., Sayer, N. A., Nugent, S., Rector, T., & Westermeyer, J. (2015). Are there racial/ethnic disparities in VA PTSD treatment retention?. Depression and anxiety, 32(6), 415-425.

Sripada, R. K., Rauch, S. A., & Liberzon, I. (2016). Psychological mechanisms of PTSD and its treatment. Current psychiatry reports, 18(11), 1-7.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. BMC medical research methodology, 8(1), 45.

van der Kolk, B. A. (2015). The body keeps the score: Brain, mind, and body in the healing of trauma. Penguin Books.

van Minnen, A., Hendriks, L., & Olff, M. (2010). When do trauma experts choose exposure therapy for PTSD patients? A controlled study of therapist and patient factors. Behaviour research and therapy, 48(4), 312-320.

Varker, T., Jones, K. A., Arjmand, H. A., Hinton, M., Hiles, S. A., Freijah, I., ... & O'Donnell, M. (2021). Dropout from guideline-recommended psychological treatments for posttraumatic stress disorder: A systematic review and meta-analysis. Journal of Affective Disorders Reports, 100093.

Watts, B. V., Schnurr, P. P., Mayo, L., Young-Xu, Y., Weeks, W. B., & Friedman, M. J. (2013).

Meta-analysis of the efficacy of treatments for posttraumatic stress disorder. J Clin

Psychiatry, 74(6), e541-e550.

Part 2: Empirical Paper

The lifeline in narrative exposure therapy: the experience of therapists

Abstract

Aim: This study aimed to explore therapist experience of delivering the lifeline component of narrative exposure therapy (NET), an intervention for people with post-traumatic stress disorder resulting from multiple traumas. The lifeline is a unique part of NET which involves the construction of a chronological representation of the client's life using physical symbols to depict traumatic events as well as positive experiences.

Method: A semi-structured interview was conducted with 16 therapists who had experience of delivering the lifeline component of NET. The data from these interviews was analysed using thematic analysis.

Results: Five overarching domains were developed, each encapsulating three themes. The first domain pertains to the overlapping purposes of the lifeline, united by the vital function of developing the therapeutic relationship. The second domain describes the value and potential therapeutic mechanisms of the lifeline's 'whole life' perspective. The third domain speaks to the intensely emotional nature of the lifeline process, and some of the challenges of this. The fourth domain relates to the physicality of the lifeline and the value this adds beyond a purely verbal method, and the final domain encompasses several challenges of the lifeline described by therapists and potential areas for further development.

Conclusion: This study provides a rich account of the novel lifeline component in NET. These findings provide direction for refinement of clinical practice and avenues for future research.

Introduction

Traumatic events and their sequalae

The consequences of exposure to traumatic events poses a significant burden on populations worldwide (Olff et al., 2020). A meta-analysis of relevant studies suggests that a year after a trauma, around 17% of people present with experiences often conceptualised as post-traumatic stress disorder (PTSD; Santiago et al., 2013). PTSD has three main symptom clusters: re-experiencing of the traumatic event/s; persistent, high levels of arousal, and avoidance of internal and/or external reminders of the event/s (World Health Organisation, 2018). In recent decades, a further post-traumatic syndrome has been included in the diagnostic system: complex PTSD (CPTSD; Herman, 1992). A person with CPTSD will experience the three symptom clusters of PTSD, alongside difficulties with affect regulation; self-concept; and interpersonal relationships (World Health Organisation, 2018).

The term 'trauma' encapsulates a broad range of experiences, from a single incident natural disaster, through to a prolonged period of torture, for example. Thus, it is important that more specific patterns and associations between trauma and its sequelae are identified so as to refine treatments. Epidemiological studies indicate that exposure to multiple traumatic events is relatively common; often more common than exposure to a single incident alone (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Kilpatrick et al., 2013; Benjet et al., 2016). Repeated and/or prolonged experiences of trauma, especially where it is intentional and interpersonal in nature, appear to confer a higher risk of PTSD and CPTSD (Frans, Rimmö, Åberg & Fredrickson, 2015; Cloitre, 2020; Zerach, Shevlin, Cloitre & Solomon, 2019; Breslau, 2001; Luthra et al., 2009; Hyland et al., 2017), and a more complex clinical presentation of both disorders (Suliman et al., 2009; van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005; Santiago et al., 2013; Frost et al., 2019).

It is clear, therefore, there are a significant group of people who are exposed to multiple, prolonged, and/or interpersonal traumas who go on to then develop PTSD or CPTSD. This group includes people who have been exposed to war or forced displacement, amongst other experiences where the traumas are repeated, prolonged, and inflicted by other human beings, such as childhood sexual abuse. Amongst clinical experts, it is felt that this trauma background requires some considerations in treatment compared to when working with those who have experienced an isolated traumatic incident (Cloitre et al., 2011).

Narrative exposure therapy: the model and theory

Evidence-based trauma-focussed therapies include prolonged exposure (Foa & Rothbaum, 2001), trauma-focussed CBT (Ehlers & Clark, 2000), cognitive processing therapy (Resick & Schnicke, 1992) and narrative exposure therapy (NET; Schauer, Schauer, Neuner & Elbert, 2011); all recommended by the National Institute for Clinical Excellence for the treatment of PTSD (NICE, 2018). While they differ on precise theoretical underpinnings and procedures, there are some key similarities. Firstly, they are all largely based on models of maladaptive processing of the trauma memory during or after the trauma (Brewin & Holmes, 2003). Secondly, the therapies themselves generally involve some common components, most notably some form of exposure to the trauma memories. Finally, they all appear to aim for a reorganisation of the trauma memory and the construction of a coherent narrative of the traumatic events (Schnyder et al., 2015).

The model of memory in NET

NET was specifically designed for populations who have experienced multiple, prolonged, or intentional traumas (Schauer, Schauer, Neuner & Elbert, 2011). The model of memory in NET, outlined in Schauer, Schauer, Neuner & Elbert (2011), supposes that during a traumatic experience, sensory and perceptual information is processed differently to usual due to extremely high levels of arousal. The sensory-perceptual information is referred to as

'hot memory', and the factual information as 'cold memory' (Metcalfe & Jacobs, 1996), not dissimilar to the dual representation theory's situationally accessible memory and verbally accessible memory (Brewin, 2001). The NET model of memory is influenced by Conway (2001), who delineates how 'normal' memory recollection requires access between autobiographical memory (similar to NET's cold memory) and episodic memory (similar to NET's hot memory).

In PTSD, different components of hot memory form a fear network: a large, interconnected system of different sensory, perceptual and physiological elements of the trauma (Foa & Kozak, 1986). The memory associated with this fear network is not embedded in usual autobiographical memory (cold memory); it may be entirely detached from place, time, and lifetime period information. If a matching cue is encountered in the environment, this can quickly activate the entire fear network due to its isolation from the cold or autobiographical memory. This recall of the hot memory is experienced without context, as though it is happening again: as a flashback.

The desire to avoid the memories allows for the consolidation of the fear network: it prevents the hot memory from being knit together with cold memory naturally. This means that people with PTSD may have extremely confused life narratives, punctuated by deeply distressing, decontextualised hot memories that do not exist within a clear lifetime period (Ehlers & Clark, 2000; van der Kolk & Fisler, 1995).

Testimony therapy and the principles of exposure in NET

NET also draws on testimony therapy (Cienfuegos & Monelli, 1983), developed in Chile for traumatised survivors of organised violence. Initially its aim was to document the violence faced by political prisoners, but the process of telling their stories was found to be therapeutic, and so it was further developed as a therapeutic practice (Van Dijk, Schoutrop & Spinhoven, 2003). The process of testimony therapy involves the telling of a person's story

and experiences, with a particular focus on situating these within the social and political context where they occurred. These testimonies are audio-recorded, and a written account is produced, signed by therapist and survivor. Testimony therapy's aim is not one of exposure, per se, but of developing, documenting, and witnessing people's narratives. It is these aims that are incorporated into NET. NET draws also on the cognitive-behavioural principles of exposure. In particular, it incorporates habituation to the fear network, so that the memories can be spoken without eliciting the strong sensory and emotional components present at the time of the trauma (Schauer, Schauer, Neuner & Elbert, 2011).

Narrative exposure therapy: the intervention

NET is delivered in three phases. First, there is an assessment and psychoeducation phase, whereby presence of PTSD or complex PTSD symptoms is assessed, and information about PTSD and the manner of treatment are shared and discussed. The second key component is the lifeline session, where physical materials are used to construct a representation of the client's life in order from birth to present. In this session, the therapist offers a range of physical materials to the client with explanations of what they represent[1]. A string or ribbon is laid along the floor to represent the client's life from birth through to the future, which is represented by the coiled end of the string or ribbon. Together, the client and therapist move along the lifeline, laying in chronological order stones to represent traumas, and flowers to represent significant positive experiences. Each of these events is given a short label to describe it, for example '21 years old, my hometown, on my wedding day' or '12 years old, being kidnapped from the school in my village'. The labels need to describe the event in a brief way, and the time and place it occurred, but the aim is not to elicit more detail

---

[1] The COVID-19 pandemic has required the remote delivery of the lifeline. Clinical practice guidelines for the remote delivery of NET have been developed to support this, although at the time of interviews it is unlikely therapists would have had access to these as one had only just been published and the other was not published until after the interviews. The guidelines can be found in Robjant, Meyer, Schauer, Kaltenback & Kaiser (2020) and Kaltenbach et al., (2021).

than this. Indeed, the therapists' aim throughout the lifeline session is to keep the client in their 'cold memory'. The lifeline is then used as the guide for the rest of therapy: client and therapist work sequentially through the stones and flowers, narrating them in chronological order from birth to present day. An example lifeline is shown in figure 1 below.

Figure 1. *Example of a NET lifeline*

Narration involves exposure to the event through re-telling it in detail, carefully integrating the hot memory information with cold memories relating to time, place, life period, and context. After each narration, the therapist writes an account of the event, which is then read back to the client at the start of the following session. At the end of therapy, this entire written account is re-read and signed by therapist and client, and the client is given a copy to keep, which can be used to for documentation or legal uses should the client pursue these avenues.

NET was developed to be delivered in settings where access to mental health support may be limited, and there is significant organized state violence, human rights abuses, or armed conflict (Robjant & Fazel, 2010). It was designed as an intervention that can be taught

relatively rapidly to lay therapists, often people from the local community, to increase its accessibility in challenging settings. It has been delivered successfully by lay therapists (Neuner et al., 2008), and one meta-analysis found larger effect sizes for NET when delivered by lay therapists compared to external therapists (Gwozdziewycz & Mehl-Madrona, 2013).

Understanding the role of the lifeline in NET

While all trauma-focussed therapies are likely to include taking a thorough assessment and history, they tend then to involve selecting the 'worst' or most distressing events to focus on in therapy. The lifeline in NET is unique in this regard; it allows for a broader view of all of the events of significance. The NET manual suggests this is helpful, first because reflection on "the meaning of interrelated configurations of life" can support the development of a more whole identity, and second because the whole life view honours and activates people's resources and strengths which are often eclipsed by the trauma (Schauer, Schauer, Neuner & Elbert, 2011). It seems therefore that the lifeline is both a unique and potentially very powerful, humanising part of the therapy. It should be noted that NET has been found to be effective without the lifeline (Neuner et al., 2004; Schauer et al., 2006; Hijazi, 2012; as detailed in Vivo International, 2015), although it is possible the lifeline's contributions to therapy are not captured by the usual measures of effectiveness.

Despite this novelty and uniqueness, the lifeline in NET has received very little research attention of its own. NET is a relatively 'young' therapy meaning much of the evidence base at this stage focusses helpfully on effectiveness and efficacy: it has been found to be effective in reducing both PTSD and depression symptoms in a range of settings and populations (e.g. Zang, Hunt & Cox, 2013; Alghamdi, Hunt & Thomas, 2015; Stenmark, Ctani, Neuner, Elbert & Holen, 2013). This effectiveness has been shown consistently across studies and in meta-analysis (Lely, Smid, Jongedijk, Knipscheer & Kleber, 2019). Most of the

evidence for NET at present is in low- and middle-income countries, or with refugees and asylum seekers, though clinically it is used more broadly than this.

To the author's knowledge, there is one paper specifically focussed on the lifeline. There, Schauer & Ruf-Leuschner (2014) note that people with multiple traumas often require a different therapeutic approach; treating a selection of their traumatic events individually and in isolation is not likely to be beneficial. Instead, they argue that meaningful trauma therapy for people who have been multiply traumatised must involve the person developing an entire, coherent life narrative, and that the lifeline is instrumental in beginning this process. They posit that starting therapy with the lifeline facilitates a "structured and dosed contact" with the trauma memories; the early stages of contextualising the traumas within one's overall life narrative; and an opportunity to take an "allocentric position": looking at one's life narrative from the perspective of an external observer, at a distance.

Qualitative research of the therapist experience

As there is not yet a great deal of research around the lifeline, a qualitative approach may be beneficial. In therapy research, qualitative methods are able to provide insight into the "how and what" questions around the process of therapeutic change, which compliment the "how much" questions that quantitative methods would usually seek to answer (Binder, Holgersen & Moltu, 2012). Qualitative studies of the client experience of therapy have generated new, testable hypotheses and mechanisms which may not have otherwise been identified in the dominant quantitative methods of psychotherapy research (Levitt, Pomerville & Surace, 2016). Qualitative inquiry of the therapist experience of interventions could be similarly fruitful.

There is limited research exploring how therapists experience the implementation of trauma-focussed therapies, despite it being acknowledged that there are challenges (e.g.,

beliefs and attitudes about exposure: Becker, Zayfert & Anderson, 2004; or vicarious traumatization: Pearlman & Mac Ian, 1995). Trauma-focussed therapy is a complex, sometimes distressing, innately interpersonal task, particularly with people who are multiply traumatised, and thus there is value in understanding the therapist experience. Insight from this kind of research can be used to develop training programs, delineate clinical decision-making processes more clearly, and more generally promote self-reflection amongst therapists and supervisors (Williams & Lewitt, 2007, cited in Levitt, 2015). Moreover, therapist insights can also be helpful to develop further understanding and hypotheses about mechanisms of change in trauma-focussed interventions.

The current study will focus on understanding therapist perspectives on the lifeline component of NET. This particular component was selected due to its novelty and uniqueness amongst trauma-informed therapies. This study takes a qualitative approach to the question: *what is the experience of therapists in delivering the lifeline component of narrative exposure therapy to clients who have survived multiple traumas?*

Method

Participants

This study aimed to recruit therapists who had experience providing NET.

Inclusion criteria

Inclusion criteria were as follows:

- Experience of delivering the NET intervention, which must include completion of lifeline session, with at least one client

- Clinicians could have any professional background, and be either qualified or in training

- The clients that clinicians completed the lifeline/s with must have been seeking therapy for multiple and/or prolonged trauma (i.e., repeated, but separate, traumatic events; and/or traumatic events which continue for a long period of time, such as a period of torture).

Procedure

As there is no central register for NET therapists, recruitment focused on the use of social media and professional networks to advertise the study, with a particular focus on specialist trauma services. The study was advertised on Twitter and Facebook, and it was shared via email with professional contacts of the author and supervisor. The advert for the study can be found in Appendix B.

After expressing an interest in the study, potential participants were provided with the study information sheet (see appendix C), and the opportunity to ask any questions. If potential participants were then interested in taking part, a consent form (see appendix D) was completed by both parties, and a convenient time for the interview was arranged. The interviews took place via Microsoft Teams.

First, the demographics form was completed, followed by the semi-structured interview. The interview was audio recorded on a password-protected Dictaphone. At the end of the interview, participants were offered the opportunity to ask any further questions and thanked for their participation. A £20 online shopping voucher or charity donation was given to participants to thank them for their time.

Recruitment

Nineteen people expressed an interest in taking part in the study. Two did not respond to the researcher's follow-up email, and the remaining 17 people took part in the study. Interviews were conducted between December 2020 and February 2021. When interviewing one participant, it became apparent that they were not using NET with clients seeking therapy

for a history of multiple or prolonged trauma. The author discussed this with the research supervisor, and a decision was made to exclude this participant's interview from the analysis in line with the inclusion criteria. This left the sample with sixteen participants who were included in the analysis.

Sample characteristics

A range of general demographic information was collected from participants, detailed in Table 1 below. The sample was entirely female, and predominantly White British and European. Almost all participants were qualified clinical psychologists, and there was one trainee clinical psychologist and one counselling for depression practitioner.

Table 1. *Participant demographics*

Demographic	Description	*n* (%) or Mean (SD); [Range] in years
Gender	Female	16 (100%)
Age		34.63 (7.05); [26 – 51]
Ethnicity	White British	10 (62.50%)
	White European	3 (18.75%)
	Black African	1 (6.25%)
	White and Chinese	1 (6.25%)
	White New Zealander	1 (6.25%)
Professional status	Qualified	15 (93.75%)
	Trainee	1 (6.25%)
Professional background	Qualified clinical psychologists	14 (18.75%)
	Qualified counselling for depression practitioner	1 (6.25%)
	Trainee clinical psychologists	1 (6.25%)
Years qualified [1]		5.81 (7.10) [1– 26]

[1] As one participant was not yet qualified, the mean, standard deviation, and range for Years qualified is based on *n* = 15.

Most participants worked with refugees and asylum seekers when using NET, two participants had used NET mainly with people with PTSD or complex PTSD in community mental health settings, and one had used it predominantly with people with comorbid psychosis and PTSD. Those who worked with asylum seekers had often used NET in one of two key charities who support this population, or one of several specialist services for refugees in London. Participants largely worked in London and the surrounding counties, or the south-west of England. The sample included a range of expertise and experience levels with these client groups and with NET, from relative novices to recognised experts in the field. Most participants had received NET training from trainers formally recognised by Vivo International (the organization which co-ordinates formal training in NET; www.vivo.org), or in-house training at specialist trauma services with expert clinicians. This information is detailed in full in table 2 below.

Table 2. *NET training and clinical experience*

NET training and experience	Description	*n* (%) or Mean (SD); [range]; {mode}
NET training experience	Formal training with Vivo International	7 (43.75%)
	In-house training in specialist trauma services	6 (37.50%)
	Self-taught using manual	2 (12.50%)
	Training during DClinPsy	1 (6.75%)
Main client group used NET with	Refugees and asylum seekers	12 (75.00%)
	Adults with PTSD/CPTSD in a community mental health setting	3 (18.75%)
	People with comorbid psychosis and PTSD	1 (6.25%)
Years of experience with NET	0-2 years	6 (37.50%)
	3-5 years	7 (43.75%)
	6-10 years	1 (6.25%)
	11+ years	2 (12.50%) {3-5 years}
Estimated number of full NET treatment cases completed	1-5 clients	5 (31.25%)
	6-10 clients	4 (25.00%)
	11-15 clients	1 (6.25%)
	16+ clients	6 (37.50%) {16+ cases}
Estimated number of lifelines completed, including those as a part of full NET treatment cases	1-5 lifelines	4 (25.00%)
	6-10 lifelines	1 (6.25%)
	11-15 lifelines	2 (12.50%)
	16+ lifelines	8 (50.00%) {16+ lifelines}
Self-rated confidence with NET (/10)		6.68 (1.65) [5/10 to 10/10]
Supervision for NET work	Weekly	5 (31.25%)
	Fortnightly	4 (25.00%)
	Monthly	6 (37.50%)
	None	1 (6.25%) {monthly}
Other trauma-focussed therapy training[1]	Trauma-focussed CBT	14 (87.50%)
	EMDR	10 (62.50%)

Imagery rescripting	2 (12.50%)
Cognitive processing therapy	1 (6.25%)

[1] Some participants reported having training in more than one type of additional trauma-focussed therapy, hence these percentages do not total to 100.

Interview

A semi-structured interview schedule was constructed for this study. This format was chosen as it allowed for the probing of certain areas of interest, while still allowing space for participants to explore areas they felt were significant or important (Rabionet, 2011). An iterative approach was taken to the construction of the interview schedule. *Phase I:* In the first phase, the NET literature was reviewed (particularly a paper that directly addresses the lifeline; Schauer & Ruf-Leuschener, 2014), and the researcher attended NET training provided by a Vivo International trainer. From this, a set of preliminary questions and areas of interest were brainstormed. For example, the training had highlighted the importance of interpersonal attunement in the lifeline and later narration, so some questions pertaining to the interpersonal experience of the lifeline were drafted. *Phase II:* In the second phase, these ideas were drafted into an interview schedule, which was reviewed by the trainer from Vivo International and a qualitative research expert. These consultations allowed for further refinement of the form and content of the interview schedule. *Phase III:* The final draft of the interview was piloted with a trainee clinical psychologist with experience of NET, and some minor clarifications and changes to phrasing were introduced based on this feedback.

The final *Therapist experiences of the NET lifeline* interview aimed to explore three general areas: 1) the process of creating the lifeline, 2) the lifeline and the therapeutic relationship, 3) the impact of the lifeline. The main questions were left intentionally broad (e.g., 'How do you use the lifeline throughout the rest of therapy?'), followed by suggestions for follow up or clarifying questions (e.g., 'In what ways does the lifeline help/hinder you or the client across the following sessions?') The interview schedule can be found in Appendix E. The interviewer took a flexible approach to ensure the richness of participant's experience outside of the set questions could be captured, while still obtaining information on the areas of interest identified in the schedule. Generally, each of the three overarching areas was

covered, and the conversations naturally touched on most of the main questions in each section. Where needed to prompt further thought, detail, or to probe a different area not yet mentioned, the interviewer utilised the prompt questions listed. The interview schedule was used flexibly as a guide rather than in a prescriptive manner. Interviews lasted between 40 minutes and 1 hour and 2 minutes, and were all conducted via video call.

Analysis

Method of analysis

The interviews were analysed using thematic analysis, using the six steps outlined by Braun & Clarke (2006). First, the researcher familiarised herself with the data through the process of transcribing, and later reading through each transcript multiple times. Secondly, the research completed initial coding that captured potentially interesting ideas in the data. This stage produced 154 initial codes which were then used during the third stage: searching for themes. The researcher began to work on sorting and collating the codes into groups which could be combined to create overarching, broad themes. This was an iterative process, and mind-maps and tables were used to compare and contrast codes under themes, until a preliminary theme framework was developed. In the fourth stage, these themes were reviewed in detail, at both raw data, code, and theme level. This resulted in an updated and clarified theme framework which better fit the data and codes underlying it. In the fifth stage, themes were defined and named. The boundaries of themes were established, and labels were given to themes that aimed to capture the core essence of what they represented. In the sixth and last stage, the themes were finalised and written up for the results section of this report. An excerpt of a transcript annotated to demonstrate the process of the analysis is provided in appendix F.

Validity checks

Several means of exploring the validity of the results of analysis were deployed, as is advised in qualitative research guidelines (Elliott, Fischer & Rennie; 1999; Patton, 1999). Before conducting the interviews, the researcher took part in a bracketing interview with a co-researcher. Bracketing interviews aim to highlight potential areas of bias or preconceptions on the part of the researcher, bringing them to the researcher's attention so their impact can be considered and mitigated in the interviews (Tufford & Newman, 2012; Finlay, 2002). For example, the bracketing interview highlighted the researcher's generally positive views about the NET lifeline, and so on starting the interviews, she was careful to pay equal attention to questions about challenges of the lifeline or negative opinions on it. In addition to ensuring there were explicit questions in the interview schedule about the challenges of NET, the researcher also aimed to be attentive to any potentially critical or negative comments in the interview so they could be followed up on and explored further.

During the initial coding phase, the author coded two interviews and shared these with the research supervisor. Once a preliminary theme structure was agreed, this was also thoroughly discussed with the research supervisor. At both stages, author and research supervisor discussed the coding and themes, highlighting any inconsistencies, overlaps, or areas of bias, before reaching consensus on the final analysis.

Once the analysis had been agreed by author and research supervisor, the author shared two interview transcripts with a co-researcher. The overall theme framework was also shared, and the co-researcher was asked to re-code the transcripts, assessing 'goodness-of-fit' with the existing theme framework. She was asked particularly to focus on highlighting any data which she felt was not well-captured by the existing themes and subthemes, as well as to provide her thoughts on the analysis overall. Following this, the author and co-researcher discussed her views and worked further on the analysis until consensus was reached.

The final stage of validity checking involved consultation with a participant who is an experienced clinician in the field. Member checks are considered to be an important part of qualitative research, to assess the extent to which the final analysis accurately reflects what the participant felt they had conveyed during the interview (Creswell & Miller, 2000). The final analysis was shared with one participant who has particular expertise in NET. She provided largely affirmative feedback, and some minor inconsistencies were highlighted and then incorporated into the analysis.

Researcher background and position

Researcher reflexivity is essential in qualitative work, as the researcher and her position influence the entire research process (Finlay, 2002). The process and presentation of 'situating the researcher' (Patnaik, 2013) allows for consideration of how one's own position, motivations, and identities impact on the research process and outcome, and thus is an important part of considering the credibility and validity of qualitative research. The author is a White British woman in her 20s. She approached the research from a critical realist perspective (Willig, 2012). This meant she assumed that the participants would communicate their personal experiences of the lifeline to her, but that this does not directly reflect one truth or objective reality; it would be filtered both through their identities and experiences, and her own.

During the design phase of the project, the author had no clinical experience of trauma-focussed approaches. By the time of interviewing, she had begun work in a complex trauma team, and by the time the analysis was being worked on, the author had begun using NET and the lifeline with clients. Due to this shifting level of relevant experience, the author continually reflected on her changing thoughts, preconceptions, and learning through a self-reflective journal. Particularly during analysis, she reflected on her own experience of completing the lifeline, and ways in which this overlapped with or diverged from the

experience of participants, particularly those who were at a similar experience level to her. This allowed her to approach the data with an awareness of what participant accounts might 'grab' her and seem salient, and those which might be less appealing or resonant.

Ethical approval

This study received ethical approval from the UCL Research Ethics Committee; the approval letter is provided in appendix G.

Results

The thematic analysis resulted in five overarching domains, each encompassing three themes. The first domain pertained to the overlapping and interdependent purposes of the lifeline; the second domain concerned the value of hearing about clients' entire lives in the lifeline session; the third described the emotional experience of completing the lifeline; the fourth explored the power of the lifeline as a physical, visible, tangible part of the therapy; and the final domain encompassed several areas that were raised as challenging or for further development. Table 3 outlines the overall structure of the domains and themes.

Overall, therapists reported strong positive feelings about the lifeline, describing it as a part of their clinical practice that they enjoyed and valued: *"I really love it, it's one of my favourite things about NET"* (P17); *"it's still a very enjoyable part of the therapy"* (P11); *"it's actually quite beautiful"* (P8). Therapists often reported completing a lifeline with all the clients they were going to commence trauma-focussed work with, even if this wasn't going to be the full NET intervention.

Table 3. Summary of analysis structure

Domain	Themes
1. Strengthening the relationship through the lifeline	**1.1** Core conditions in a robust human rights framework
	1.2 Lifeline as a containing assessment tool and roadmap
	1.3 A gentle introduction to the work of therapy
2. Hearing it all: contextualising, coherence, and witnessing in the lifeline	**2.1** The centrality of witnessing and being witnessed
	2.2 Flowers alongside stones: supporting contextualization and coherence
	2.3 Meeting a whole person, a whole life
3. "It's definitely a rollercoaster": emotions in the lifeline	**3.1** A big ask for all involved: the lifeline as a powerful exercise
	3.2 Affect in the session is changeable, but usually resolves in a positive way
	3.3 Containment vs validation: the difficult task of pacing
4. Beyond words: the value of a physical, visible, tangible lifeline	**4.1** The visual, physical, tangible lifeline adds something to the verbal
	4.2 The lifeline "takes the heat out" of the task
	4.3 Symbols generally aid cross-cultural understanding
5. Challenges and areas for further development	**5.1** Client buy in and understanding
	5.2 Ensuring cultural sensitivity
	5.3 Technical challenges and off-model use

Domain 1: Strengthening the relationship through the lifeline

The first domain describes key functions and purposes of the lifeline from therapists'

perspectives. While there was a number of functions identified, it was felt that these were

useful largely because they were taking place in the context of a developing relationship:

without this, they would be less powerful. This domain therefore also explored the

fundamental relational function of the lifeline: supporting the development of a therapeutic

relationship.

Figure 2. *Domain 1 summary*
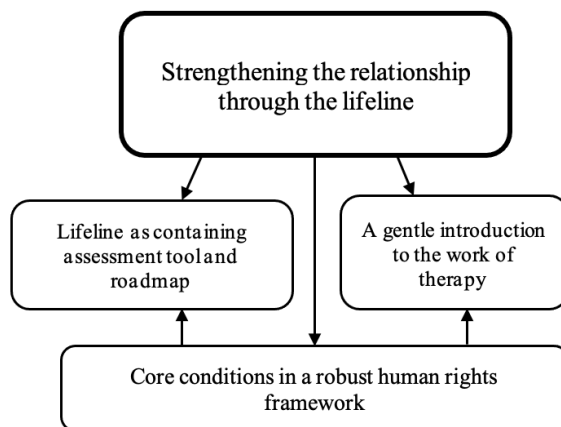
Theme 1.1: Core conditions in a robust human rights framework

Developing a strong therapeutic relationship and fostering trust was seen as a core

purpose of the lifeline component of therapy, and one which was vital to facilitating the other

functions and outcomes of the lifeline: *"one [purpose] is definitely to try to establish the*

intimate rapport from the beginning" (P3); *"there is that trust building that comes in when*

[…] starting that process" (P2).

In particular, therapists described the lifeline as a good way of promoting a

relationship with a balanced power dynamic. The active nature of being on the floor with the

client and moving things around together was commented on as being useful for this: *"we*

took our shoes off and we were both on the floor and we were both kind of even in that" (P1).

Therapists described a range of qualities and attitudes they aimed to bring to lifeline sessions to support the development of rapport. These largely represented Rogers' 'core conditions' (Rogers, 1957) of empathy, unconditional positive regard, and congruence. Therapists used words like *"compassionate"* (P1), *"non-judgmental"* (P4), and *"attentive"* (P17) to describe this stance. The core difference in therapist mode appeared to be the intentional inclusion of a robust human rights stance. For example, therapists commented on the importance of the model giving permission to state when things that had happened to clients were wrong, unlawful, or immoral.

Theme 1.2: Lifeline as a containing assessment tool and roadmap

Many therapists commented on how the lifeline functions as an efficient and comprehensive means of assessment, which feeds smoothly into a 'roadmap' for the rest of the therapy sessions. They pointed out how gathering information in the lifeline feels different to other forms of assessment, or indeed how agencies like the Home Office would gather not dissimilar information. The difference, as highlighted in theme 1.1, appeared to largely be the fact that in the lifeline, the assessment is taking place in the context of a developing, supportive relationship: *"that being listened, being heard, getting it out there without the sort of Home Office questioning style which comes up"* (P12).

Descriptions of the 'roadmap' function of the lifeline indicated it provides a containing plan for both therapists and clients. It was noted that for therapists, the lifeline gives a clear sense of what work would need to follow:

"I find it quite containing, it gives us a guide, so for example when I'm doing NET it sets out what the sessions are and you know what's coming, and they know what's coming as well so that containing aspect of it." (P12).

**Theme 1.3: A gentle introduction to the work of therapy**

Participants commented on how the lifeline provides a gentle introduction to, or a 'taster' of what the rest of therapy would be like without going into any detail about the traumatic events. It was felt that for clients, naming events during the lifeline might help them understand how it would feel to talk about these traumatic experiences in more detail later in therapy: *"it gives people a chance to talk through their story in brief and maybe in a way that is good practice for what's going to come next."* (P7).

This was viewed as valuable, as it helps therapists to understand and plan for how clients are likely to fare during the more intense narration sessions. Some participants also commented that the lifeline gives clients a sense of how the therapist responds to both their history and the emotions in session. Participants felt it was important that they *"emit this sense that [I] can take it, it's not going to phase [me]"* (P11), and that this was an important 'message' for clients to take away from the 'gentle introduction' that the lifeline provides.

Domain 2: Hearing it all: contextualising, coherence, and witnessing in the lifeline

This domain pertained to the significance and impact, on therapist and client, of covering a client's entire life story through the lifeline.

Figure 3. *Domain 2 summary*
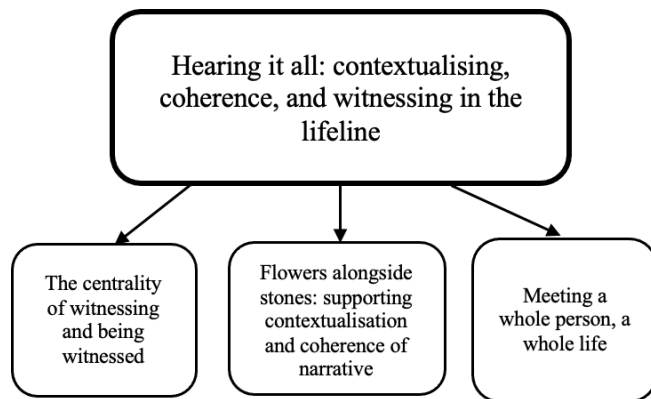
Theme 2.1: The centrality of witnessing and being witnessed

Participants frequently referred to the power of witnessing clients' stories, and the assumed power of being witnessed for clients. Participants referred to 'hearing it all' as allowing them to bear witness to a client's testimony, and this being of central importance: *"I think something I'm also aware of is how some of the bearing witness process starts from there"* (P2); *"it's really helpful because in a way people think, I feel like people feel really heard"* (P10). The therapeutic stance adopted to attain this was described as *"sitting back"* (P1), *"allowing the space"* (P12) and deploying relatively few, or no, 'technical' therapy skills or techniques.

Theme 2.2: Flowers alongside stones: supporting contextualization and coherence

Participants commented on the lifeline's use in supporting clients with early memory contextualization, helping clients to begin consolidating the traumatic events into their autobiographical narrative: *"it puts it in a 'that event happened in that time and that place' and you have to say where and when stuff happened […]. So it does contextualise stuff"* (P8).

84

The use of flowers appeared particularly important in facilitating a shift from clients having an understandable focus on the traumatic memories themselves, towards seeing them as awful, yet discrete life events embedded in a broader context.

There was also a sense that the lifeline contributes to clients gaining a more coherent life narrative. Participants described how clients appeared to gain a sense of order and chronology through the process of completing the lifeline with them, moving toward a clearer shared narrative: *"it has quite an integrative function, and starts the process of biographical order, I think it can help things almost feel like they've fallen into place."* (P1)

Theme 2.3: Meeting a whole person, a whole life

Participants described how the all-encompassing nature of the lifeline facilitates their taking of a 'whole person-whole life' perspective, in a way that is not inherent to other approaches. While other trauma-focussed therapies largely focus on the trauma and their sequalae, participants valued the broader view of the lifeline:

"It makes it about the person and their life rather than just the trauma. It gives them an idea of like 'I am interested in you, and your life, I'm not just gonna sit here and ask you to talk about the worst possible things, you're not just defined essentially by what's happened to you'" (P6)

Hearing the entire story of a client's life was experienced as a privilege and an honour, as well as being materially helpful for later sessions. Participants described, for example, how learning about a person more broadly supports the identification of *"resources and positive experiences"* (P9), and a greater sense of a person's untraumatised identity.

Domain 3: "It's definitely a rollercoaster": emotions in the lifeline

This domain described, from the therapist perspective, the emotional experience of lifeline sessions, which is variable, intense, and sometimes difficult to navigate.

Figure 4. *Domain 3 summary*
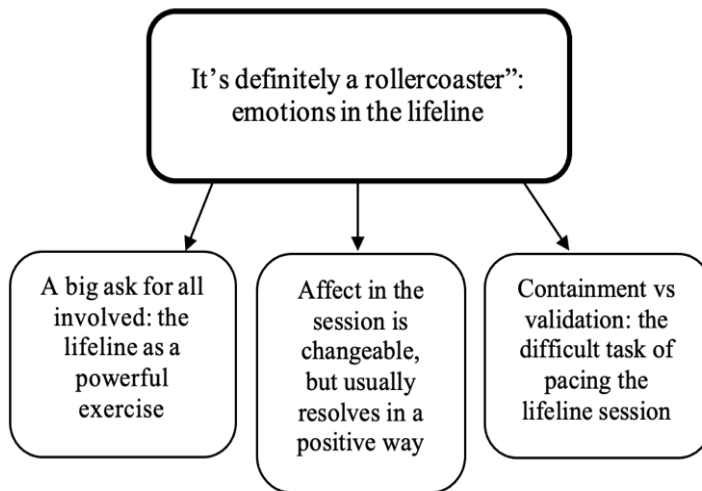
Theme 3.1: A big ask for all involved: the lifeline as emotionally intense

The lifeline was described as an incredibly emotionally intense process. Participants felt that for clients it had the potential to be deeply exposing and distressing; due to the content discussed as well as the amount of information disclosed in a short period of time: *"I have had people say it was really hard to do. I have had people say that it felt quite overwhelming when they looked at it"* (P5). Participants seemed to have a respect for the gravity of the task of the lifeline, and how demanding a request this was for clients.

The lifeline was described as emotionally intense for therapists. They described a range of emotions they often feel through the lifeline, such as *"pride"* (P6); a deep sense of *"anger at the injustice"* (P2); and *"pain and upset"* (P9) when witnessing high levels of client distress. Some participants commented on the importance of therapists giving space to debrief and process lifeline sessions before being able to move on with one's day.

Theme 3.2: Affect in the session is changeable, but usually resolves in a positive way

The affective 'journey' through lifeline sessions seemed to be changeable and dynamic. The lifeline was described as feeling *"active"* (P9) and energised, and affect throughout sessions would often fluctuate along with the narrative of a person's life. Some participants described the way that flowers help to modulate affect, providing useful moments where arousal reduced:

"he was smiling and laughing and saying 'I hadn't thought of that for so long' and that was amazing, because that gave him a stepping stone, it kinda just connected him with an internal resource that then allowed us to go through the next bit" (P12).

Many participants described how after this "rollercoaster", when reviewing the lifeline as a whole, there was a sense of positive resolution for clients. Participants described this emotional resolution in different ways, using words such as *"achievement"* (P17), *"relief"* (P13) and *"wow"* (P14).

It is important to note, however, that the fluctuating affect of the session was not always described as resolving positively. Some participants described how on viewing the whole lifeline, clients could feel hopeless, or upset by the lack of positive events across their lives. This suggests that there is some variation in the final emotional tone of lifeline sessions, and it may not always leave clients with a sense of satisfaction or resolution:

"people can look at it afterwards and go… 'it just reinforces that feeling of I've not had a life'" (P5).

Theme 3.3: Containment vs validation: the difficult task of pacing

A key emotional tension described by participants was how to helpfully manage client's affect via the level of detail they allow them to give about specific events.

Participants described a difficult balance between two positions: a) cutting clients' accounts short, risking them feeling invalidated and b) letting clients go into detail and risking them feeling overwhelmed. It seemed that this was a continual 'balancing act' throughout lifeline sessions, underpinned also by the need to complete the whole lifeline in one session:

"you don't want them to go into too much detail, because they really struggle once they open that door, that memory just kind of overwhelms them and you really don't want them to do that." (P8)

"how do you move it along in a way that doesn't invalidate what the person's just told you, which could be a massive massive trauma?" (P11)

Some participants noted how important this pacing is to ensure the emotional safety of the session, for two reasons. First, it is key to keeping clients in the 'cold memory', as is detailed in the therapy manual. Secondly, because splitting the lifeline across multiple sessions is anecdotally described as having the potential to leave clients with a sense that their experiences are too overwhelming and unmanageable.

Domain 4: Beyond words: the value of a physical, visible, tangible lifeline

This domain described the ways that participants felt the lifeline being a physical, visual, and tangible thing was superior to a primarily verbal way of gathering information, developing relationships, or telling one's life story.

Figure 5. *Domain 4 summary*
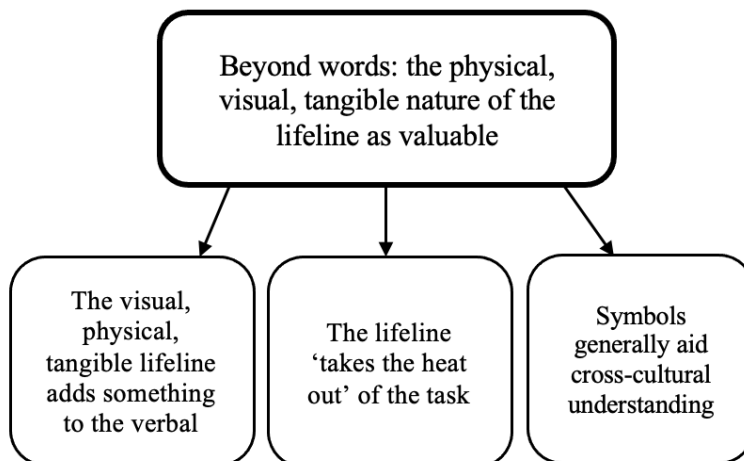
Theme 4.1: The visual, physical, tangible lifeline adds something to the verbal

The physical, visual, and tangible nature of the lifeline was frequently commented on in interviews, with a resounding sense that it provides something to the session that would not be attainable just through verbal conversation. The choice of stones and flowers was described as meaningful by some participants:

"people will spend a lot of time thinking about what flower to select and what stones to select. […] it gives you an opportunity to sort represent something in a way that you can't by words" (P17).

Being able to both look down on the lifeline on completion and reflect on its totality visually seemed to be felt to be valuable: *"we're looking at a picture of their life with all the very sacred and painful things in it, I think it just helps. It just helps people"* (P13). Most of the participants commented on how they would photograph the lifeline and clients could take a copy of this. This was felt to provide a sense of ownership and agency, that wouldn't be possible were it to be a solely verbal session, and which carried more weight and depth than a client receiving a copy of a report: *"then they've got ownership of it"* (P10).

89

Theme 4.2: The lifeline "takes the heat out" of the task

The lifeline's presence and the focus on it in the session was felt to be a diluting force in some ways, described as *"[taking] the heat out"* (P1) or *"[taking] the pressure out"* (P14) of the distress and difficulty of the content it represents. This was felt by participants to make the lifeline session easier and gentler in some way: *"it is actually easier to contain I think, [...] because they've got an actual physical thing that's saying 'oh yeah I need to keep doing this task'"* (P5).

There was sometimes a sense that the lifeline acted as a third presence in the room, providing a shared focus for both participant therapist to work on together: *"there's also something that we can both focus our attention on. [...] I think maybe people find it easier to open up in that way as well"* (P10), and that this too helped to dilute some of the emotional intensity of the session.

Theme 4.3: Symbols generally aid cross-cultural understanding

A smaller number of participants commented on how the symbols used in the lifeline themselves help make it an approach which can be flexibly used with people from many different cultures. It was felt that the symbols themselves are generally well-understood as holding an inherent meaning of stones = bad, flowers = good. This helps to bridge cultural and linguistic gaps, by providing a kind of 'tangible language':

> *"you're using tools, stones and nature, foliage, everyone experiences them, no matter what your background, so I think that is relatively more of a universal language"* (P17).

That said, there were rare instances where the symbols were not viewed by clients as neutral, easily understood objects. An important caveat was made, for example, about how stones might represent trauma too directly for people who have been stoned, and how caution is required when assessing this before the lifeline.

Domain 5: Challenges and areas for further development

The final domain encompassed several areas that were highlighted as particularly

challenging by participants, as well as some areas which may be helpful for the NET

community to consider and develop further.

Figure 6. *Domain 5 summary*
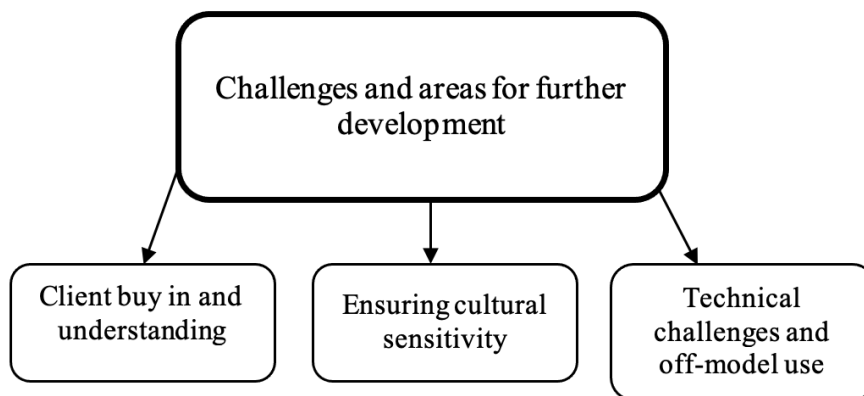
Theme 5.1: Client buy in and understanding

A few participants commented on difficulties with clients 'buying in' to the lifeline

task, for example *"some clients have just been like, 'no I don't want to do that' […] that*

doesn't resonate with them and they don't really kind of get it" (P9). Further to this, there

were a few accounts of clients not understanding the lifeline task, and using the materials in

their own idiosyncratic way during the session (e.g. using the objects to depict family trees,

or conflict zones they had experienced). It seemed difficult to know how to respond when this

happened due to a recognition that it was not a lifeline as detailed in the NET manual, but

that clients appeared to have found it helpful anyway.

Theme 5.2: Ensuring cultural sensitivity

Most clients felt the lifeline was generally a culturally sensitive exercise; many

responded similarly to P12: *"Um, I think it generally is [culturally sensitive]. I can't think of*

anything that really [is] insensitive". A small number of participants offered important reflections on challenges to the lifeline as a culturally sensitive component of NET. Some commented on the fact the lifeline is, at least partly, based on Western models of PTSD, and of therapy more generally (*"it's a very Western thing to think that talking about something will make it better";* P16). Another participant noted that it is a relatively individualistic approach, which may be incongruent with people it is often used with, who may come from more collectivist societies. A challenge highlighted by a few participants was how to guide clients in selecting what events are 'significant' and for inclusion across cultures, for example:

"the way we guide people is using our own frame. Our prompts are 'did you have brothers and sisters, what was it like growing up, what did your dad do?' Those are all the kind of things that we're interested in but it may very well be not the way people kind of punctuate their life" (P13).

Those participants who did not fully agree with the idea that the lifeline was largely culturally sensitive suggested that therapists need to intentionally attend to culture and language in the lifeline, rather than assume that it is culturally sensitive in its raw form:

"you need to think about kind of cross-cultural working, and people understanding the role of the lifeline and the meaning of it, and understanding of their PTSD symptoms, as we would label it" (P11).

Theme 5.3: Technical challenges and off-model use

There were a number of technical challenges described in the interviews, often pertaining to specific "what do you do when Y" or "how to manage X" questions. For example, a number of participants were not sure how to represent prolonged traumas (e.g., a period of torture) on the lifeline, or how to support clients to label the traumatic events in a

concise but descriptive way. Those participants who had conducted lifelines over videoconferencing during the pandemic reflected on the *"fiddly"* (P7) nature of this, and how some depth and power was lost in this medium.

Across a number of interviews, it seemed that participants were unsure or hesitant about whether their practice matched what the model and manual instruct. Participants often said things such as *"I don't know if I'm on or off model, but…"* (P14), or *"this is slightly not in the manual, but…"* (P9). An issue a number of participants had in relation to this conflict was completing the lifeline in a single session, and how complex this can be if a client is old, requires an interpreter, or is especially dissociative e.g.: *"I think as well the ability to do it in one session isn't always there"* (P5); *"with somebody with so many traumas I'm exhausted as well, I've done two hour, two and a half hour sessions at the worst and then I would just stop it probably and just spread over two sessions, even longer"* (P14).

Discussion

This study aimed to explore the therapist experience of the lifeline component of narrative exposure therapy. The thematic analysis resulted in five domains pertaining to the function, experience, value, and challenges of the lifeline, encompassing 15 themes.

The lifeline helps to support the therapeutic relationship

This study highlighted the importance of the relational dimension of the lifeline. Participants felt that the lifeline supported the development of the therapeutic relationship, and that this relational context allowed for the lifeline's other useful functions. This finding echoes research that identifies the relationship as key to both the process and outcomes of therapy generally (Martin, Garske, & Davis, 2000; Flückiger, Del Re, Wampold, & Hogarth, 2018); as well as to trauma-focussed therapy specifically (Cloitre et al., 2004). It is also

congruent with clinical guidelines that suggest adequate time and attention needs to be paid to forming a strong therapeutic alliance with people who have experienced complex trauma (McFetridge, Hauenstein Swan, Heke & Karatzias, 2017). While this is of course important in any therapy, the impact of multiple, particularly interpersonal, trauma on a person's attachment style and capacity for trust mean it is especially indicated in this population (Pearlman & Courtois, 2005).

Interestingly, a qualitative meta-analysis of research into alliance building in early therapy sessions (across a broad range of therapies and clinical presentations) found that "being understood as a whole person" was considered by clients as an important part of building a strong alliance (Lavik, Frøysa, Brattebø, McLeod & Moltu, 2018). As an inherently "whole person" component of the therapy, it seems the lifeline is uniquely well-suited to supporting the development of a strong therapeutic alliance.

The lifeline and physicality: an opportunity to externalise

The physical nature of the lifeline was a strong thread in therapists accounts, and many spoke of its value in promoting engagement and energy, and providing a safely 'distanced' way to begin to connect with one's experiences. The concept of 'externalising' comes from the narrative therapy literature and refers to the situating of the 'problem' as separate to the person (White, Wijaya, White & Epston, 1990). This allows for distance from the problem and enables the person to take a different position in relation to it. This idea of distancing was referred to by therapists in this study, with the lifeline often being viewed a separate presence in the room which client and therapist observed together, often from above. It is possible that the lifeline's physicality is helpful in externalising the problem of the trauma and allowing for clients to see it from a different vantage point and with a broader, more inclusive scope.

Art therapy is increasingly used with survivors of trauma, and has a developing evidence base (Schouten, de Niet, Knipscheer, Kleber & Hutschemaekers, 2015). While its method and underpinning principles are very different to that of more mainstream trauma-focussed therapies, it's inherent use of physical materials offers an interesting comparison for the lifeline. Smith (2016) explores the potential mechanisms of change in art therapy for veterans with PTSD across eleven papers. A theme found across all of the studies was how the art and images facilitated the externalising of the traumatic events. The tangible images could be 'stepped back from' allowing them to become symbolic representations of the traumas which could be observed from a separated, distanced position by the clients (Lobban, 2014). The use of art materials in therapy was also seen as a way to gradually connect with the trauma material at a pace clients had control over, and a means of providing emotional distance, with this supporting the development of a "newly constructed and coherent narrative" (Smith, 2016; Speigal et al., 2016). Furthermore, Speigal et al., (2016) posits that images in art therapy may act as a 'container', in the way a therapist often does for difficult, sometimes unverbalizable experiences.

These findings may be a useful lens through which to view some of the power therapists described the physical, visual, tangible lifeline has; these insights from art therapy research suggest that part of its power might be in externalising the client's story and allowing them to view it from the allocentric perspective (Schauer & Ruf-Leuschner, 2014). Additionally, the idea of the physical image as a container from Spiegal et al., (2016) might help to explain why the lifeline was experienced as a containing way of being in contact with the trauma memories by therapists: the emotional and physical distance it affords offering a gentler way to be with the memories of terrible events.

Traumas in context: the lifeline and broader theory

Issues of memory contextualisation and coherence in PTSD have received considerable research attention and were mentioned by therapists in this study. The dual representation theory (Brewin, Dalgleish & Joseph, 1996; Brewin, Gregory, Lipton & Burgess, 2010) proposes that the lack of association between sensory and contextual representations of the trauma is a key mechanism giving rise to intrusive phenomena in PTSD. A range of studies have found that trauma memories often lack narrative coherence (Foa, Molnar & Cashman, 1995; Vrana, Bono, Konig & Scalzo, 2019; Brewin, 2016), and there is some evidence that people's narratives can appear more coherent following treatment (Knutsen & Jensen, 2019; van Minnen, Wessel, Dijkstra & Roelofs, 2002).

Therapists in this study felt that the lifeline promoted contextualisation of the traumas and coherence of the life narrative, but potentially in a different way to how these terms are used in the broader literature. The lifeline's aim is not to begin the process of connecting sensory hot memory with contextual cold memory for individual traumas, but rather to elicit an ordered, cold narrative encapsulating all significant events. Thus, when participants talked of contextualisation in the lifeline, it is difficult to relate this to memory contextualisation in the theory and evidence more broadly (i.e., Brewin, Gregory, Lipton & Burgess, 2010). Similarly, when therapists spoke about increasing coherence through the lifeline, it does not seem that this reflects increased narrative coherence within specific trauma memories detailed in the research (e.g., Foa, Molnar & Cashman, 1995). Therapists seemed to be talking about a broader process of embedding trauma memories in a lifelong autobiographical context that slowly becomes more coherent and chronologically accurate. Without further study, it is difficult to ascertain whether the processes of contextualisation and coherence that are well-evidenced in relation to individual memories can also be extended to explain how the lifeline is therapeutically useful.

This speaks to a key issue in PTSD research: much of the theory that evidence-based therapies are based on maps most neatly onto single incident trauma and does not always encapsulate the complexity of multiple traumas, particularly those involving human rights violations (Silove, 1999; Robjant & Fazel, 2010). While this research has still led to treatments that can be beneficial for survivors of multiple traumas, extending beyond these theories and adapting them to multiple traumas may provide a more nuanced account of how best to approach treatment. Here, the referenced literature provides an excellent account of how narration in NET promotes contextualisation and coherence *within* trauma memories. What it does not do is support a case for the lifeline specifically being a beneficial element of the treatment in these domains, despite this apparently being part of the therapist experience of delivering the lifeline. This is because of the focus on traumatic events in isolation, as opposed to traumatic events occurring in the context of a whole life and socio-political milieu.

Research implications

This study has provided an account of the lifeline in NET from the therapists' perspective. Next, it may be useful to explore this qualitatively with clients who have received NET themselves. While a few past studies have explored the client experience of NET generally (Cicconi, 2018; Said, Algadri, & King, 2021), none of them specifically focused on the lifeline. In particular, it would be interesting to see to what extent client accounts align with the assumptions made about the client experience by therapists in this sample.

Another avenue for future research could take a more quantitative approach. This study has highlighted a range of constructs of interest and mechanisms of change, such as the potential memory contextualization that happens in the lifeline or the important role of the

lifeline in developing rapport. Future research could take the form of a dismantling study, where a range of session-by-session measures are administered to clients, some of whom receive NET with the lifeline, and some whom receive it without. An analysis of this would allow for a better understanding of if the lifeline makes a unique contribution to the outcomes of NET, and should therefore be considered a mandatory component of the protocol.

Clinical implications

The lifeline is clearly an element of NET that is held in high regard by the therapists interviewed. In their experience, completing a lifeline is a valuable part of NET and indeed, can be a valuable part of any trauma-focussed therapy. While the quantitative effectiveness of the lifeline has not been evaluated here, the lived experience of therapists would suggest the lifeline should be conducted as far as possible with all clients who will be receiving NET. This is perhaps in contrast to some studies which have found NET to be effective without the lifeline (Neuner et al., 2004; Schauer et al., 2006; Hijazi, 2012; as detailed in Vivo International, 2015), and may reflect a difference between what is experienced as helpful and what is shown to be helpful in quantitative research.

Some useful areas for future development were highlighted in this study, including the important role of culture in the lifeline. The lifeline could be seen as an individualistic intervention: it is a physical depiction of one person's linear narrative, whereas many of the clients NET is designed for and used by may be from more collectivist societies. Indeed, some feel that NET as a whole should not be presumed to be culturally neutral and the best treatment option for traumatised people from non-Western cultures (Afuape, 2020). Therefore, therapists must pay attention to culture. First, a consideration of ones' own culture may be beneficial in improving the ability to recognise how culture impacts the experience people have of different services, professionals, and treatments are experienced. By

understanding that the dominant demographic in the clinical psychology profession – White British women – are not culturally neutral, the importance of adapting interventions carefully for each person's culture becomes clearer. From here, reflection on how culture might impact the delivery of the lifeline is important. There are many factors to reflect on here, for example, considering what events we privilege placing on the lifeline through our prompts; or how we can adapt the protocol to incorporate important community experiences in the individual's lifeline. Supervisors should ensure there is space to reflect on issues of culture and the lifeline, and therapists should aim to apply the same level of cultural consideration to the structured, manualised lifeline session as they would to any other. Feedback should be sought from clients about the fit of the lifeline with their own cultural, religious and family values, and opportunities to respectfully liaise with other people from a client's cultural background to gain broader knowledge should be considered.

Limitations

There are a number of limitations to the present study. Firstly, the advertisement made clear that the study focussed on the NET lifeline specifically, and it is possible that only those who had generally positive feelings about the lifeline would feel compelled to contact the author regarding participation. This is a common problem in much qualitative clinical psychology research (Robinson, 2014). Here, it may mean that despite the author intentionally probing challenges or more negative experiences of the lifeline, that positive experiences of the lifeline are overrepresented and the views of clinicians who have encountered NET but have chosen not to use in practice are not captured.

A further limitation is the relatively homogenous sample. The sample was all female and largely made up of White British clinical psychologists in their late 20s and 30s, as is generally typical of the profession as a whole (British Psychological Society, 2015). It is likely that the clients that participants were reflecting on having worked with were from

considerably more diverse backgrounds. While the perspectives of this 'majority' in the professions is useful, it is helpful to highlight the way this majority lens may influence the participant's accounts and overall analysis, especially when working from a critical realist perspective (Willig, 2002). This is especially pertinent at a time where diversifying therapy professions and ensuring cultural competence and anti-racist practice should be at the centre of all aspects of clinical and research work.

Conclusions

This study, to the author's knowledge, is the first qualitative exploration of the lifeline in narrative exposure therapy. While there are limitations to the study, it provides an interesting account of the experience of therapists, with a range of expertise, in conducting the lifeline in NET. Further exploration of the client experience of the lifeline should be prioritised to move towards a full qualitative account of this unique aspect of the evidence-based trauma-focussed intervention of NET.

References

Afuape, T. (2020, November 20). *Know Better, Do Better: A webinar of practices to challenge social injustice in therapeutic work* [Conference talk]. Know Better, Do Better: A webinar of practices to challenge social injustice in therapeutic work, Online, UK.

Alghamdi, M., Hunt, N., & Thomas, S. (2015). The effectiveness of narrative exposure therapy with traumatised firefighters in Saudi Arabia: A randomized controlled study. Behaviour research and therapy, 66, 64-71.

Becker, C. B., Zayfert, C., & Anderson, E. (2004). A survey of psychologists' attitudes towards and utilization of exposure therapy for PTSD. Behaviour research and therapy, 42(3), 277-292.

Benjet, C., Bromet, E., Karam, E. G., Kessler, R. C., McLaughlin, K. A., Ruscio, A. M., ... & Koenen, K. C. (2016). The epidemiology of traumatic event exposure worldwide: results from the World Mental Health Survey Consortium. Psychological medicine, 46(2), 327-343.

Binder, P. E., Holgersen, H., & Moltu, C. (2012). Staying close and reflexive: An explorative and reflexive approach to qualitative research on psychotherapy. Nordic Psychology, 64(2), 103-117.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Breslau, N. (2001). The epidemiology of posttraumatic stress disorder: what is the extent of the problem?. *Journal of Clinical Psychiatry*, *62*, 16-22.

Brewin, C. R. (2001). A cognitive neuroscience account of posttraumatic stress disorder and its treatment. Behaviour research and therapy, 39(4), 373-393.

Brewin, C. R. (2016). Coherence, disorganization, and fragmentation in traumatic memory reconsidered: A response to Rubin et al.(2016).

Brewin, C. R., Dalgleish, T., & Joseph, S. (1996). A dual representation theory of posttraumatic stress disorder. Psychological review, 103(4), 670.

Brewin, C. R., Gregory, J. D., Lipton, M., & Burgess, N. (2010). Intrusive images in psychological disorders: characteristics, neural mechanisms, and treatment implications. Psychological review, 117(1), 210.

Brewin, C. R., & Holmes, E. A. (2003). Psychological theories of posttraumatic stress disorder. Clinical psychology review, 23(3), 339-376.

British Psychological Society. (2015, November). Clinical Psychology Workforce Project. https://www.bps.org.uk/sites/www.bps.org.uk/files/Page%20-%20Files/Clinical%20P sychology%20Workforce%20Report%20%282015%29%20-%20Executive%20Sum mary.pdf

Cicconi, F. (2018). Asylum-seeking peoples' experiences of Narrative Exposure Therapy (Doctoral dissertation, UCL (University College London)).

Cienfuegos, A. J., & Monelli, C. (1983). The testimony of political repression as a therapeutic instrument. American Journal of Orthopsychiatry, 53(1), 43.

Cloitre, M. (2020). ICD-11 complex post-traumatic stress disorder: Simplifying diagnosis in trauma populations. The British Journal of Psychiatry, 216(3), 129-131.

Cloitre, M., Chase Stovall-McClough, K., Miranda, R., & Chemtob, C. M. (2004). Therapeutic alliance, negative mood regulation, and treatment outcome in child abuse-related posttraumatic stress disorder. Journal of consulting and clinical psychology, 72(3), 411.

Cloitre, M., Courtois, C. A., Charuvastra, A., Carapezza, R., Stolbach, B. C., & Green, B. L. (2011). Treatment of complex PTSD: Results of the ISTSS expert clinician survey on best practices. Journal of traumatic stress, 24(6), 615-627.

Conway, M. A. (2001). Sensory–perceptual episodic memory and its context: Autobiographical memory. *Philosophical Transactions of the Royal Society of London. Series B: Biological Sciences*, *356*(1413), 1375-1384.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into practice*, *39*(3), 124-130.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. Behaviour research and therapy, 38(4), 319-345.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British journal of clinical psychology*, *38*(3), 215-229.

Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative health research*, *12*(4), 531-545.

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. Psychotherapy, 55(4), 316.

Foa, E. B., Molnar, C., & Cashman, L. (1995). Change in rape narratives during exposure therapy for posttraumatic stress disorder. Journal of traumatic stress, 8(4), 675-690.

Foa, E. B., & Rothbaum, B. O. (2001). Treating the trauma of rape: Cognitive-behavioral therapy for PTSD. Guilford Press.

Frans, Ö., Rimmö, P. A., Åberg, L., & Fredrikson, M. (2005). Trauma exposure and post-traumatic stress disorder in the general population. Acta Psychiatrica Scandinavica, 111(4), 291-290.

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: exposure to corrective information. Psychological bulletin, 99(1), 20.

Frost, R., Hyland, P., McCarthy, A., Halpin, R., Shevlin, M., & Murphy, J. (2019). The complexity of trauma exposure and response: Profiling PTSD and CPTSD among a refugee sample. Psychological trauma: theory, research, practice, and policy, 11(2), 165.

Gwozdziewycz, N., & Mehl-Madrona, L. (2013). Meta-analysis of the use of narrative exposure therapy for the effects of trauma among refugee populations. The Permanente Journal, 17(1), 70.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. Journal of traumatic stress, 5(3), 377-391.

Hijazi, A. M. (2012). Narrative exposure therapy to treat traumatic stress in Middle Eastern refugees: A clinical trial (doctoral dissertation).

Hyland, P., Murphy, J., Shevlin, M., Vallières, F., McElroy, E., Elklit, A., ... & Cloitre, M. (2017). Variation in post-traumatic response: The role of trauma type in predicting ICD-11 PTSD and CPTSD symptoms. Social psychiatry and psychiatric epidemiology, 52(6), 727-736.

Kaltenbach, E., McGrath, P. J., Schauer, M., Kaiser, E., Crombach, A., & Robjant, K. (2021). Practical guidelines for online Narrative Exposure Therapy (e-NET)–a short-term treatment for posttraumatic stress disorder adapted for remote delivery. European Journal of Psychotraumatology, 12(1), 1881728.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. Archives of general psychiatry, 52(12), 1048-1060.

Kilpatrick, D. G., Resnick, H. S., Milanak, M. E., Miller, M. W., Keyes, K. M., & Friedman, M. J. (2013). National estimates of exposure to traumatic events and PTSD prevalence using DSM-IV and DSM-5 criteria. Journal of traumatic stress, 26(5), 537-547.

Knutsen, M., & Jensen, T. K. (2019). Changes in the trauma narratives of youth receiving trauma-focused cognitive behavioral therapy in relation to posttraumatic stress symptoms. Psychotherapy Research, 29(1), 99-111

Lavik, K. O., Frøysa, H., Brattebø, K. F., McLeod, J., & Moltu, C. (2018). The first sessions of psychotherapy: A qualitative meta-analysis of alliance formation processes. Journal of Psychotherapy Integration, 28(3), 348.

Lely, J. C., Smid, G. E., Jongedijk, R. A., W. Knipscheer, J., & Kleber, R. J. (2019). The effectiveness of narrative exposure therapy: A review, meta-analysis and meta-regression analysis. European Journal of Psychotraumatology, 10(1), 1550344.

Levitt, H. M. (2015). Qualitative psychotherapy research: The journey so far and future directions. Psychotherapy, 52(1), 31.

Levitt, H. M., Pomerville, A., & Surace, F. I. (2016). A qualitative meta-analysis examining clients' experiences of psychotherapy: A new agenda. Psychological bulletin, 142(8), 801.

Lobban, J. (2014). The invisible wound: Veterans' art therapy. International Journal of Art Therapy, 19(1), 3-18.

Luthra, R., Abramovitz, R., Greenberg, R., Schoor, A., Newcorn, J., Schmeidler, J., ... & Chemtob, C. M. (2009). Relationship between type of trauma exposure and

posttraumatic stress disorder among urban children and adolescents. Journal of interpersonal violence, 24(11), 1919-1927.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. Journal of consulting and clinical psychology, 68(3), 438.

Metcalfe, J., & Jacobs, W. J. (1996). A "hot-system/cool-system" view of memory under stress. PTSD Research Quarterly, 7(2), 1-3.

McFetridge, M., Hauenstein Swan, A., Heke, S., & Karatzias, T. (2017). UK Psychological Trauma Society (UKPTS) Guideline for the treatment and planning of services for Complex Post-Traumatic Stress Disorder in adults. UKPTS (United Kingdom Post Traumatic Stress Society).

Neuner, F., Onyut, P. L., Ertl, V., Odenwald, M., Schauer, E., & Elbert, T. (2008). Treatment of posttraumatic stress disorder by trained lay counselors in an African refugee settlement: a randomized controlled trial. Journal of consulting and clinical psychology, 76(4), 686.

Neuner, F., Schauer, M., Karunakara, U., Klaschik, C., Robert, C., & Elbert, T. (2004). Psychological trauma and evidence for enhanced vulnerability for posttraumatic stress disorder through previous trauma among West Nile refugees. BMC psychiatry, 4(1), 1-7.

National Institute for Health and Care Excellence. (2013) Post-traumatic stress disorder. Retrieved from https://www.nice.org.uk/guidance/ng116

Olff, M., Bakker, A., Frewen, P., Aakvaag, H., Ajdukovic, D., Brewer, D., ... & Schnyder, U. (2020). Screening for consequences of trauma–an update on the global collaboration on traumatic stress. European journal of psychotraumatology, 11(1), 1752504.

Patnaik, E. (2013). Reflexivity: Situating the researcher in qualitative research. *Humanities and Social Science Studies*, *2*(2), 98-106.

Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health services research*, *34*(5 Pt 2), 1189.

Pearlman, L. A., & Courtois, C. A. (2005). Clinical applications of the attachment framework: Relational treatment of complex trauma. Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies, 18(5), 449-459.

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. Professional psychology: Research and practice, 26(6), 558.

Rabionet, S. E. (2011). How I learned to design and conduct semi-structured interviews: an ongoing and continuous journey. *Qualitative Report*, *16*(2), 563-566.

Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. Journal of consulting and clinical psychology, 60(5), 748.

Robinson, O. C. (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. Qualitative research in psychology, 11(1), 25-41.

Robjant, K., & Fazel, M. (2010). The emerging evidence for narrative exposure therapy: A review. *Clinical psychology review*, *30*(8), 1030-1039.

Robjant, K., Meyer, D., Schauer, M., Kaltenbach, E., & Kaiser, E. (2020). E-NET: narrative exposure therapy online: the challenges and opportunities of delivering trauma therapy remotely. E-NET: narrative exposure therapy online: the challenges and opportunities of delivering trauma therapy remotely, 11-24.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of consulting psychology, 21(2), 95.

Said, G., Alqadri, Y., & King, D. (2021). Unaccompanied minors' experiences of narrative exposure therapy. the Cognitive Behaviour Therapist, 14.

Santiago, P. N., Ursano, R. J., Gray, C. L., Pynoos, R. S., Spiegel, D., Lewis-Fernandez, R., ... & Fullerton, C. S. (2013). A systematic review of PTSD prevalence and trajectories in DSM-5 defined trauma exposed populations: intentional and non-intentional traumatic events. PloS one, 8(4), e59236.

Schauer, M., Elbert, T., Gotthardt, S., Rockstroh, B., Odenwald, M., & Neuner, F. (2006). Wiedererfahrung durch Psychotherapie modifiziert Geist und Gehirn. Verhaltenstherapie, 16(2), 96-103.

Schauer, M., & Ruf-Leuschner, M. (2014). Lifeline in der Narrativen Expositionstherapie. Psychotherapeut, 59(3), 226-238.

Schauer, M., Schauer, M., Neuner, F., & Elbert, T. (2011). Narrative exposure therapy: A short-term treatment for traumatic stress disorders. Hogrefe Publishing.

Schouten, K. A., de Niet, G. J., Knipscheer, J. W., Kleber, R. J., & Hutschemaekers, G. J. (2015). The effectiveness of art therapy in the treatment of traumatized adults: a systematic review on art therapy and trauma. Trauma, violence, & abuse, 16(2), 220-228.

Schnyder, U., Ehlers, A., Elbert, T., Foa, E. B., Gersons, B. P., Resick, P. A., ... & Cloitre, M. (2015). Psychotherapies for PTSD: what do they have in common?. *European Journal of Psychotraumatology*, *6*(1), 28186.

Silove, D. (1999). The psychosocial effects of torture, mass human rights violations, and refugee trauma: Toward an integrated conceptual framework. The Journal of nervous and mental disease, 187(4), 200-207.

Smith, A. (2016). A literature review of the therapeutic mechanisms of art therapy for

    veterans with post-traumatic stress disorder. International Journal of Art Therapy,

    21(2), 66-74.

Spiegel, D., Malchiodi, C., Backos, A., & Collie, K. (2006). Art therapy for combat-related

    PTSD: Recommendations for research and practice. Art Therapy, 23(4), 157-164.

Stenmark, H., Catani, C., Neuner, F., Elbert, T., & Holen, A. (2013). Treating PTSD in

    refugees and asylum seekers within the general health care system. A randomized

    controlled multicenter study. Behaviour research and therapy, 51(10), 641-647.

Suliman, S., Mkabile, S. G., Fincham, D. S., Ahmed, R., Stein, D. J., & Seedat, S. (2009).

    Cumulative effect of multiple trauma on symptoms of posttraumatic stress disorder,

    anxiety, and depression in adolescents. Comprehensive psychiatry, 50(2), 121-127.

Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative social*

    work, *11*(1), 80-96.

Van der Kolk, B. A., & Fisler, R. (1995). Dissociation and the fragmentary nature of

    traumatic memories: Overview and exploratory study. Journal of traumatic stress,

    8(4), 505-525.

Van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of

    extreme stress: The empirical foundation of a complex adaptation to trauma. Journal

    of Traumatic Stress: Official Publication of the International Society for Traumatic

    Stress Studies, 18(5), 389-399.

Van Dijk, J. A., Schoutrop, M. J., & Spinhoven, P. (2003). Testimony therapy: Treatment

    method for traumatized victims of organized violence. American journal of

    psychotherapy, 57(3), 361-373.

Van Minnen, A., Wessel, I., Dijkstra, T., & Roelofs, K. (2002). Changes in PTSD patients' narratives during prolonged exposure therapy: A replication and extension. Journal of traumatic stress, 15(3), 255-258.

Vivo International. (2015). Narrative Exposure Therapy (NET). Www.Vivo.Org. https://www.vivo.org/wp-content/uploads/2015/09/Narrative_Exposure_Therapy.pdf

Vrana, S. R., Bono, R. S., Konig, A., & Scalzo, G. C. (2019). Assessing the coherence of narratives of traumatic events with latent semantic analysis. Psychological Trauma: Theory, Research, Practice, and Policy, 11(5), 521.

White, M., Wijaya, M., White, M. K., & Epston, D. (1990). Narrative means to therapeutic ends. WW Norton & Company.

Williams, D. C., & Levitt, H. M. (2007). A qualitative investigation of eminent therapists' values within psychotherapy: Developing integrative principles for moment-to-moment psychotherapy practice. Journal of Psychotherapy Integration, 17(2), 159.

Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In H. Cooper (Ed.), *APA handbook of research methods in psychology: Vol. 1 Foundations, planning, measure and psychometrics* (pp.5-21). Washington, DC: American Psychological Association.

World Health Organisation. (2018). ICD-11 International Classification of Diseases 11th Revision [Web page]. Retrieved from https://icd.who.int

Zang, Y., Hunt, N., & Cox, T. (2013). A randomised controlled pilot study: the effectiveness of narrative exposure therapy with adult survivors of the Sichuan earthquake. BMC psychiatry, 13(1), 1-11.

Zerach, G., Shevlin, M., Cloitre, M., & Solomon, Z. (2019). Complex posttraumatic stress disorder (CPTSD) following captivity: A 24-year longitudinal study. *European Journal of Psychotraumatology*, *10*(1), 1616488.

Part 3: Critical Appraisal

Critical appraisal

The focus of this thesis is on trauma-focussed therapies and the lifeline. Inherent to these topics are the concepts of narratives, stories, chronology, and meaning-making. Given this, it feels fitting that I critically appraise my research process in this way: in an ordered, chronological fashion. This critical appraisal will tell the 'story' of my thesis, exploring the various challenges and considerations that arose through the research process, chronologically from the initial proposal through to the final project detailed in this thesis.

The beginnings of the project: locating myself and my motivations

This project was originally intended to be a qualitative feasibility study of narrative exposure therapy (NET) in people with comorbid psychosis and PTSD. This had initially appealed to me as it was at the intersection of several areas of clinical interest. Prior to my first clinical post in mental health, my understanding of psychosis was largely from a medical perspective, informed heavily by the 'dopamine hypothesis' (see Meltzer & Stahl, 1976). My undergraduate teaching had not touched on the role of trauma or discrimination on psychosis, and so my formative clinical experiences with people experiencing psychosis were a shock; the dopamine hypothesis offered little in helping me understand the people I was seeing. I recall looking through the notes of people with schizophrenia diagnoses and being struck by just how many traumatic events they had experienced, and how little attention this was paid clinically.

My undergraduate teaching on trauma and PTSD had been theoretically rigorous. I had found it fascinating to hear how the memory models we had learned about in our 'Learning and Memory' module could be disrupted under the immense pressure of a traumatic event, and why this disrupted processing might give rise to the peculiar memory phenomena of flashbacks or nightmares. I remember it feeling like an area where

psychologists were uniquely positioned to offer valuable insight and expertise to really make a difference to people's lives.

Later, as I began training, I heard about narrative exposure therapy and it had immediately appealed to me. Working in an IAPT service and completing the BABCP pathway had meant I needed to work in a very structured and specific manner, often targeting one problem area and trying my best to remain focussed on this despite the inevitable complexity of people's lives and difficulties arising across the course of therapy. NET appealed to me for similar reasons as it ultimately did to many of my participants: the way the lifeline captures life's most sacred and painful moments felt congruent with my values and a powerful way of genuinely honouring the wholeness of the people we work with as psychologists. Given these intersecting interests and experiences, when a project exploring the experience of NET in people with psychosis and PTSD was advertised, I was very keen for this to be the focus of my thesis.

The challenges of research in the NHS and third sector

Conducting research in the NHS is a complex task, but one which has much potential to positively impact healthcare provision (Boaz, Hanney, Jones & Soper, 2015). A complex range of factors are involved in successfully initiating and completing a research project in the NHS, and some argue it is becoming increasingly difficult due to manage in face of rising pressures in the NHS (Sheard & Peacock, 2019; Maranovic et al., 2019). Conducting research in the NHS within the timescale of a DClinPsy, or indeed any student project, is very challenging (Jonker, Cox & Marshall, 2011). The NHS ethics process is notoriously onerous (Jamrozik, 2004; Robinson, Murdoch-Eaton & Carter, 2007), and balancing the timeline of this with the demands of the academic and clinical components of training is difficult.

Given this, my supervisor and I explored what kind of project would be feasible within this system and the available time. We decided that completing a qualitative study of the entire NET process with people with psychosis and PTSD was a potentially ambitious task in the time available, and so we decided that a focus on the lifeline would be both pragmatic and valuable. The lifeline is one of the first parts of the therapy, meaning that practically, participants could be interviewed early in their treatment and would be less likely to be lost to follow up. The lifeline was also an interesting target for me: it was the part of therapy I found to be most distinct and interesting, and it had not received a great deal of attention in the literature. It remained in line with the values and interests that had initially drawn me to the project, but in a format that felt much more achievable.

Ultimately, the complexities of completing research in an NHS setting were an insurmountable challenge for this iteration of the thesis. The coordination of a large number of clinical staff, who each have a remarkable level of clinical demand, and a complex client group seemed increasingly infeasible within the strictly limited time available for a DClinPsy thesis. The next avenue for the thesis involved engaging with a charity that provides NET to explore the possibility of them supporting the research. This would shift the focus of the project from exploring people with psychosis and PTSD's experience of the lifeline, to a focus on a population who were likely to only experience PTSD, but as exploration of the lifeline generally is still new this was not a problem. Unfortunately, similar practical challenges arose with this iteration of the project and it was not possible to proceed. This also coincided with the beginning of the COVID-19 pandemic, which had a profound impact on the functioning of vital third sector organisations (Hyndman, 2020), and on the progress of clinical research more generally (Iacobucci, 2020).

I was disappointed not to be able to proceed with the original project or its second iteration. I had been aware of the challenges of conducting research with clinical populations

and in NHS settings, but experiencing these challenges personally was frustrating. Historically, around 600 people gain a place on clinical training each year, and this number is set to further increase (Clearing House for Postgraduate Courses in Clinical Psychology, 2020). I recall reflecting on the amount of research time this equates to, and how many valuable clinically focussed projects are not possible because they are incompatible with the systems they must occur in.

Researching therapists

The third iteration of the project shifted the focus once more, this time from service users to therapists. I was not initially too eager to conduct a project focussing on the therapist experience. I had been excited to be completing research with service users, and disappointed that this had proved to be so difficult and had been further challenged by the pandemic. The project now also felt more displaced from my original interests and motivations. As it became clear that researching therapists may be the only feasible way for the thesis to progress, I thought more carefully about why it might be important to study therapists.

I reflected on research demonstrating the centrality of the therapeutic relationship to therapy outcome (e.g., Lambert & Barley, 2001). Even research like this, apparently quite far removed from the niche of my project, helped me to re-evaluate the potential importance of researching therapists. The therapist-client dyad is just that: a dyad, and thus studying therapists is important to do alongside researching clients (Najavits, 2000). Conceptualising things in this way made the idea of researching the therapist experience feel more appealing and important. A paper by Mirdal, Ryding & Essendrop Sondei (2012) helped me to formalise my motivation and interest in pivoting toward exploring the therapist experience of the lifeline. In their research, they explored the perspectives of refugees, therapists, and interpreters on psychological therapy for PTSD. I found it interesting that for some elements, all parties were aligned and had a shared experience (e.g., that the therapeutic relationship

116

was the most important 'curative factor'). But in some ways, their views diverged: for example, therapists cited lack of motivation as a key contributor to treatment failure, but clients were more likely to cite the treatment itself being unsuitable as a reason for its lack of effectiveness. This disparity was interesting to me, and further highlighted the importance of research targeting the therapist perspective alongside that of the service user. I also considered the power that therapists inevitably hold in the therapy room, perhaps especially with clients who are traumatised and subject to a range of oppressive state systems like refugees and asylum seekers.

With this in mind, gaining a thorough understanding of how therapists delivered and experienced delivering the lifeline felt valuable. The lifeline, while generally viewed as useful by therapists, has potential to be a source of great distress and the cause of a potentially uncomfortable level of exposure and vulnerability for clients. It is also an aspect of treatment that is slightly unusual and perhaps has less of a precedent for its use than other parts of NET like the narration. Together, I noticed a shift away from the disappointment of having to abandon my original projects and toward the opportunities this new project might afford.

A note on the service user voice

While I now see great value in studies exploring the therapist experience, I am conscious that my project lacks direct input from service users. While my thematic synthesis explores the service user experience, I did not consult with any service users through the process of this review, and similarly did not consult with service users in my empirical project either. Throughout the thesis, I acknowledge the deeply difficult nature of trauma-focussed therapy, and yet I have not incorporated the service user voice into the questions I chose to ask or the methods I used in either the thematic synthesis or empirical paper. This is

perhaps a point of shame for me as a researcher: the absence of the service user voice does not align with my values or identity as a psychologist. In an ideal world, I would have hoped to be able to adopt a more co-productive stance in the research, where the focus of the research questions, interview questions, and data analysis were driven by the people they most affect: here, service users receiving trauma-focussed therapy (McMullin & Needham, 2018). This kind of working requires a radically different stance to traditional ways of doing research (Lambert & Carr, 2018; Pinfold et al., 2015). I have wondered to what extent this is compatible with or made possible within the DClinPsy thesis process, and the implications of it being difficult to achieve given that increasing patient and public involvement is an NHS priority (NHS England, 2017).

As it stands, the results of my thesis must be held tentatively: the thematic synthesis is based on the words of service users filtered through the original researchers and then myself, and the empirical paper includes accounts of my understanding of the therapists' understandings of the service user experience! These caveats do not detract value from my research, but perhaps underline the importance of coproduction in research of this type and the way that conclusions that have not been coproduced should not be held as absolute truths.

Being a scientist-practitioner

The scientist-practitioner model is the underpinning model of UK clinical psychology training (Shapiro, 2002; Jones & Mehr, 2007). The scientist-practitioner model suggests that clinical psychologists should be dual-trained in both advanced research methods and clinical treatment methods. This aims to develop psychologists whose clinical work is informed by research, and who actively contribute toward research that relates to clinical practice (British Psychological Society, 2019). Part of the aim of the transition toward a doctoral level of training for clinical psychologists was to support a higher level of research output (Thomas,

Turpin & Meyer, 2002), although in practice the scientist-practitioner model seems to be conceptualised as "an attitude to practice" as opposed to a resolution to continue to engage in research following training (Kennedy & Llewelyn, 2001).

I found myself reflecting on my own scientist-practitioner role throughout the project, but it came into particularly clear focus when I began working in a specialist complex trauma service in my third year of training. Here, I was simultaneously delivering and researching evidence-based trauma-focussed interventions. I found the process of this incredibly enriching. Being immersed in research pertaining to my clinical practice, in a way which is rarely possible or practical in 'real-life', helped me enormously to consider and refine my therapy work on the basis of the evidence base. I particularly valued the fact that the research I was immersed in was largely qualitative in nature. I felt as though the richness and complexity of my clinical work was neatly reflected in the underpinning ethos and methods of qualitative research (Silverstein, Auerbach & Levant, 2006).

Conducting my research was similarly satisfying. While analysing the data, I had to take care to bracket my own experiences of the lifeline (which were very similar to some participants, and very different to others; often a function of the level of experience; Fischer, 2009; Tufford & Newman, 2012), while also being aware of the influence my new research understandings might have on my own clinical practice. For example, as I generated the theme pertaining to the key relational task of the lifeline, I found myself holding this in mind with when conducting lifeline sessions. At a time of being a relatively novice NET practitioner, I often found myself concerned with the technicalities of the therapy, and 'doing it right'. Thus, it was reassuring and instructive to see in the research that building a relationship had seemed to be an important part of the process of the lifeline from the perspective of the therapists. This is an example reflection on the dual scientist-practitioner role I held: many times across the process I experienced a similar mutual influence between

the two intersecting roles. That said, it is useful to also hold in mind that I was not a neutral force in the analysis process: it is likely that my own values and assumptions influenced the interviews I had with participants, and the resulting analysis I created.

In spite of my enjoyment of my overlapping research and clinical activities, the process was not without practical challenges. I was keenly aware of the competing demands and pressures often cited as one reason for the lack of post-qualification research in clinical psychology (Smith & Thew, 2017; Thomas, Turpin & Meyer, 2002; Corrie & Callanan, 2001). I reflected on how the value I derived from embodying the scientist-practitioner model came at the cost of a complex balancing act of demands, and that this was the case despite having clear and ring-fenced time dedicated to fulfilling the 'scientist' side of my duties! As I come to the end of this piece of research and the end of my training more broadly, I am interested in furthering my understanding of the factors that cause this paucity of post-qualification research in the profession, so as to aim to overcome them (e.g., Holttum & Goble, 2006).

Learning to be a qualitative researcher

My undergraduate degree in psychology was largely quantitative in orientation, and my limited research experience prior to this thesis was also quantitative. When I started the process of analysis in my thematic synthesis, I felt very apprehensive and uncertain about 'how to do it', which is not an uncommon feeling for novice qualitative researchers (Roberts & Castell, 2016; Kalpokaite & Radivojevic, 2018). It felt like a very different way of working and thinking to quantitative research; there was not set of techniques I could pick up and apply to my question, instead I needed to "learn how to use them rather like one learns a craft" (Harper, 2013). I would now conceptualise my qualitative analysis process as one of tolerating uncertainty and having faith (Mansourian, 2008). While there were swathes of time

during my literature review where I felt very unclear about and confused by my developing analysis, I can now see that as a perhaps unavoidable part of an iterative analytic process. When completing the qualitative process a second time on my empirical paper, I was satisfied to see a much greater ability to tolerate the mess and confusion of my early-stage analysis, safe in the knowledge that I would find a way to bring things together in time.

It was also helpful to understand more deeply the role of the researcher in qualitative research, specifically the concept of reflexivity (see Shaw, 2010; Berger, 2015). When I was approaching my analysis with a lens of objectivity and seeking of 'truth', it felt impossible. Once I had fully acclimatised to the fact that it was firstly unavoidable, but secondly okay and expected for my own perspectives to influence the analysis process to some degree, I was able to engage in it with much more ease and openness. Keeping a reflective diary supported this process, allowing me to strike a balance between attempts to keep my influence out of my analysis entirely and ensuring that my analysis was more than just my influence (Ortlipp, 2008).

This consideration of the self and reflexivity was perhaps especially important due to the type of research I was conducting. I occupied a kind of 'insider researcher' position (Costley, Elliott & Gibbs, 2010): I was a clinical psychology trainee recruiting and interviewing from within my own professional community. All participants were aware of my position, and many of them of my additional insider status as a fellow trauma therapist. I experienced a range of benefits from this position: an existing understanding of the contexts and language of the work of my participants and relatively easy access to participants who fitted my recruitment criteria, for example (Brannick & Coghlan, 2007; Greene, 2014). However, I also had to be alert to some of the potential pitfalls: participants giving limited detail due to the assumed pre-understanding, or the potential for me to assume shared meaning rather than probing for my participant's idiosyncratic meanings (Asselin, 2003;

Mercer, 2007). For example, I noticed a few participants seemed to feel apprehensive mentioning small deviations from the model, or gaps in their theoretical vocabulary. I wondered whether it made a difference that I was a clinician: would they have felt as nervous or embarrassed to disclose these clinical issues to a pure academic or someone they did not know the background of? This example further highlighted to me how, perhaps especially for insider research, the identity of the researcher is instrumental to the data that is gathered.

I employed a range of methods, formal and informal, of working towards reflexivity: reflective research diaries, bracketing interviews, conversations with supervisors, recording and listening back to myself talking through my assumptions, motivations, and thoughts on the research process. This was sometimes a frustrating and demanding task, and one that felt quite difficult to monitor the progress of at times. At these times, I could simultaneously see the appeal of more positivist models that position the researcher as neutral, and the value and richness inherent to qualitative working of this type and how it fit with my broader worldview.

The end product

This thesis presents two qualitative explorations: the first, a thematic synthesis of qualitative study of the service user experience of trauma therapy; and the second, a thematic analysis of the therapist experience of the lifeline in narrative exposure therapy. Both sought to answer similar questions: what do we know about this? How is it experienced? Why might this be important or useful? This appraisal of the issues I encountered, sequentially and iteratively, through the research process aim to give a broader, richer context to these two pieces of research work and the story that preceded their writing.

The 'end product' of this thesis is significantly different to what I had planned for in early 2019; the thesis process has added several small stones and flowers to my own lifeline

through its journey. While there are a range of limitations, challenges, and things I might now do differently in both pieces of work, I feel they provide rich and useful accounts of the two phenomena studied. The process of writing the critical appraisal has also highlighted to me how integral both pieces of work have been to my development as a clinical psychologist and researcher. This thesis has emphasised to me the power of stories and narratives, and I hope to continue to explore and utilise this power in therapy, research, and beyond.

References

Asselin, M. E. (2003). Insider research: Issues to consider when doing qualitative research in your own setting. Journal for Nurses in Professional Development, 19(2), 99-103.

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in

    qualitative research. Qualitative research, 15(2), 219-234.

Boaz, A., Hanney, S., Jones, T., & Soper, B. (2015). Does the engagement of clinicians and

    organisations in research improve healthcare performance: a three-stage review. BMJ

    open, 5(12), e009415.

Brannick, T., & Coghlan, D. (2007). In defense of being "native": The case for insider

    academic research. Organizational research methods, 10(1), 59-74.

British Psychological Society. (2019, January). *Standards for the accreditation of Doctoral*

    programmes in clinical psychology.

    https://www.bps.org.uk/sites/www.bps.org.uk/files/Accreditation/Clinical%20Accredi

    tation%20Handbook%202019.pdf

Clearing House for Postgraduate Courses in Clinical Psychology. (2020). *Clearing House -*

    Numbers. https://www.leeds.ac.uk/chpccp/.

    https://www.leeds.ac.uk/chpccp/numbers.html

Corrie, S., & Callanan, M. M. (2001). Therapists' beliefs about research and the scientist-

    practitioner model in an evidence-based health care climate: A qualitative study.

    British Journal of Medical Psychology, 74(2), 135-149.

Costley, C., Elliott, G., & Gibbs, P. (2010). Key concepts for the insider-researcher. Doing

    work based research: Approaches to enquiry for insider-researchers, 1-7.

Fischer, C. T. (2009). Bracketing in qualitative research: Conceptual and practical matters.

    Psychotherapy Research, 19(4-5), 583-590.),

Greene, M. J. (2014). On the inside looking in: Methodological insights and challenges in

    conducting qualitative insider research. The qualitative report, 19(29), 1-13.

Harper, D. (2013, March). Reflections on qualitative research in clinical psychology training.

    In Clinical Psychology Forum (Vol. 243, No. 21, pp. 20-23).

Holttum, S., & Goble, L. (2006). Factors influencing levels of research activity in clinical

      psychologists: A new model. Clinical Psychology & Psychotherapy: An International

      Journal of Theory & Practice, 13(5), 339-351.

Hyndman, N. (2020). UK charities and the pandemic: navigating the perfect storm. Journal of

      Accounting & Organizational Change.

Iacobucci, G. (2020). Covid-19 makes the future of UK clinical research uncertain. BMJ,

      369.

Jamrozik, K. (2004). Research ethics paperwork: what is the plot we seem to have lost?. Bmj,

      329(7460), 286-287.

Jones, J. L., & Mehr, S. L. (2007). Foundations and assumptions of the scientist-practitioner

      model. American Behavioral Scientist, 50(6), 766-771.

Jonker, L., Cox, D., & Marshall, G. (2011). Considerations, clues and challenges: gaining

      ethical and trust research approval when using the NHS as a research setting.

      Radiography, 17(3), 260-264..

Kalpokaite, N., & Radivojevic, I. (2018, October). Demystifying qualitative data analysis for

      novice qualitative researchers. In World Conference on Qualitative Research (Vol. 2).

Kennedy, P., & Llewelyn, S. (2001). Does the future belong to the scientist practitioner?.

      PSYCHOLOGIST-LEICESTER-, 14(2), 74-79.

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship

      and psychotherapy outcome. Psychotherapy: Theory, research, practice, training,

      38(4), 357.

Lambert, N., & Carr, S. (2018). 'Outside the Original Remit': Co-production in UK mental

      health research, lessons from the field. International Journal of Mental Health

      Nursing, 27(4), 1273-1281.

Mansourian, Y. (2008). Exploratory nature of, and uncertainty tolerance in, qualitative research. *New Library World*.

Marjanovic, S., Ball, S., Harshfield, A., Dimova, S., Prideaux, R., Carpenter, A., ... & Simmons, R. (2019). Involving NHS staff in research. The Healthcare Improvement Studies Institute.).

McMullin, C., & Needham, C. (2018). Co-production in healthcare. In Co-Production and Co-Creation (pp. 151-160). Routledge

Meltzer, H. Y., & Stahl, S. M. (1976). The dopamine hypothesis of schizophrenia: a review. Schizophrenia bulletin, 2(1), 19.

Mercer, J. (2007). The challenges of insider research in educational institutions: Wielding a double-edged sword and resolving delicate dilemmas. Oxford review of education, 33(1), 1-17.

Mirdal, G. M., Ryding, E., & Essendrop Sondej, M. (2012). Traumatized refugees, their therapists, and their interpreters: Three perspectives on psychological treatment. Psychology and psychotherapy: Theory, research and practice, 85(4), 436-455.

Najavits, L. M. (2000). Researching therapist emotions and countertransference. Cognitive and Behavioral Practice, 7(3), 322-328.

NHS England. (2017, April). *Patient and Public Participation Policy*. https://www.england.nhs.uk/wp-content/uploads/2017/04/ppp-policy.pdf

Ortlipp, M. (2008). Keeping and using reflective journals in the qualitative research process. The qualitative report, 13(4), 695-705.

Pinfold, V., Szymczynska, P., Hamilton, S., Peacocke, R., Dean, S., Clewett, N., ... & Larsen, J. (2015). Co-production in mental health research: reflections from the people study. *Mental Health Review Journal*.

Roberts, L. D., & Castell, E. (2016). "Having to shift everything we've learned to the side": expanding research methods taught in psychology to incorporate qualitative methods. Frontiers in Psychology, 7, 688.

Robinson, L., Murdoch-Eaton, D., & Carter, Y. (2007). NHS research ethics committees. *BMJ*, *335*(7609), 6. https://doi.org/10.1136/bmj.39201.508692.2c

Shapiro s, D. (2002). Renewing the scientist-practitioner model. Psychologist-Leicester-, 15(5), 232-235.

Shaw, R. (2010). Embedding reflexivity within experiential qualitative psychology. Qualitative research in psychology, 7(3), 233-243.

Sheard, L., & Peacock, R. (2019). Fiddling while Rome burns? Conducting research with healthcare staff when the NHS is in crisis. Journal of health organization and management.

Silverstein, L. B., Auerbach, C. F., & Levant, R. F. (2006). Using qualitative research to strengthen clinical practice. Professional Psychology: Research and Practice, 37(4), 351

Smith, K. V., & Thew, G. R. (2017). Conducting research in clinical psychology practice: Barriers, facilitators, and recommendations. British Journal of Clinical Psychology, 56(3), 347-356.

Thomas, G. V., Turpin, G., & Meyer, C. (2014). Clinical research under threat. *The Psychologist*, *15*(6), 286–289.

Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. Qualitative social work, 11(1), 80-96.

Appendix A: Critical Appraisal Skills Program Checklist – Amended

Paper for appraisal and reference:

SECTION A: Are the results valid?

1. Was there a clear statement of the aims of the research?

    What was the goal of the research?
    Why it was thought important?
    It's relevance?

Yes	
Can't tell	
No	

2. Is a qualitative methodology appropriate?

    If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants?
    Is qualitative research the right methodology for addressing the research goal?

Yes	
Can't tell	
No	

IS IT WORTH CONTINUING?

3. Was the research design appropriate to address the aims of the research?

    If the researcher has justified the research design (e.g., have they

    Discussed how they decided which method to use)

Yes	
Can't tell	
No	

4. Was the recruitment strategy appropriate to the aims of the research?

Yes	
Can't tell	
No	

If the researcher has explained how the participants were selected?
If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study?
If there are any discussions around recruitment (e.g. why some chose not to take part)?

- 4a) Supplementary question: was the recruitment strategy inclusive of accessing participants who had dropped out of therapy?

Yes	
Can't tell	
No	

- 4b) Supplementary question: was there any description of the demographics of participants, and/or the impact this might have on the results?

Yes	
Can't tell	
No	

5. Was the data collected in a way that addressed the research issue?

Yes	
Can't tell	
No	

If the setting for the data collection was justified?
If it is clear how data were collected (e.g. focus group, semi-structured interview etc)?
If the researcher has justified the methods chosen
If the research has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)?
If methods were modified during the study. If so, has the researcher explained how and why?
If the form of data is clear (e.g. tape recordings, video material, notes etc)?
If the researcher has discussed saturation of data?

6. Has the relationship between researcher and participants been adequately considered?

Yes	
Can't tell	
No	

If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions, (b) data collection, including sample recruitment and choice of location?
How the researcher responded to events during the study and whether they considered the implications of any changes in the research design?

SECTION B: What are the results?

7. Have ethical issues been taken into consideration?

Yes	
Can't tell	
No	

If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained?
If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)?
If approval has been sought from the ethics committee?

8. Was the data analysis sufficiently rigorous?

Yes	
Can't tell	
No	

If there is an in-depth description of the analysis process?
If thematic analysis is used, if so, is it clear how the categories/themes were derived from the data?
Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process?
If sufficient data are presented to support the findings?
To what extent contradictory data are taken into account?
Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation?

9. Is there a clear statement of findings?

Yes	
Can't tell	
No	

If the findings are explicit?
If there is adequate discussion of the evidence both for and against the researcher's arguments?
If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)?
If the findings are discussed in relation to the original research question?

SECTION C: Will the results help locally?

10. How valuable is the research?

Yes	
Can't tell	
No	

If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature?
If they identify new areas where research is necessary?
If the researched have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used?

Appendix B: Study advert

The Lifeline in Narrative Exposure Therapy

My name is Jayde Dix, I am a trainee clinical psychologist from University College London.

As a part of my thesis, I am looking to interview **therapists who deliver NET** for clients who have experienced multiple traumas. The interview explores the **lifeline**, the ways in which you find it helpful or challenging, and how you think it impacts on the rest of therapy.

The interview will take around 1 hour and will be conducted virtually. You will receive a £20 voucher or charity donation for your participation.

If you would like to hear more, please email me on **jayde.dix.13@ucl.ac.uk.** I am happy to answer any questions you have and would be very grateful for your participation.

This study has been approved by the UCL Research Ethics Committee 17263/001. Supervised by Dr Miriam Fornells-Ambrojo and Dr Katy Robjant.

Appendix C: Information sheet

<u>**PARTICIPANT INFORMATION SHEET FOR THERAPISTS**</u>
UCL Research Ethics Committee Approval ID Number: 17263/001

Creating the lifeline for multiple traumas in narrative exposure therapy: the experience of therapists
Principal Researcher: Dr Miriam Fornells-Ambrojo, <u>Miriam.fornells-ambrojo@ucl.ac.uk,</u> University College London Department of Clinical, Educational, and Health Psychology, 1-19 Torrington Place, London, WC1E 7HB.

My name is Jayde Dix and I am studying for a Doctorate in Clinical Psychology at University College London. You have been invited to take part in a research study I am running with my supervisor Dr Fornells-Ambrojo. Please read this information sheet and ask us any questions you might have. Then you can decide if you would like to take part or not.

- Why have I been asked to take part in this study?

You have been invited to take part because you either currently offer, or have in the past offered narrative exposure therapy as a part of your clinical practice. We are inviting all therapists who provide NET to take part in our study.

- What is study about?

We will be researching the lifeline component of narrative exposure therapy. As the lifeline is a relatively unique aspect of NET, we hope to find out more about how therapists experience the process of creating it early in therapy. There is not much research about the lifeline to date. We hope to contribute to the literature by exploring the views of therapists and how these fit with some of the existing ideas about why the lifeline is a useful addition to therapy.

- What happens during the study?
The study involves an interview with me where we will talk about your experiences of delivering the lifeline session of therapy. This interview will need to be audio-recorded; this is a mandatory part of the study, and if you would prefer not to be recorded unfortunately you will not be able to take part. I will ask questions like 'In your view, what is the purpose of the lifeline?' and 'What impact, if any, do you feel the lifeline has on your relationship with the client?'

The interview will take around an hour. It will take place online via Microsoft Teams.

If you wish to take part, we will ask you to sign a consent form which explains what you are willing to do in the study and what information you are happy for me to have about you. We will ask you for some information about yourself, such as your age, gender and ethnicity. We will also ask about your experience of NET and clinical background. You can still take part even if you would prefer not to complete this information.

We will give you a copy of your information sheet and consent form at the end of the interview.

- Do I have to take part?
<u>No.</u> You do not have to take part if you don't want to. If you don't want to take part in

the study, it won't affect you in any way. Your employment/volunteering will carry on as planned, whether you do or do not take part.

If you change your mind during the study and decide you no longer want to take part, that is fine too. You can tell us at any time that you don't want to carry on, and we can stop immediately. If you change your mind about taking part after the interview, you can contact us and you will be able to withdraw your data from the study up until May 2021. Unfortunately after this time, it will not be possible to withdraw your data.

- Is what I say confidential?
The information we collect about you in the interview is confidential. Only people involved in the research will be able to read the information you give.

Please note that confidentiality will be maintained as far as it is possible, unless during our conversation we hear anything which makes me worried that you or someone else might be in danger of harm. We would have a duty to inform relevant agencies of this, in the same way as we do in clinical practice.

We will write a report about what we found out during the study. This will cover everyone we speak to, not just you. In the report, we might use quotes of things people said in the interview. We wouldn't use your name, and so nobody would be able to know it was you who said the things we quote. If you would like to read the report when it is complete, we would be happy to provide it to you via email.

- Are there any risks of benefits to taking part?
There are no benefits to taking part, but some people can find research interviews an interesting experience. We do not anticipate there will be any significant risks involved in your participation. We appreciate the people you offer NET to have been through a range of upsetting experiences. If you need to take a break at any stage, please just let us know.

Data Protection privacy notice	If I have any questions, who can I ask?
UCL's Data Protection Officer is Lee Shailer and he can be contacted at data-protection@ucl.ac.uk. You can read UCL's privacy notice at: https://www.ucl.ac.uk/legal-services/privacy/participants-health-and-care-research-privacy-notice and details of your rights at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/ Your personal data (name, contact details, gender, ethnicity) will be processed as described in this information sheet. The legal basis for this is that you provide your consent (by completing and signing the study consent form) for you to "perform a task in the public interest".	Ask the researchers: Dr Miriam Fornells-Ambrojo (Principal Researcher) Miriam.fornells-ambrojo@ucl.ac.uk Jayde Dix Jayde.dix.13@ucl.ac.uk University College London Department of Clinical, Educational, and Health Psychology, 1-19 Torrington Place, London, WC1E 7HB. *If you are unhappy about the study at any stage, please contact Miriam on the email address above. If you would like to complain further, you can email ethics@ucl.ac.uk.*

Appendix D: Consent form

THERAPIST PARTICIPANT CONSENT FORM
Creating the lifeline for multiple traumas in Narrative Exposure Therapy: the experience of therapists

If you agree with these sentences, tick the corresponding boxes.

- I have read the participant information sheet (version 24.04.20) and I understand what I will be asked to do in this study. ☐

- The researcher has answered any questions I had about the study. ☐

- I understand that I do not have to take part if I don't want to. ☐

- I understand that I can stop taking part in the study at any point and I don't have to explain why to anybody. ☐

- I understand that data protection law says that 'Public Task' is the basis for collecting and using my information. This is because my information will be used for research that might help other people in the future. ☐

- I understand that my information will be kept confidential unless the researcher is worried about my safety or someone else's safety. ☐

- I agree that the researcher can record our conversation and keep it for up to 2 years. This will be stored safely at University College London. I agree that the written version of our conversation will be stored for 10 years. ☐

- I agree to giving demographic information about myself to the researcher, as outlined in the participant demographic sheet (version 24.04.20). ☐

- I have been given the name and telephone number of who I can call if I want to ask any more about the study. ☐

- I agree that the researcher can use anonymized quotes from what I have said when the research is written up as a report, as long as nobody can tell it was me that said it. ☐

- I agree to take part in this study. ☐

Your name: _____

Your signature: _____

Date: _____

Researcher's name: _____

Researcher's signature: _____

Date: _____

Data Protection privacy notice	**If I have any questions, who can I ask?**
UCL's Data Protection Officer is Lee Shailer and he can be contacted at data-protection@ucl.ac.uk. You can read UCL's privacy notice at: https://www.ucl.ac.uk/legal-services/privacy/participants-health-and-care-research-privacy-notice and details of your rights at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of- the-gdpr/individuals-rights/ Your personal data (name, contact details, gender, ethnicity) will be processed as described in this information sheet. The legal basis for this is that you provide your consent (by completing and signing the study consent form) for you to "perform a task in the public interest".	Ask the researchers: Dr Miriam Fornells-Ambrojo (Principal Researcher) Miriam.fornells-ambrojo@ucl.ac.uk Jayde Dix Jayde.dix.13@ucl.ac.uk University College London Department of Clinical, Educational, and Health Psychology, 1-19 Torrington Place, London, WC1E 7HB. *If you are unhappy about the study at any stage, please contact Miriam on the email address above. If you would like to complain further, you can email ethics@ucl.ac.uk.*

Appendix E: Therapist experience of the NET lifeline demographics and interview

schedule

Creating the lifeline for multiple traumas in narrative exposure therapy: the experience of therapists
Therapist interview schedule – version 5

Introduction
I am going to ask some questions about your experience of creating the lifeline with clients in narrative exposure therapy.

We are interested in finding out about therapist's understanding and experience of creating the lifeline. Please answer openly and honestly; your responses are confidential and we hope to find out about both the benefits and challenges of the lifeline component of NET. We appreciate that discussing one's work as a therapist can come with these anxieties, but I want to emphasise that we are not assessing your competence in NET, or how 'successfully' individual courses of therapy went.

The interview should last around 1 hour. If you would like to take a break, or would prefer not to answer any of the questions, just let me know and we can stop or skip to the next question. The interview is divided into three sections: about the process of creating the lifeline, the therapeutic relationship, and the impact of the lifeline.

THERAPIST PARTICIPANT DEMOGRAPHICS FORM
Creating the lifeline for multiple traumas in Narrative Exposure Therapy: the experience of therapists

Participant number	
Age	
Ethnicity	
Gender	
Professional qualification/s and years qualified (or trainee details)	
Client group/s you have used NET with	
Years of experience with client group	**0-1 years** **2-5 years**

	6-10 years **11+ years**
NET training	Please check those that apply and fill in details: **Received formal NET training** Date: Trainer: **Received informal NET training** Date: Context: (e.g. service CPD, external CPD) **Self-taught** Date: Materials/resources used:

Experience with NET	Years of experience with NET
	
	    0-2
	
	    3-5
	
	    5-8
	
	    8-10
	
	    10+
	
	Approximate number of clients seen for NET
	
	    1-5
	
	    6-10
	
	    11-15
	
	    16+
	
	Approximate number of lifelines completed
	
	    1-5
	
	    6-10
	
	    10+

Confidence with NET	Confidence with NET

	0	2	3	4	5	6	7	8	9	10	
	Novice				**Confident**				**Very confident**		

Supervision	Do you have regular supervision for NET clients? Yes / No
	
	      Weekly
	
	      Fortnightly
	
	      Monthly
	
	      Less than monthly										

Training in other trauma-focussed therapies (e.g. TF-CBT, EMDR)	Please give brief details on **formal** training you have received in other trauma-focussed therapies (e.g. date, what therapy, trainer): Please give brief details on **informal** training you have received in other trauma-focussed therapies (e.g. date, what therapy, context of training):										

Process: the lifeline

1) What originally drew you to NET?
   ● What got you interested in NET?
   ● What do you like about the NET approach?
   ● How did you come to start using NET?

2) In your view, what is the purpose of completing the lifeline?
   ● What is important about using the lifeline in NET?
   ● What is your <u>understanding</u> of why the lifeline is a part of NET?
   ● What in your <u>opinion</u> is the main point of using the lifeline in NET?

3) How do you explain the rationale for completing the lifeline to your clients?
   ● What do you tell your clients at the beginning of the lifeline session?
   ● What do you want your clients to understand about the lifeline before you start it?
   ● What do you think it's important to convey to clients about the lifeline?

4) Could you describe how you typically create the lifeline in NET?

- Can you describe what happens in your lifeline sessions?

5) What is it like using physical materials (e.g. stones, flowers, rope) when creating the lifeline with clients?
Prompts:
- In what ways do you feel the use of stones is important? What do you think the stones add to or take away the session?
- In what ways do you feel the use of flowers is important? What do you think the flowers add to or take away from the session?
- In what ways do you feel the use of rope is important? What do you think the rope adds to or take away from the session?
- In what ways do you feel the use of other symbols (e.g. sticks, candles) is important? What do you think the other symbols add to or take away from the session?
- Does using the materials help or raise any particular challenges?

6) How do you use the lifeline throughout the rest of therapy?
Prompts
- How do you understand the role of the lifeline in the rest of therapy?
- In what ways do you think therapy would be better/worse without the lifeline?
- In what ways does the lifeline help/hinder you or the client across the following sessions?

In the demographics form you indicated you mainly use the lifeline with [client group]. I am going to ask some questions about your experience of using NET with [client group]:

6a) What things are important to consider when using the lifeline with [your client group] specifically?
- What issues do you need to hold in mind that are specific to [client group]?
- What, if any, adjustments do you make to the usual protocol when using the lifeline with [client group]?

6b) What are the barriers, if any, to using the lifeline with [client group]?
- In what ways does the lifeline feel difficult to implement with [client group]?
- What are some challenges you notice when using the lifeline with [client group]?
  - Their understanding?
  - Their engagement?
  - The impact of their symptoms?

6c) What about the lifeline works well with [client group]?
- Are there particular clients you find the lifeline works well with?
- What are the factors you think contribute to it being useful with [client group]?

Process: therapeutic relationship

7) How would you describe what you are like/what you aim to be like during the lifeline session?
Prompts
- If you were describing how you are in the lifeline session to a colleague, what words would you use?

- What kind of traits or attitudes do you try to bring to lifeline sessions?

8) What impact, if any, do you feel the lifeline has on the relationship you have with the client?
Prompts
- Are your thoughts and feelings about the client impacted by doing the lifeline?
- What do you think your relationship with the client would be like without the lifeline?
- Does the lifeline facilitate building rapport with the client? If so, how?
- Does it make building rapport harder? If so, how?

9a) What do you feel the client needs from the therapist to help them engage with the lifeline?
- What qualities do you think the client needs from you in the lifeline session?
- What things do you do that help the client feel able to engage with the lifeline?

9b) Why do you think these values/features/characteristics are of particularly importance in the lifeline session?
- What about these features helps clients engage with the lifeline?
- What would the lifeline session be like without these characteristics?

10) Do you feel there is anything unique or different about the interpersonal skills required in the lifeline session of NET compared to other therapies?
- If yes, what are they? Why do you feel they're important?
- What about the lifeline necessitates these qualities/skills?
- In what ways, if any, are you different in lifeline sessions compared to any other therapy session?

Impact of the lifeline

11) In what ways do you think the lifeline session is helpful for clients?
Prompts:
- What positive impact do you think the lifeline has on clients?
- How do you think clients feel after the session?
- What have clients told you about helpful aspects of the lifeline session?

12) In what ways do you think the lifeline session is challenging for clients?
Prompts:
- What negative impact do you think the lifeline has on clients?
- How do you think clients feel after the session?
- What have clients told you about the difficult aspects of the lifeline session?
- How to do you manage the difficult elements of the session in line with NET protocol? What other therapeutic techniques do you use to make it more manageable?

13) In what ways do you think the lifeline session is helpful for you as a therapist?

147

Prompts:
- How do you feel after completing a lifeline session?
- What would you tell someone who is learning NET about how the lifeline helps you as a therapist?

14) In what ways is the lifeline session challenging for you as a therapist?
Prompts:
- How do you feel after completing a lifeline session?
- What would you tell someone who is learning NET about how the lifeline is difficult for you as a therapist?

15) What, if anything, do you feel the lifeline brings to NET that is unique or different to other trauma-focussed therapies?
- In what ways does the lifeline make things easier/add value to NET when compared to other therapies?
- In what ways does the lifeline make things more difficult/detract from NET when compared to other therapies?
- What does the lifeline add to the therapy for you as a therapist?
- What does the lifeline add to the therapy for clients?

[If participant has been using NET for a substantial length of time/with many patients]:
Has your thinking about the lifeline evolved or changed over time? If so, how?

We have now finished the interview. Thank you for agreeing to take part and making time to attend today. Do you have any comments or questions on the interview, or the research in general? Would you like to hear about the results of the research once it is completed?

Appendix F: Demonstration of analysis process

Extract	Initial notes	Coding	Theme	Domain
I: So what do you think the relationship with your client would be like if you just received that information say in a letter, or a report, or you just knew it without going through the process? PP X: Oh yeah I see. **It's a shared understanding isn't it, I suppose, like they know that you know**. And even the things they haven't been able to fully disclose, they know that you know it exists. So I think it puts everything on the table in the beginning, and that's why I think you know, **you have to be very containing because they need to know that is a safe place for them**, and if you don't start off with that you – you know – you're not gunna make much progress in the rest of therapy, **so I think that is your chance as a therapist to make a good impression on the client.**	"They you that you know" Lifeline aims to help them feel safe Therapist can use it to make good first impression	Lifeline gives shared understanding of their life Lifeline as the start of the therapy process	Core conditions in a robust human rights framework Gentle introduction to the work of therapy	Strengthening the therapeutic relationship through the lifeline

I: Yeah, okay. And are your thoughts or feelings about clients impacted in any significant ways by doing the lifeline? PPX: I mean sometimes you look at the lifeline and you think, **I am so impressed** that person is still sat in front of me and alive after what they've survived. It can really **confront you with the horrors** that our clients have seen. So I think like, **admiration and respect and strength** are often my main thoughts about clients in terms of when you think about that. But I think it can also be really lovely – like one thing I really enjoy with working in NET in general is that **you get to see a viewpoint of the person's whole life**, and **you get to walk alongside them in that**, and the lifeline is a snapshot of that, but **it's so rare in every other modality of therapy do you get to**, or maybe area of therapy, **do you get to like actually talk about someone's entire life with them.**	Impressed by how much they have survived Seeing the horrors they've experienced Feel admiration and respect Like getting to see whole life Walking alongside them Seeing whole life as different to other therapies	Therapists feel a lot about clients during lifeline Value of getting to hear about a whole person's whole life Witnessing Value of getting to hear about a whole person's whole life	A big ask for all involved: lifeline as emotionally intense Meeting a whole person, a whole life The centrality of witnessing and being witnessed Meeting a whole person, a whole life	"It's definitely a rollercoaster": emotions in the lifeline Hearing it all: contextualising, coherence, and witnessing in the lifeline

151

Examples of codes within the theme "Challenges and areas for further development"

Code	Quote
How to represent periods of trauma	"so I guess that can be sometimes a bit confusing for people or people not being sure about how they might signify let's say several years of child sexual abuse and how many rocks does this take if the abuse was happening every night for example over you know"
How to briefly label the events	"sometimes people can struggle to know how to describe the event. And again, whether that sort of about a kind of language production issue or whether there's issues for… possibly even more marked in terms of sort of shame and kind of difficulties around disclosure. I find sometimes I'm having to sort of give suggestions"
How to get the chronology of events right during the lifeline	"even if you've done the lifeline, the client, if it's something from you in that, and you get halfway through doing all the reliving and it actually turns out that there's something three years before we've got to talk about"
Difficult to do it well remotely	"whereas remotely, I've got him sort of propped up over here on WhatsApp calling, I've got my interpreter over here, and I'm trying to stumble around on my desktop, it's so disconnected"
Off-model, or off-manual use	"For a couple of clients at the moment, they're the people who each session lay out the section – slightly not in the manual, but you know – but so she lays out the section that we're talking through so she'll lay out the, lay out the string and then she'll – she talks about stones so then she'll put that down, and then when she gets to the flowers she'll put that down, so kind of as we're talking putting the symbols down as she talks through"
Not always managing to get it in one session	"Um, you know sometimes I say this as well sometimes in [BOROUGH] where I work it can take a couple of sessions to create the timeline [laughs] especially with the more complex stuff or if people are really struggling with the memory for example"

Appendix E: Ethical approval

UCL RESEARCH ETHICS COMMITTEE
OFFICE FOR THE VICE PROVOST RESEARCH

4th May 2020

Dr Miriam Fornells-Ambrojo
Department of Clinical, Educational and Health Psychology
UCL

Cc: Jayde Dix

Dear Dr Fornells-Ambrojo

Notification of Ethics Approval with Provisos
Project ID/Title: 17263/001: Creating the lifeline for multiple traumas in narrative exposure therapy: the experience of refugees, asylum seekers, and therapists

Further to your satisfactory responses to the Committee's comments, I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee (REC) that your study has been ethically approved by the UCL REC until **31st December 2021.**

Ethical approval is subject to the following conditions:

Notification of Amendments to the Research
You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing an 'Amendment Approval Request Form'
http://ethics.grad.ucl.ac.uk/responsibilities.php

Adverse Event Reporting – Serious and Non-Serious
It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Joint Chairs will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Joint Chairs of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Joint Chairs will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Office of the Vice Provost Research, 2 Taviton Street
University College London
Tel: +44 (0)20 7679 8717
Email: ethics@ucl.ac.uk
http://ethics.grad.ucl.ac.uk/

Final Report
At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research i.e. issues obtaining consent, participants withdrawing from the research, confidentiality, protection of participants from physical and mental harm etc.
In addition, please:
- ensure that you follow all relevant guidance as laid out in UCL's Code of Conduct for Research: https://www.ucl.ac.uk/srs/file/579
- note that you are required to adhere to all research data/records management and storage procedures agreed as part of your application. This will be expected even after completion of the study.

With best wishes for the research.

Yours sincerely

Professor Michael Heinrich
Joint Chair, UCL Research Ethics Committee

Tables

Part 1

Table 1. *Search terms used*

Population	AND	Focus of study	AND	Intervention	AND	Qualitative methodology
patient* OR "service user*" OR client* OR outpatient* OR inpatient* OR "trauma survivor*" OR "trauma victim*" OR veteran* or "post?traumatic stress disorder" OR PTSD OR traumati?ed OR refugee* OR "asylum seek*" OR "low?resource" OR "torture victim*" OR "torture survivor*"		experience* OR feedback OR view* OR understanding* OR subjective* OR testimon*		"trauma therap*" OR "trauma work" OR "trauma?focu*ed therap*" OR "trauma?focu*ed work" OR "CBT for PTSD" OR "cognitive?behavio*ral therap* for PTSD" OR "trauma?focu*ed CBT" OR "trauma?focu*ed cognitive?behavio*ral therap*" OR "TF?CBT" OR "prolonged exposure" OR PE OR "cognitive processing therap*" OR CPT OR "eye movement desensiti*ation reprocessing therap*" OR EMDR OR "narrative exposure therap*" OR NET		qualitative* OR interview* OR "thematic analysis" OR "interpretive phenomenological analysis" OR IPA or "grounded theory" OR "discourse analysis" OR "narrative analysis" OR "Foucauldian discourse analysis" OR exploratory OR "focus group*" OR survey* OR descriptive OR perspective* OR acceptability OR narrative* OR perception* OR inquiry or theme* or thematic*

Table 2. *Summary of studies included in thematic synthesis*

Study	Main aim	Sample	Intervention	Data collection and analysis method
Ashwick, Turgoose & Murphy, 2019 UK	To explore the acceptability of using tele-therapy for treating PTSD in a sample of UK veterans.	$n = 16$ (1 female, 15 male, 27-58 years old, White ($n = 15$), Black ($n = 1$)) UK veterans	Cognitive processing therapy	Semi-structured interviews Thematic analysis
Chouliara et al., 2011 UK	To elicit perceptions and experiences of talking therapy services for adult survivors of childhood sexual abuse.	$n = 13$ (13 female; no age or ethnicity reported) Adult survivors of childhood sexual abuse	A range of trauma-focussed therapies	Semi-structured interviews Interpretive phenomenological analysis
Cicconi, 2018 UK	To explore the experience of asylum seekers with narrative exposure therapy	$n = 11$ (7 female, 4 male, 27-62 years old, Sub-Saharan African ($n = 5$), Middle Eastern ($n = 2$), Eastern European ($n = 1$), Central American ($n = 1$), East Asian ($n = 1$), South-East Asian ($n = 1$). Asylum seekers who have received NET for PTSD	Narrative exposure therapy	Semi-structured interviews Thematic analysis
Dittman & Jensen, 2014 Norway	To explore traumatised youths' experiences of receiving trauma-focussed CBT.	$n = 30$ (23 female, 7 male, 11-17 years old, no ethnicity reported) Young people who had received TF-CBT	Trauma-focussed CBT	Semi-structured interviews Thematic analysis

Study	Main aim	Sample	Intervention	Data collection and analysis method
Edmond, Sloan & McCarty, 2004 USA	To examine what women who have experienced trauma due to sexual abuse think about the effectiveness of prolonged exposure or eclectic therapy	$n = 38$. Demographics for prolonged exposure group only not reported. (Full sample: 59 female, 0 male, 18-51 years old, White ($n = 50$), African American ($n = 2$), Hispanic ($n = 1$), Asian ($n = 1$), Pacific Islander ($n = 1$), Finno-Ugaric ($n = 1$), Russian Jewish ($n = 1$), Lebanese ($n = 1$), Racially Mixed ($n = 1$)) Adult survivors of childhood sexual abuse	Prolonged exposure	Semi-structured individual interviews Analysis method not stated
Grubaugh, Veronee, Ellis, Brown & Knapp, 2017 USA	To explore service users' reactions and responses to prolonged exposure through feasibility indices, including post-intervention interviews	$n = 9$ (no demographics available) (Full sample: $n = 14$, 1 female, 13 male, mean age = 47 years old, African American ($n = 7$), Caucasian ($n = 7$)) Veterans with psychosis spectrum disorder	Prolonged exposure	Semi-structured interviews Constructivist grounded theory

Study	Main aim	Sample	Intervention	Data collection and analysis method
Hundt et al., 2015 USA	To explore veteran's experiences of initiating an evidence-based psychotherapy for PTSD.	$n = 23$ (6 female, 17 male, mean age = 54, African American ($n = 10$), Non-Hispanic White ($n = 8$), Hispanic ($n = 2$), Asian ($n = 2$), Native American ($n = 1$)) USA veterans	Prolonged exposure or cognitive processing therapy	Semi-structured interviews Grounded theory
Hundt, Barrera, Arney & Stanley, 2017 USA	To elicit first-hand accounts of veterans who had completed prolonged exposure or cognitive processing therapy	$n = 23$ (6 female, 17 male, mean age = 54 years old, African American ($n = 10$), Non-Hispanic White ($n = 8$), Hispanic ($n = 2$), Asian ($n = 2$), Native American ($n = 1$)) USA veterans	Prolonged exposure or cognitive processing therapy	Semi-structured interviews Grounded theory
Hundt, Ecker, Thompson, Helm, Smith & Stanley, 2018 USA	To examine veteran's reasons for dropping out of prolonged exposure or cognitive processing therapy	$n = 28$ (11 female, 17 male, mean age = 45 years old, African American ($n = 17$), Non-Hispanic White ($n = 7$), Hispanic/Latino ($n = 4$)) USA veterans	Prolonged exposure or cognitive processing therapy	Semi-structured interviews Grounded theory
Mead, 2019 USA	To explore the experiences of military sexual trauma survivors in cognitive processing therapy, including changes in their	$n = 21$ (21 female, 0 male, early 20s – late 60s, sample included White, Black, Latino, and American Indian people; no n reported for ethnicity)	Cognitive processing therapy	Written questionnaires Thematic analysis

Study	Main aim	Sample	Intervention	Data collection and analysis method
	symptoms, social lives, and relationships	USA veterans		
Murray, Merritt & Grey, 2015 UK	To ascertain whether people find site visits as a part of PTSD therapy useful, and whether the function of site visits in participant's narratives confirm/not the cognitive model of them	$n = 25$ (9 female, 16 male, 28-65 years old, White British ($n = 15$), Black British ($n = 4$), South Asian ($n = 3$), White Other ($n = 2$), Middle Eastern ($n = 1$)) Service users receiving TF-CBT for PTSD	Trauma-focussed CBT	Written questionnaires Grounded theory
Naccarato, 2008 USA	To examine how service users experienced the EMDR process	$n = 15$ (11 female, 4 male, 22-55 years old, no ethnicity reported) Diagnosed with PTSD or DESNOS	EMDR	Semi-structured interviews Grounded theory
Schwarz, Baber, Barter & Dorfman, 2020 USA	To assess, using a mixed methods design, the efficacy of EMDR for women who experienced trauma due to sexual or domestic violence.	$n = 12$ (12 female, 0 male, no age or ethnicity reported) (Full sample: $n = 21$, 21 female 0, male, 20-60 years old, White ($n = 12$), Latina ($n = 4$), African American ($n = 3$), Asian ($n = 1$), and biracial ($n = 1$)) Women who have experienced trauma due to sexual or domestic violence	EMDR	Semi-structured interviews Constant comparative method

Study	Main aim	Sample	Intervention	Data collection and analysis method
Sharpe-Lohrasbe, 2012 Canada	To explore the resourcing experience of children and young people in triphasic trauma treatment	$n = 10$ (no gender reported, 13-17 years old, no ethnicity reported) Children and young people receiving trauma-focussed interventions	EMDR	Semi-structured interviews Descriptive phenomenological psychological method
Shearing, Lee & Clohessy, 2011 UK	To explore service users' experience of reliving in trauma-focussed CBT for PTSD	$n = 7$ (6 female, 1 male, 20-50 years old, White British ($n = 4$), Afro-Caribbean British ($n = 3$)) PTSD resulting from type 1 traumatic event	Trauma-focussed CBT	Semi-structured interviews Interpretive phenomenological analysis
Tong, Simpson, Alvarez-Jiminez & Bendall, 2017 Australia	To explore young people with first episode psychosis' reactions to trauma-focussed PTSD therapy	$n = 8$ (7 female, 1 male, 19-25 years old, no ethnicity reported) Young people with first episode psychosis and PTSD/sub-threshold PTSD	Trauma-focussed treatment adapted for people with first-episode psychosis	Semi-structured interviews Interpretive phenomenological analysis
Tong, Simpson, Alvarez-Jiminez & Bendall, 2018 Australia	To explore the experience of young people with first episode psychosis of talking about trauma in therapy	$n = 11$ (9 female, 2 male, 18-27 years old, no ethnicity reported) Young people with first episode psychosis and PTSD/sub-threshold PTSD	Trauma-focussed treatment adapted for people with first-episode psychosis	Semi-structured interviews Interpretive phenomenological analysis

Study	Main aim	Sample	Intervention	Data collection and analysis method
van de Water, Rossouw, Yadin & Seedat, 2018a South Africa	To explore the experiences of adolescents accessing psychotherapy for PTSD in a school setting	$n = 10$ (demographics unclear) Adolescents with PTSD or sub-threshold PTSD	Prolonged exposure for adolescents	Semi-structed interviews and focus groups Thematic content analysis
van de Water, Rossouw, van der Watt, Yadin & Seedat, 2018b South Africa	To explore the experiences of adolescents accessing psychotherapy for PTSD in a school setting	$n = 10$ (demographics unclear) Adolescents with PTSD or sub-threshold PTSD	Prolonged exposure for adolescents	Semi-structed interviews and focus groups Thematic analysis
Vincent, Jenkins, Larkin & Clohessy, 2013 UK	To examine the acceptability of trauma-focussed CBT for PTSD to asylum seekers by exploring their experience of treatment	$n = 7$ (3 female, 4 male, 19-42 years old, Burundian ($n = 2$), Sudanese ($n = 2$), Zimbabwean ($n = 1$), Afghan ($n = 1$), Iraqi ($n = 1$)) Asylum seekers with PTSD	Trauma-focussed CBT	Semi-structured interviews Interpretive phenomenological analysis
Wise & Marich, 2016 USA	To explore the lived experience of people with co-occurring PTSD and substance misuse disorders in standard and addiction-specific EMDR programmes.	$n = 9$ (6 female, 3 male, 28-60 years old, no ethnicity reported) Co-occurring PTSD and addiction disorder	EMDR	Semi-structured interviews Creswell's system for interpreting meaning

Table 3. *Summary of CASP ratings for each study*

Amended CASP items	Ashwick et al., 2019	Chouliara et al., 2011	Cicconi, 2018	Dittman & Jensen, 2014	Edmond et al., 2004	Grubaugh et al., 2017	Hundt et al., 2015	Hundt et al., 2017	Hundt et al., 2018	Mead, 2019	Murray et al., 2015	Naccarato, 2008	Schwarz et al., 2020	Sharpe-Lohrasbe, 2012	Shearing et al., 2011	Tong et al., 2017	Tong et al., 2018	van der Water et al., 2018a	van der Water et al., 2018b	Vincent et al., 2013	Wise & Marich, 2016
1) Statement of aims	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2) Appropriateness of qualitative method	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3) Appropriateness of design	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4) Appropriateness of recruitment strategy	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	X	X	✓	✓	✓	✓	✓	✓	✓	✓	✓
4a) Inclusion of people who dropped out	✓	X	X	✓	X	✓	X	✓	X	X	X	X	X	X	X	X	X	✓	✓	X	X
4b) Inclusion of minimum demographics	✓	X	✓	X	X	✓	✓	✓	✓	✓	✓	X	✓	X	✓	X	X	✓	✓	✓	X
5) Appropriateness of data collected to research issue	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
6) Consideration of relationship between researcher and participants	✓	✓	✓	X	X	X	X	X	X	✓	X	X	✓	✓	X	X	X	X	X	X	✓
7) Consideration of ethical issues	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	X	✓	✓	✓	X	✓	✓	X	✓	X	X
8) Rigor of data analysis	✓		✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
9) Clear statement of findings	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
10) Value of research	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Table 4. *Analytical theme summary*

Theme number	Analytical theme	Number of studies supporting theme (k)
1	What helps people to begin therapy, and to persist through its challenges?	k = 18
2	Safety makes or breaks the therapeutic relationship, and therefore the therapy.	k = 19
3	Therapy as a transformative experience	k = 21
4	Therapy as a profoundly challenging, and not always curative, process	k = 20

Table 5. *Illustrative quotes for descriptive themes under analytical theme 1*

Descriptive theme	Illustrative quote	k
Starting therapy at the right time, with the right knowledge	Participant: "I felt pressured to talk about it when I didn't feel ready. I wished we could have done it another time when I was more ready and that I could have decided when, but I felt that I couldn't. . . that I had to say it right away." (Dittman & Jensen, 2013) Participant: "…because it was explain[ed], I knew what was up. If someone said do that…I'd probably be like, no, why don't you do that…like tell me why first – so it's better just to not be thrown into something" (Sharpe-Lohrasbe, 2012).	k = 15
Desperation	Participant: "I done tried everything and that (expletive) don't work. […] I know what's next after this. What's next is the penitentiary or the graveyard for me." (Hundt et al., 2015)	k = 10
Hoping for, expecting, or experiencing, an improvement	Author: Participants were encouraged by "seeing signs of progress" […]. These changes helped them to persevere with therapy. (Vincent, Jenkins, Larkin & Clohessy, 2013) Participant: "I was hoping that "Maybe this will be the time that was going to be the turnaround and my anxiety and everything would be lessened." (Hundt et al., 2015)	k = 10

Table 6. *Illustrative quotes for analytical theme 2's descriptive themes*

Descriptive theme	Illustrative quote	k
Trust	Author/participant: The ability to share trauma memories with their case manager was a sign of the level of trust attained in the therapeutic relationship. "I did trust her so I told her what had happened". Author: using techniques such as asking for permission to continue talking about a certain topic and regularly monitoring participant distress (Tong, Simpson, Alvarez-Jiminez & Bendall, 2018) Participant: "If you don't trust your therapist you don't tell everything. If you don't tell everything, it's you you can't, you can't, you can't get any better I think." (Cicconi, 2018)	k = 17
Therapist as caring and competent	Participant: "She knew it [EMDR] very well. I think she is an advanced EMDR specialist or something like that. She is good because if one angle wouldn't work she'd try a different angle." (Edmond, Sloan & McCarty, 2004) Author/participant: It was a surprise to find "someone out there that really cares." (van de Water, Rossouw, Yadin & Seedat, 2018a)	k = 15
Balancing control and encouragement	Participant: "I didn't feel like I was pushed into it and I was given lots of warning, and umm, I was given enough time to talk about all my fears. But they also didn't allow me to procrastinate" (Shearing, Lee & Clohessy, 2011) Author/participant: Being pushed whilst respected [...] appeared to encourage participants' engagement in difficult therapeutic processes: "Sometimes I tell him, 'No, I don't want to speak any more' He will, sometimes he will push me to speak..." (Vincent, Jenkins, Larkin & Clohessy, 2013)	k = 12
Feeling understood	Participant: "She really listened but as well as listening she heard me and for me there is a huge difference between listening and hearing" (Chouliara et al., 2011)	k = 7

Table 7. *Illustrative quotes for analytical theme 3's descriptive themes*

Descriptive theme	Illustrative quote	k
Improved symptoms	Participant: "It's like I said, once I'm here, I can be in here, and talk with her (therapist). She will speak to me and I can go home that day and feel less symptoms" (Grubaugh et al., 2017) Participant: "before CPT, I had bad PTSD and depression. I didn't go anywhere or trust anyone. Today, I don't often have any symptoms. I still get triggered, but I have the tools to handle it" (Mead, 2019)	k = 18
Improved coping and functioning	Author: Many of the youths (9) said that it was helpful to learn techniques such as breathing exercises that they could use to deal with difficult emotions. (Dittman & Jensen, 2013) Author: Many were now engaging in more activities including exercise, attending religious services, playing more with their children, and doing things they used to enjoy but had lost interest in. (Cicconi, 2018)	k = 17
Memory changes	Participant: "Like at first when we started, like it was really difficult to tell the story. It made me upset and made me feel as if I was reliving it as I told it. . . and as I got to the end, it was almost boring." (Grubaugh, Veronee, Ellis, Brown & Knapp, 2017) Participant: "I can get distance on it, and it doesn't feel like I'm in it any more, you know" (Naccarato, 2008)	k = 14
Improved relationship with self	Participant: "The something that shifted is a more concrete sense of self […] It is actually the ability to perceive that there is a difference between what's being done to me and who I am." (Edmond, Sloan & McCarty, 2004)	k = 14
Moving on and closure	Author/participant: Eight (32%) commented that the result of the visit was a sense of moving on and putting the event in the past, leading to a sense of peace and release. One participant likened the site visit to "closing a big book I had been reading for a long time." (Murray, Merritt & Grey, 2015)	k = 14
Therapy as life-changing, life-saving	Participant: "the world is more colorful and worthwhile now. I am not isolating or having suicidal thoughts anymore. Now I feel human and I love life."	k = 12

Descriptive theme	Illustrative quote	k
	(Mead, 2019)	
Increased understanding	Author: Although they typically entered EBP knowing the symptoms of PTSD, EBP helped them understand how these were triggered and how automatic thoughts influenced their reactions. This greater understanding was comforting in that it provided a greater sense of predictability and control. (Hundt, Barrer, Arney & Stanley, 2017)	k = 12
Relief	Participant: "each night after it [reliving] I felt very much relieved when I was at work. Very much relieved. […] a weight being lifted off your shoulders". (Shearing, Lee & Clohessy, 2011)	k = 10

Table 8. *Illustrative quotes for descriptive themes under analytical theme 4.*

Descriptive theme	Illustrative quote	k
Anxieties about therapy	Participant: "I was very hesitant- scared honestly. I was afraid of what would come out- too much pain and anger!" (Mead, 2019) Author/participant: Some admitted that they were scared to see the counselor because "maybe she's not interested . . . will judge me," the counselor may not "believe" her, and "she is going to speak about it with . . . other counselors." (van der Water et al., 2018a)	k = 15
Avoidance – I don't want to talk about it	Participant: "Leave it alone. "Don't trouble trouble, trouble won't trouble you." One of my mother's greatest sayings." (Hundt et al., 2015) Participant: "I was ashamed. I was ashamed of what had happened and I hadn't told anyone. I'd just, it's embarrassing. Especially from young. You don't feel like telling anyone. Just disgusting." (Tong et al., 2018)	k = 10
Therapy is painful, both in and out of session	Author/participant: Others described experiences which might indicate that their high level of distress during the narration lead to dissociation: "I was um…um…losing myself like…I wasn't aware of where I am." (P1) "Sometimes my spirit would leave my body." (P2) (Cicconi, 2018) Author/participant: The researcher observed that many participants described feeling consumed by reliving during the process. Jamie: 'it took over my life for a couple of weeks'. Participants spoke about the emotional exhaustion after reliving. […]Participants spoke about experiencing a temporary increase in PTSD symptoms immediately after undertaking reliving, particularly with regard to nightmares (Shearing et al., 2011)	k = 10
Therapy is not a cure	Author/participant: Nevertheless, participants stressed that although their symptoms had reduced, the therapy was not a cure: "I mean, sometimes it's good, sometimes it's bad. But I would say that it has helped me but not all." (Ashwick et al., 2019) Author/participant: Although not common among this sample of treatment completers, it is important to note that some veterans had this experience: "Well, I wasn't feeling better at the end; I was feeling worse... the more I talked about it the worse that I felt about it".	k = 12

Descriptive theme	Illustrative quote	k
	(Hundt et al., 2017)	
Therapy isn't the whole picture	Author: 'Siyoli's' individual interview suggested that it was not the counselling that enabled her to change, but rather the birth ofher child which made her stay at home and try and rebuild a new life. (van der Water et al., 2018b)	k = 11

Table 1. *Participant demographics*

Demographic	Description	n (%) or Mean (SD); [Range] in years
Gender	Female	16 (100%)
Age		34.63 (7.05); [26 – 51]
Ethnicity	White British	10 (62.50%)
	White European	3 (18.75%)
	Black African	1 (6.25%)
	White and Chinese	1 (6.25%)
	White New Zealander	1 (6.25%)
Professional status	Qualified	15 (93.75%)
	Trainee	1 (6.25%)
Professional background	Qualified clinical psychologists	14 (18.75%)
	Qualified counselling for depression practitioner:	1 (6.25%)
	Trainee clinical psychologists	1 (6.25%)
Years qualified [1]		5.81 (7.10) [1– 26]

[1] As one participant was not yet qualified, the mean, standard deviation, and range for Years qualified is based on n = 15.

Table 2. *NET training and clinical experience*

NET training and experience	Description	*n* (%) or Mean (SD); [range]; {mode}
NET training experience	Formal training with Vivo International	7 (43.75%)
	In-house training in specialist trauma services	6 (37.50%)
	Self-taught using manual	2 (12.50%)
	Training during DClinPsy	1 (6.75%)
Main client group used NET with	Refugees and asylum seekers	12 (75.00%)
	Adults with PTSD/CPTSD in a community mental health setting	3 (18.75%)
	People with comorbid psychosis and PTSD	1 (6.25%)
Years of experience with NET	0-2 years	6 (37.50%)
	3-5 years	7 (43.75%)
	6-10 years	1 (6.25%)
	11+ years	2 (12.50%)
		{3-5 years}
Estimated number of full NET treatment cases completed	1-5 clients	5 (31.25%)
	6-10 clients	4 (25.00%)
	11-15 clients	1 (6.25%)
	16+ clients	6 (37.50%)
		{16+ cases}
Estimated number of lifelines completed, including those as a part of full NET treatment cases	1-5 lifelines	4 (25.00%)
	6-10 lifelines	1 (6.25%)
	11-15 lifelines	2 (12.50%)
	16+ lifelines	8 (50.00%)
		{16+ lifelines}
Self-rated confidence with NET (/10)		6.68 (1.65) [5/10 to 10/10]
Supervision for NET work	Weekly	5 (31.25%)
	Fortnightly	4 (25.00%)
	Monthly	6 (37.50%)
	None	1 (6.25%)
		{monthly}
Other trauma-focussed therapy training[1]	Trauma-focussed CBT	14 (87.50%)
	EMDR	10 (62.50%)
	Imagery rescripting	2 (12.50%)
	Cognitive processing therapy	1 (6.25%)

[1] Some participants reported having training in more than one type of additional trauma-focussed therapy, hence why these percentages do not total to 100.

Table 3. Summary of analysis structure

Domain	Themes
1. Strengthening the relationship through the lifeline	**1.1** Core conditions in a robust human rights framework
	1.2 Lifeline as a containing assessment tool and roadmap
	1.3 A gentle introduction to the work of therapy
2. Hearing it all: contextualising, coherence, and witnessing in the lifeline	**2.1** The centrality of witnessing and being witnessed
	2.2 Flowers alongside stones: supporting contextualization and coherence
	2.3 Meeting a whole person, a whole life
3. "It's definitely a rollercoaster": emotions in the lifeline	**3.1** A big ask for all involved: the lifeline as a powerful exercise
	3.2 Affect in the session is changeable, but usually resolves in a positive way
	3.3 Containment vs validation: the difficult task of pacing
4. Beyond words: the value of a physical, visible, tangible lifeline	**4.1** The visual, physical, tangible lifeline adds something to the verbal
	4.2 The lifeline "takes the heat out" of the task
	4.3 Symbols generally aid cross-cultural understanding
5. Challenges and areas for further development	**5.1** Client buy in and understanding
	5.2 Ensuring cultural sensitivity
	5.3 Technical challenges and off-model use

Figures

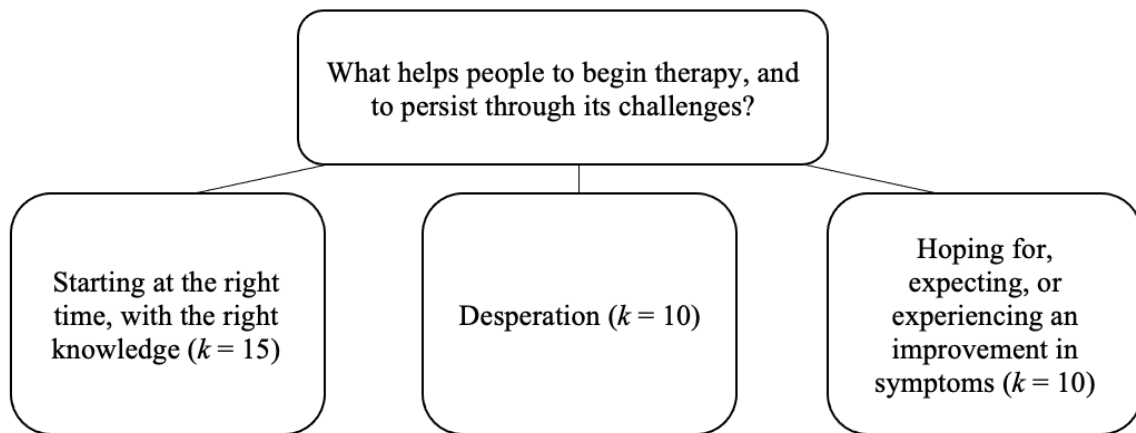**Part 1**

Figure 1. *PRISMA flowchart*
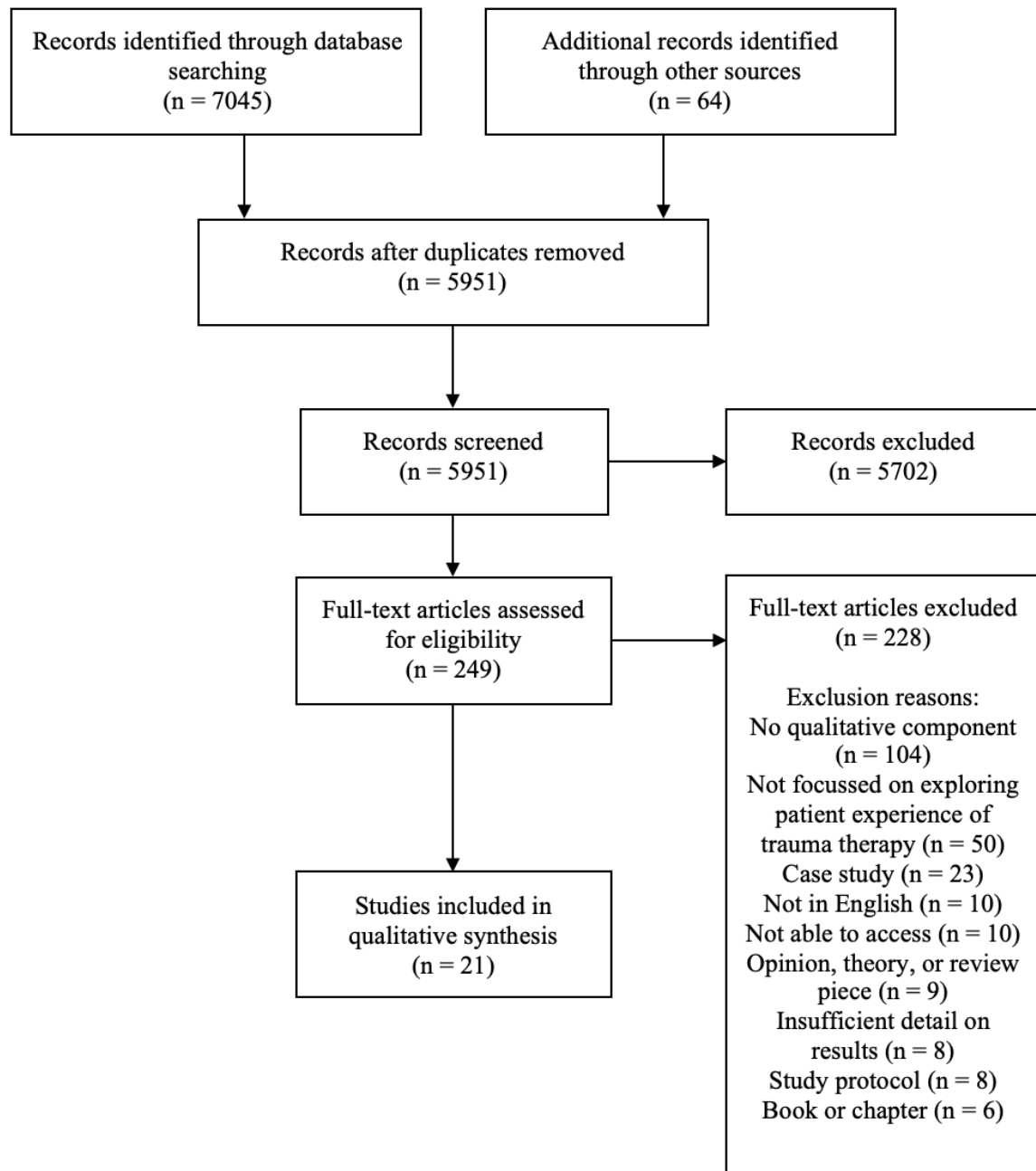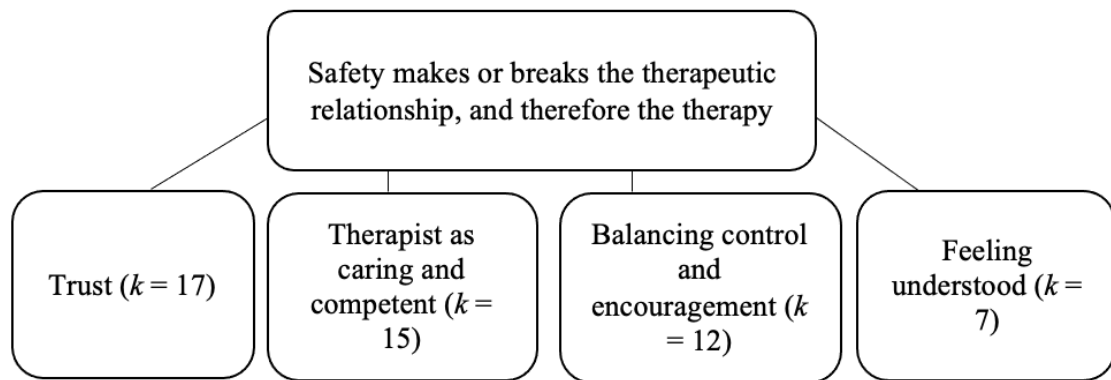
Figure 2. *Analytical theme 1.*

Figure 3. *Analytical theme 2*

Safety makes or breaks the therapeutic relationship, and therefore the therapy

Trust ($k = 17$)

Therapist as caring and competent ($k = 15$)

Balancing control and encouragement ($k = 12$)

Feeling understood ($k = 7$)

Figure 4. *Analytical theme*

Figure 5. *Analytical theme 4.*

Therapy is a profoundly challenging, and not always curative, process

- Anxieties about therapy ($k = 15$)
- Avoidance – I don't want to talk about it ($k = 10$)
- Therapy is painful, both in and out of session ($k = 10$)
- Therapy is not a cure ($k = 12$)
- Therapy is not the whole picture ($k = 12$)

Part 2

Figure 1. *Example of a NET lifeline*
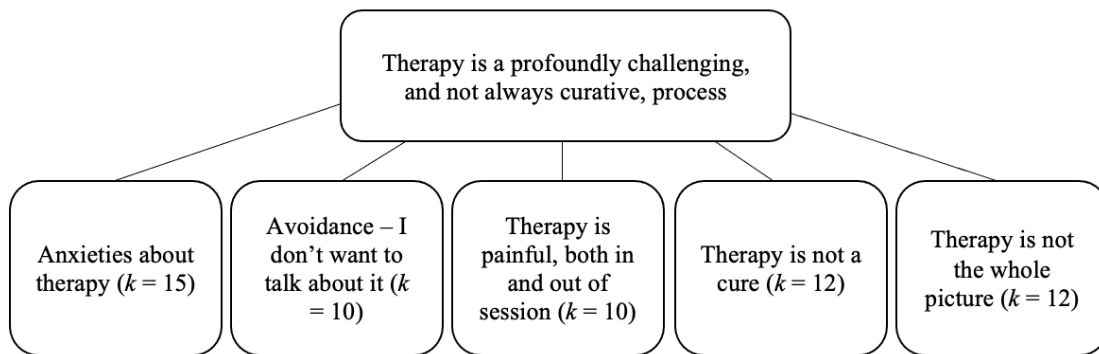
Figure 2. *Domain 1 summary*

Figure 3. *Domain 2 summary*

The figure shows a hierarchy diagram. The top box reads "Hearing it all: contextualising, coherence, and witnessing in the lifeline" with three arrows pointing down to three boxes: "The centrality of witnessing and being witnessed"; "Flowers alongside stones: supporting contextualisation and coherence of narrative"; and "Meeting a whole person, a whole life".
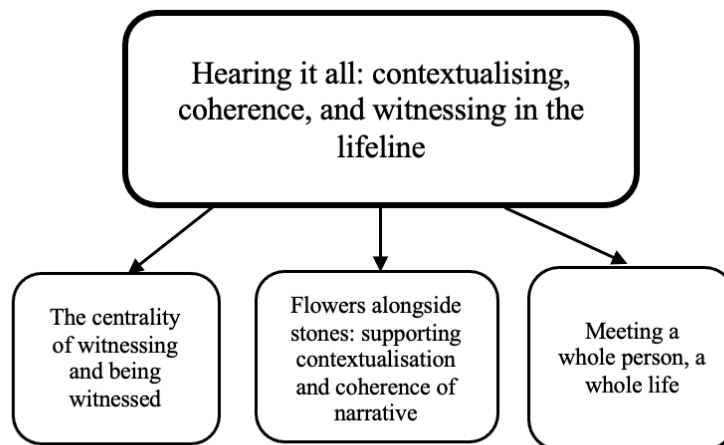
Figure 4. *Domain 3 summary*

Figure 5. *Domain 4 summary*

Beyond words: the physical, visual, tangible nature of the lifeline as valuable

The visual, physical, tangible lifeline adds something to the verbal

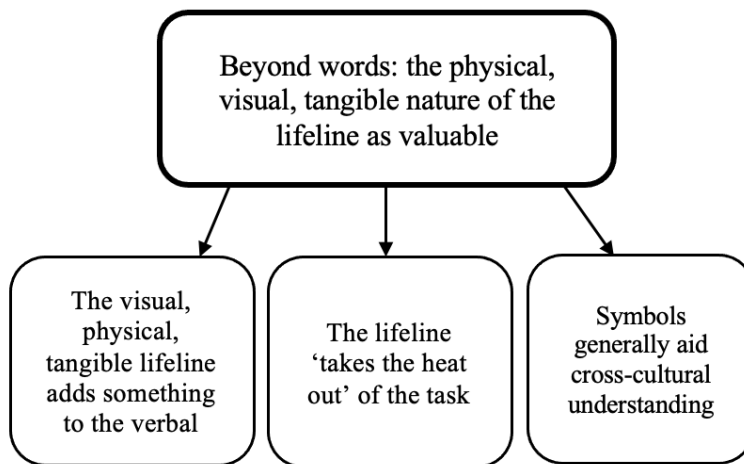The lifeline 'takes the heat out' of the task

Symbols generally aid cross-cultural understanding

Figure 6. *Domain 5 summary*