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THE ACCEPTABILITY OF TRAUMA-FOCUSED INTERVENTIONS

Section A: Barriers and facilitators to the delivery of trauma-focused interventions for PTSD: a thematic synthesis comparing clinicians' and service users' experiences and perspectives.

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Section B: Therapists' experience of delivering trauma-focused cognitive-behavioural therapy for psychosis (TF-CBTp) in the Study of Trauma and Recovery (STAR) randomised clinical trial (RCT).

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Summary of Major Research Project

Section A: Ambivalence towards trauma-focused interventions (TFIs) exist due to its perceived concerns of safety and symptom exacerbation. Despite previous reviews that have explored the barriers and facilitators to the implementation of TFIs, there continues to be a translational gap between the evidence base for TFIs from RCTs and its implementation in routine clinical practice. This review sought to compare and contrast clinician's and service user's perspectives to inform the barriers and facilitators to the uptake and engagement of TFIs. Identified subthemes were mapped to the theoretical domains framework (TDF). Nineteen qualitative and mixed-methods studies were synthesised using a thematic synthesis approach. Four main themes emerged: 'Core elements to heal from trauma', 'Readiness', 'Therapeutic Processes', and 'Factors outside of therapy'. Subthemes were mapped to 13 of the TDF domains. Interpretations of the findings and its research and clinical implications are discussed.

Section B: This study explored therapists' experiences and perceptions in delivering trauma-focused cognitive-behavioural therapy for psychosis (TF-CBTp) in the Study of Trauma and Recovery (STAR) randomised controlled trial. The study aimed to assess the acceptability of the newly integrated intervention for people with psychosis and post-traumatic stress disorder, how they understood and promoted service user's self-efficacy in the intervention, and how the therapists' expectations impacted on their perceived acceptability of TF-CBTp. Seventeen trial therapists were interviewed, and reflexive thematic analysis was used to analyse the data. Five themes and its associated subthemes were developed: 'Flexibility is key', Perceived stability of service users', 'Rebuilding life goals as a main thread', 'Addressing the ambivalence and avoidance', and 'Training and supervisory needs'. Interpretation of the findings in the context of previous literature, limitations of the study, and the research and clinical implications are discussed.

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Section A

Barriers and facilitators to the delivery of trauma-focused interventions for PTSD: a thematic synthesis comparing clinicians' and service users' experiences and perspectives.

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Abstract

Introduction and Aim: Previous systematic reviews have explored the barriers and facilitators to the implementation of evidence-based trauma-focused interventions (TFIs). However, ambivalence with TFIs continue to be reported by clinicians and service users, and it remains underutilised as well as having higher dropout rates compared to other psychological therapies. The present review aimed to synthesise both clinicians' and service users' experiences and perspectives of the barriers and facilitators to the uptake and delivery of TFIs, and map the identified factors to the Theoretical Domains Framework (TDF) to better inform implementation strategies.

Method: A systematic literature search was conducted by searching three databases. Nineteen qualitative and mixed-method studies were selected for review and analysed using thematic synthesis. The identified subthemes were then mapped to the TDF domains.

Key Findings: Four themes were generated from the data: Core elements needed to heal from trauma, readiness, therapeutic processes, and factors outside of therapy. The associated subthemes were mapped to 13 of the TDF domains, most of which were salient for both groups. Some unique factors were identified for each group, such as training and supervision for clinicians, and service users reporting the need to strengthen their resilience in engaging with TFIs.

Discussion: The interpretation of the findings in the context of previous literature, study limitations, research and clinical implications are discussed. Future studies should simultaneously explore clinicians' and service users' experiences with TFIs to allow a direct comparison of the key barriers and facilitators to maximise effective implementation and delivery.

Key words: evidence-based practice, post-traumatic stress disorder, barriers, facilitators, implementation.

Introduction

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) can develop from exposure to traumatic events, and is often comorbid with other diagnoses, including psychotic disorders (American Psychiatric Association; APA, 2013; Shevlin et al., 2008). Symptoms of PTSD include re-experiencing the traumatic event (flashbacks, nightmares, distressing images, and physical sensations), avoidance of reminders of the trauma, changes in arousal and reactivity, and changes in cognition and mood (APA, 2013). The lifetime prevalence of PTSD is approximately 4% in the general population (Koenen et al., 2017). Receiving treatment for PTSD is crucial for recovery from adverse effects such as unemployment, strained relationships, and reduced quality of life (Blankenship, 2017). However, implementing evidence-based treatments for PTSD in clinical services remains challenging due to the perception that addressing the traumatic experiences will worsen client distress (Finch et al., 2020; Burger et al., 2023).

Trauma-Focused Interventions (TFIs)

TFIs focus primarily on targeting traumatic memories and combine cognitive techniques with exposure work (Mavranezouli et al, 2020). TFIs include trauma-focused cognitive behavioural therapy (TF-CBT), narrative exposure therapy (NET), eye-movement desensitisation reprocessing (EMDR), cognitive processing therapy (CPT), and prolonged exposure (PE) – all of which are recommended first-line interventions for PTSD (APA, 2017; National Institute of Health Care and Excellence; NICE, 2018). TFIs should not be confused with trauma-informed interventions, which focus on how the person’s life is adversely affected by the context of trauma only. By contrast, TFIs specifically target traumatic memories and their associated post-traumatic stress symptoms (Peters et al., 2022).

Moreover, TFIs are not limited to specific trauma types, populations, or demographics, and are utilised in both westernised and non-westernised countries (Schnurr, 2017).

The mechanisms of change in TFIs have been compared across the interventions. With TF-CBT, CPT, PE, and NET, the shared mechanisms of change locate within processing the trauma memories by targeting unhelpful posttraumatic stress-related cognitions, fear reduction, and between-session habituation (Kangaslampi & Peltonen, 2019; Sripada et al., 2016; Zalta, 2015). The underlying mechanisms of change with EMDR is of ongoing debate where it is hypothesised to be associated with reduction in physiological arousal and improved connectivity of memory networks (Scelles & Bulnes, 2021). However, EMDR also involves direct exposure to the traumatic memory and its associated cognitive, emotional, and physiological responses, without formal restructuring and verbal dialogues between the client and therapist like in CBT (Landin-Romero et al., 2018). As such, it seems all TFIs target traumatic memories and avoidance - e.g., suppression of thoughts and feelings (Burger et al., 2023). However, research on the change mechanisms across all TFIs are beyond the scope of this review.

Systematic reviews and meta-analyses have found TFIs to be effective (e.g., Bisson et al., 2013; Khan et al, 2018), in particular TF-CBT and EMDR (Bisson et al, 2013; Lewis et al., 2020; Watts et al., 2013). Clinicians have questioned whether the evidence-base for TFIs based on RCTs can be applied in routine clinical services, relative to clinical trials that employ strict inclusion criteria (Murray et al., 2022; Ronconi et al., 2014). RCTs of TFIs mainly recruited veterans and mostly excluded participants with severe mental health conditions such as psychosis, bipolar disorder, and substance misuse (Ronconi et al., 2014). Nonetheless, positive clinical outcomes have been found for TFIs in routine clinical care, as evidenced by dissemination trials (e.g., Duffy et al., 2007) and clinical audits in specialist clinics (Ehlers et al., 2013; Gillespie et al., 2002).

Barriers to the use of TFIs

Despite the evidence base for TFIs, these remain underutilised in clinical services (Maguen et al., 2019). For example, Borah et al, (2017) found that, in veterans outpatient services in the United States, only approximately 20% of the 91 surveyed clinicians used TFIs for soldiers with PTSD. Similarly, Lu, et al. (2016) found only 8 out of 63 veterans with PTSD (13%) opted for and received TFIs, where the barriers included perceived intolerability and stigma towards addressing the trauma. Finch et al's (2020) systematic review included studies of non-veteran samples and a range of professional groups. Perceived barriers to the implementation of TFIs amongst clinicians included lack of flexibility with manualised treatment protocols, working with comorbidities, and the need for training. This suggests that perceived barriers to implementing TFIs exist across various professionals and clinical settings. Furthermore, this review found that ambivalence towards delivering TFIs was reported even amongst experienced clinicians (Finch et al., 2020). Clinicians' avoidance of TFIs also related to concerns around exacerbation of symptoms, client safety, and expected burden (Farrell et al., 2013; Foa et al., 2013; van den Berg et al., 2016). This is despite evidence showing that such risks are minimal, and large RCTs have not shown any adverse effects (Rusek et al., 2016; APA, 2017). Compared to people receiving TFIs, those in the control condition in RCTs showed a worsening of symptoms (Ehlers et al., 2014; Jayawickreme et al., 2014). Therapists with negative expectations regarding harm, safety, and tolerability tend to deliver exposure therapies more cautiously (Deacon et al., 2013; Meyer et al., 2014; Pittig et al., 2019). Moreover, service-related constraints (e.g., caseload demand, lack of capacity) can potentially restrict the number of sessions delivered, despite recommendations based on RCTs, which can influence the therapist's beliefs and decision-making regarding the applicability, suitability, and feasibility of TFIs (Murray et al., 2022).

Dropout rates and low uptake are much greater in TFIs compared to other psychological therapies for PTSD (Lewis et al., 2020). Dropouts were associated with service users having difficulties coping with distressing emotions for TFIs with exposure-based components (Amsalem et al., 2022). Smith et al's (2020) systematic review, exploring barriers to help-seeking in individuals with PTSD, found that avoidance of facing traumatic memories, doubts on the effectiveness of the intervention, lack of access, and conflicting values with treatment-seeking, were the main barriers. Help-seeking was also found to be impacted by the social stigma faced by trauma survivors (Kazlauskas, 2017; Mueller et al., 2008; Wagner et al., 2012). Overall, findings in both clinicians and service users indicate a range of potential barriers and facilitators to the uptake and delivery of TFIs. Integrating these findings systematically may help to reduce both the reluctance of using TFIs and premature dropout from therapy.

Implementation Science

Despite previous reviews that have explored the barriers and facilitators, there continues to be a translational gap between the evidence base for TFIs from RCTs and its implementation in routine clinical practice (Brennan et al., 2022; Finch et al., 2020; Marques et al., 2016). Implementation science aims to help translate research findings to clinical practice through the identification of barriers and facilitators (Nilsen, 2015). The Theoretical Domains Framework (TDF), a model of implementation science that integrates behaviour change theories, has been used to help explain how specific factors interact and impact on health-related behaviours (Cane et al., 2012). In the context of TFIs, identifying the barriers and facilitators related to the TDF can support clinicians and policymakers to improve engagement with these interventions. This framework will be used to map themes from the findings to the TDF domains (Figure 1) and help inform the interpretation of the findings.

Figure 1.

The Theoretical Domains Framework and definitions (Cane et al., 2012).

TDF Domains	Definition (Cane et al., 2012)
Knowledge	An awareness of the existence of something
Skills	An ability or proficiency acquired through practice
Memory, attention, and decision processes	The ability to retain information, focus selectively on aspects of the environment and choose between two or more alternatives
Behavioural regulation	Anything aimed at managing or changing objectively observed or measured actions
Environmental context and resources	Any circumstance of a person's situation or environment that discourages or encourages the development of skills and abilities, independence, social competence and adaptive behaviour
Social influences	Those interpersonal processes that can cause individuals to change their thoughts, feelings, or behaviours
Beliefs about capabilities	Acceptance of the truth, reality or validity about an ability, talent or facility that a person can put to constructive use
Optimism	The confidence that things will happen for the best or that desired goals will be attained
Social/Professional role and identity	A coherent set of behaviours and displayed personal qualities of an individual in a social or work setting
Intentions	A conscious decision to perform a behaviour or a resolve to act in a certain way
Goals	Mental representations of outcomes or end states that an individual wants to achieve
Emotion	A complex reaction pattern, involving experiential, behavioural, and physiological elements, by which the individual attempts to deal with a personally significant matter or event
Reinforcement	Increasing the probability of a response by arranging a dependent relationship, or contingency, between the response and a given stimulus

Aim and Rationale for the Review

The current literature shows ambivalence from service users and clinicians regarding the uptake and delivery of TFIs respectively. To date, no systematic reviews have directly compared clinicians' and service users' perspectives and experiences with TFIs. How therapists perceive the barriers and facilitators may bring a different lens to service users' perspectives. For example, clinicians may perceive disengagement as lack of motivation in a service user, whereas it may be associated with their limited knowledge about the intervention (Meis et al., 2022). Clinicians' and service users' perceptions may possibly be more aligned, particularly in relation to the importance of parallel processes, such as

therapeutic alliance (Harrington et al., 2021). Finding the commonalities and differences may therefore help in addressing the aforementioned translational gap.

The aim of this review was to conduct a meta-synthesis of mixed-methods and qualitative studies exploring the barriers and facilitators to the uptake and delivery of TFIs for those experiencing PTSD from clinician and service user perspectives. The identified factors will also be mapped to the relevant TDF domains to inform implementation strategies for TFIs.

A qualitative review was chosen to explore the subjective experiences and perceptions of trauma, as qualitative designs are equipped to help explore the complexity of such issues (Dixon-Woods et al., 2006). Compared to quantitative methods, qualitative methods provide different layers of information regarding engagement (Gulliver et al., 2010). As such, quantitative papers will not be included in this review.

Method

Several methods exist for conducting meta-syntheses that uses systematic approaches to review qualitative research (Dixon-Woods et al., 2006). Thematic synthesis (Thomas & Harden, 2008) was selected for this review as its methodology allows one to draw out perspectives and experiences within and across the papers. The following steps apply:

- Preparatory phase – searching the literature; screening and assessing the quality of the papers; extracting data from the selected literature.
- Thematic synthesis: a) initial coding of text; b) developing descriptive categories; c) generating analytical themes.

Search Strategy

The search was conducted on 23rd September 2022; Psychinfo, MedLine, and PubMed databases were selected for their relevance to the field. Search terms were generated from existing research and literature addressing barriers and facilitators to treatments with

PTSD (Table 1). Additional studies were also manually searched on google scholar, and they were checked to see if they were included in the database search.

Table 1.

Search terms

Search terms used and Boolean operator	Field
“Clinician” OR “therapist” OR “psychologist” OR “counsellor” OR “practitioner” OR “professional” OR “staff” OR “service user” OR “patient”	Title and abstract
AND	
“psychological trauma” OR “trauma” OR “PTSD” OR “post-traumatic stress disorder” OR “posttraumatic stress disorder” OR “posttraumatic stress” OR “post-traumatic stress”	Title and abstract
AND	
“experience” OR “perspective” OR “perception” OR “belief OR “view”	Title and abstract
AND	
“trauma-focused” OR “intervention” OR “treatment” OR “therap*” OR “TF-CBT” OR “EMDR” OR “cognitive behav* therapy”	Title and abstract
AND	
“qualitative” OR “mixed-method’ OR ‘mixed-methods” OR ‘mixed method” OR “mixed method”	Title and abstract

Inclusion and Exclusion Criteria

Table 2 summarises the inclusion and exclusion criteria based on the search and screening process. Replicating previous systematic reviews, 1980 was chosen as the earliest publication date because the PTSD diagnosis was first introduced in the third edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III; 1980). This review was not limited to any specific population or TFIs based on the following reasons: Previous systematic reviews (Finch et al., 2020; Smith et al., 2020) have

found consistent themes across a range of professional and service user groups, TFIs, and types of traumas regarding barriers and facilitators; all TFIs necessitate desensitisation to trauma memories through exposure, and change in unhelpful posttraumatic cognitions (Kangaslampi & Peltonen, 2022), both previously identified as barriers to implementation (Finch et al., 2020; Smith et al., 2020) . Studies that reported perspectives of clinicians that have not delivered TFIs were also included.

Table 2.

Inclusion and exclusion criteria

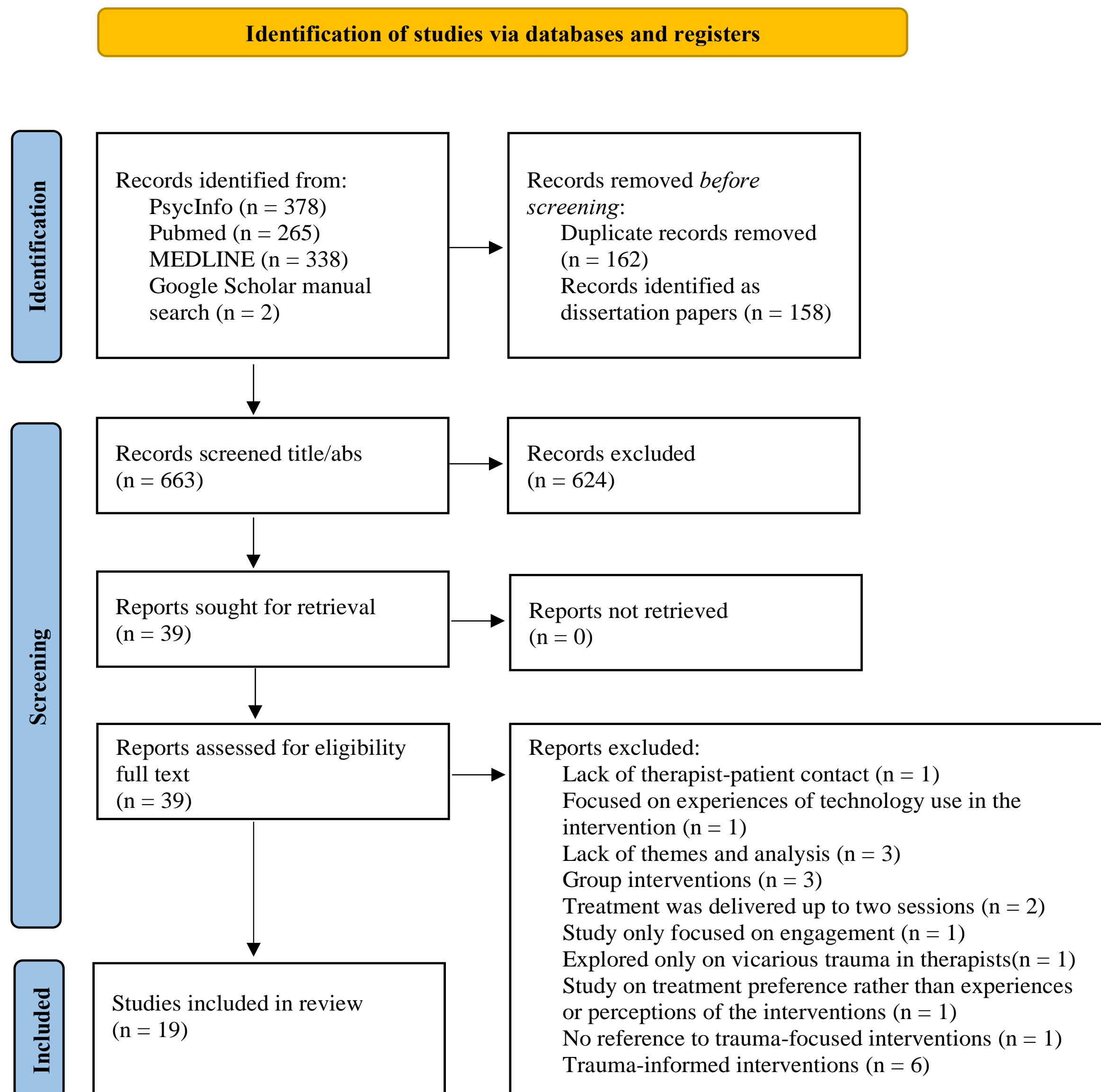
Inclusion Criteria	Exclusion Criteria
(1) Explores perceptions and experiences of using or receiving TFIs (2) Addresses working with, or capturing the experiences of, individuals aged 18 or over (3) Published in or after 1980 (4) Published in peer reviewed journals	(1) Studies exploring working with, or capturing the perception and experiences of children and adolescents (2) Quantitative studies (3) Group interventions (4) Studies that do not include TFIs (5) Efficacy or clinical effectiveness studies of TFIs (6) Not published in peer reviewed journals (7) Studies that address trauma-informed care

Screening

The screening process is shown in Figure 2. Duplicated papers were removed before screening by title and abstract. Full texts were then obtained and reviewed; reasons for exclusion were stated. The database search found 981 papers, 17 of which were relevant. Two papers were found through searching on google scholar. Table 3 summarises the 19 included studies.

Figure 2.

PRISMA Diagram



Approach to the Thematic Synthesis

Data were analysed inductively, to allow themes to be derived from the data (Thomas & Harden, 2008). Familiarity of the included studies was obtained before line-by-line coding of the results section for each study. Codes were then compared and grouped into a hierarchical tree structure. New codes were created to capture the meaning of groups of initial codes, resulting in a tree structure with layers of descriptive themes. Analytical themes were generated by ‘going beyond’ what the original studies have achieved by using the generated

descriptive themes (Thomas & Harden, 2008). The inductively generated themes were then mapped to the appropriate TDF domains. A deductive approach was rejected, as this would constrain the generation of themes strictly to those fitting the TDF domains, which risks losing the context and understanding of the topic of interest (McGowan et al., 2020). The themes mapped to the TDF domains were reviewed with the researcher supervisor until agreement was reached.

Quality Assessment

The Critical Appraisal Skills Programme (CASP, 2018) is most widely used as a tool to appraise qualitative studies (Long et al., 2020). This was used to assess the quality of the included studies with the lead author, GN, independently completing the appraisal. As there is limited consensus around the best methodology for excluding studies based on critical appraisals (Majid & Vanstone, 2018; Thomas & Harden, 2008), all the selected studies were included in the thematic synthesis. Overall ratings were also not given to each paper, as recommended by the Cochrane Collaboration (Noyes et al., 2019). Instead, the CASP was used to appraise the quality of the methods used in each study, to help contextualise findings rather than offer explicit ratings of quality (Dixon-Woods et al., 2006; Thomas & Harden, 2008).

Researcher's Reflexivity

GN retained a reflective stance throughout the review process. Both GN and research supervisor, RU, have professional backgrounds in clinical psychology with strong interest in TFIs. GN completed the screening of abstracts/titles, data coding, extraction, synthesising, and write up of the findings. GN consulted with RU, who has experience in publishing and peer reviewing both quantitative and qualitative research. RU reviewed the synthesis and write up of the findings and critically engaged with the interpretation of the data. Both authors discussed the impact of their own professional and individual factors on the

interpretations of the data and its comparison to previous findings. This helped to minimise the review process being skewed, which further refined the analysis and write-up of the findings.

Review

Overview of the Studies

Nineteen studies were selected for this review, summarised in Table 3. Six papers explored clinicians' perspectives, ten papers explored service user perspectives, and three papers explored both groups. Studies were published between 1998 and 2022 in peer-reviewed journals. Studies took place in the UK, US, Australia, Netherlands, with one study across Bosnia, Herzegovina, and Turkey (Hasandedic-Dapo, 2021). A total of 483 participants were included in the 19 studies; 112 of which were clinicians (psychologists, therapists, nurses, social workers, and psychiatrists) and 371 were service users.

Majority of the studies focused on veterans who faced combat stress; two of the studies focused on people with psychosis (Chadwick & Billings, 2022; Hardy et al., 2022). The types of traumas discussed or targeted in therapy included combat stress, adulthood victimisation, childhood victimisation, road traffic accidents, natural disasters, witnessing violence, and psychosis-related trauma. TFIs included trauma-focused cognitive behavioural therapy (TF-CBT), prolonged exposure (PE), and cognitive processing therapy (CPT), imagery rescripting, imaginal flooding, eye-movement desensitisation reprocessing (EMDR), with one study exploring the experiences of having CPT remotely (Ashwick et al., 2019). Studies explored perceptions and experiences of TFIs, with two studies that were not exclusively focused on TFIs (Amsalem et al., 2021; Edmond et al., 2004).

Four studies used a mixed-methods design (Amsalem et al., 2021; Doran et al., 2021; Edmond et al., 2004; Hardy et al., 2022), with the remaining using qualitative designs. The studies mainly used individual interviews, with one study using focus groups (Frueh et al.,

2006). A range of qualitative analyses were used, with Grounded Theory (N=4) and Thematic Analysis (N=4), as most common. Two studies did not clearly state their chosen qualitative analysis (Amsalem et al., 2021; Edmond et al., 2004).

Table 3.

Summary of included studies in the review

Author, year, and country	Participant group and sample size	Purpose of study	Interventions	Traumas targeted	Design, data collection, and qualitative analysis	Key Qualitative Findings
Amsalem et al. (2021) US	Clinicians who delivered TFIs (psychologists, nurses, social workers) N = 10	Therapists' perspectives on treatment dropout with US veterans and families	Interpersonal therapy, CPT, PE, CBT, emotion focused therapy, supportive therapy	Combat stress, physical and sexual abuse, loss, terrorism, interpersonal violence	Mixed-methods Semi-structured interviews Analysis not stated	Clinicians interpreted dropouts as the patient's challenges coping with intense emotions in therapy. Themes: • Difficulty coping with intense emotions • Readiness for change • Suitability for outpatients treatment • Role of treatment and communication
Chadwick & Billings (2022) UK	Clinicians (psychologists, nurses, social workers, occupational therapists, psychiatrists) No delivery of TFIs described N = 18	Clinician's perceived barriers and facilitators to the implementation of trauma-focused interventions in psychosis	Non-specified trauma-focused interventions	A range of traumas, psychosis and non-psychosis related	Qualitative Semi-structured interviews Grounded Theory	Three inter-related barriers to trauma-focused interventions reported by clinicians. Themes: • Coherent understanding • Structural support • Safe space
Doran et al (2019) US	Clinicians who delivered TFIs (psychologists, social workers, and nurses)	Experiences and challenges administering evidence-based practices in PTSD	CPT and PE	Combat stress in Veterans	Qualitative Semi-structured Interviews	Findings captured a range of strengths and weaknesses of the treatments, and improvements recommended by the clinicians. Themes:

	N = 8				Consensual Qualitative Research	• EBP Strengths, • EBP Weaknesses, • Challenges Specific to the Veteran Population • Perceived EBP Effectiveness • Active Ingredients for Treating PTSD • Treatment Structure and Process • Suggested Changes/Improvements to EBPs.
Frueh et al (2006) US	Clinicians No delivery of TFIs reported N = 33	Therapists' perceptions in addressing PTSD in CBT for people with severe mental health difficulties	CBT	None stated	Qualitative Focus groups Content Analysis	Clinicians reported ambivalent to address the trauma with the SUs, but also felt CBT may be effective. Perceived facilitators to implementing treatment for trauma included gender-specific treatment groups, establishing therapeutic alliance, safety plan with SUs, considering cognitive difficulties of SUs, and the need to integrate care with multidisciplinary teams.
Kemal Kaptan & Brayne (2021) US	Clinicians who delivered TFIs (EMDR Consultant Therapists) N = 8	How AF-EMDR is experienced in practice by qualified and accredited AF-EMDR-trained therapists;	AF-EMDR	Attachment-related traumas	Qualitative Semi structured interviews Reflexive Thematic Analysis	Personal and professional factors associated with the use of AF-EMDR. Themes: • Perceptions of AF-EMDR • It is not versus, it is with • EMDR itself as an innovative approach
Hasandedic-Dapo (2021) Bosnia, Herzegovina, and Turkey	Clinicians (Psychologists) Number of interviewed clinicians that had delivered TFIs were not clearly described	How the psychologists experience and perceive EMDR	EMDR	Not specified	Qualitative Semi-structured interviews Phenomenological Approach	Perception of EMDR were influenced by whether they had training. Participants with no training reported that the perception were informed by personal reading or perceptions from colleagues: Themes: • Positive personal or anecdotal experiences with EMDR • EMDR is primarily used for trauma

	N = 20					• EMDR is used as an adjunct therapy • Obstacles to EMDR training/certification • Limited knowledge and information about EMDR

Ashwick et al. (2019)
UK
	SUs (Veterans)
	
	N = 16
		Experiences of cognitive processing therapy on skype	CPT	Combat stress	Qualitative
					
					Semi-structured interviews
					
					Thematic Analysis
						Themes:
						
						• Effect of your own environment
						  ○ Subthemes of control over your own environment; lack of support between sessions; snap back to reality
						• Importance of good therapeutic alliance
						  ○ Subthemes of putting a face to the name; impersonal feeling; no different from being in the room
						• Technicalities and practicalities
						  ○ Subthemes of good preparation is key; the flexibility of Skype; technical aspects and session; length and timing.
						• Personal accountability
						  ○ Subthemes of finding the time and space; managing; attendance and engagement; moving forward.
						• Measuring change.
						  ○ Subthemes of Negative past experiences with therapy, improving self-recognition and managing symptoms.

Doran et al (2021) US	SUs (Veterans)	Experiences of EBP for PTSD	CPT and PE	Combat stress	Mixed-method	Multiple factors that the SUs reported to have influenced treatment dropout.

	N = 18				Self-report measures and structured interviews Consensual Qualitative Research	Themes: • Previous EBP & Outcome, • Barriers to Treatment, • Treatment Process, • Treatment Outcome, • Treatment Drop Out, • Feelings about Treatment.
Edmond et al (2004) US	SUs (Female survivors of childhood sexual abuse) N = 38	Perceptions of the effectiveness of EMDR and Eclectic therapy	EMDR and Eclectic therapy	Childhood sexual abuse	Mixed-method Semi-structured interviews Analysis not stated	Comparisons between EMDR and Electric therapy on the experiences and perceptions with relation to client-therapist relationship and the nature of change. The facilitators of EMDR were related to addressing the feelings associated with the sexual abuse, and addressing the view of self and others.

Hardy et al (2022)
UK
	SUs (Individuals with psychosis and PTSD)
	
	N = 6
		Feasibility, safety, and effectiveness of TF-CBTp and lived experience perspectives on TF-CBTp	TF-CBTp	Victimisation (physical, abuse, emotional); war/conflict; accident; psychosis-related trauma	Mixed Methods
					
					Semi-structured Interviews
					
					Thematic Analysis
						Qualitative findings highlighted the impact of trauma and receiving therapy.
						
						Themes:
						
						• Perseverance
						  ○ Subthemes: Finding suitable help; stamina for the therapeutic process
						• Establishing safety
						  ○ Subthemes: therapeutic alliance; coping strategies,
						• The challenges of therapy
						  ○ Subthemes: systemic issues; emotional burdens and barriers,
						• Rebuilding one's life after trauma
						  ○ Subthemes: Expression and exploration; hope and healing

Hundt et al (2020) US	SUs (Veterans) N = 23	Reasons for dropping out of therapy	CPT and PE	Combat Stress	Qualitative Semi-structured interviews Grounded Theory	Themes: • Practical reasons for noncompletion • Emotional reasons for noncompletion • Therapy-related reasons for noncompletion ○ Subthemes: buy-in to treatment, alliance, treatment “didn’t work” for them, referred to different treatment, • System-related reasons for noncompletion • Co-occurrence between barrier categories
Hundt et al (2017) US	SU (Veterans) N = 28	Experiences of therapy	CPT and PE	Combat Stress	Qualitative Semi-structured interview Grounded Theory	Themes: • Emotionally challenging • Considered terminating prematurely • Factors encouraging retention to treatment • Experience completing homework • Perceptions of treatment mechanisms • Greater self-understanding • Exposure • Changing thoughts/beliefs • Perceptions of symptom improvement • Mismatch between initial expectations and treatment outcome
Kehle-Forbes et al. (2022) US	SUs (Veterans) N = 126 (60 therapy completers and 66 dropouts)	Perceived reasons for therapy dropout or completion	CPT and PE	Combat Stress	Qualitative Semi-structured interview Framework Analysis	Themes: • Therapists “in the trenches” with patients • Patient-centred rather than protocol-centred delivery • Community support around the shared goal of completion

						• Meaning attributed to increased distress and symptom worsening • Anticipated impact of treatment on social and role functioning • Hassles and stressors differentially impact treatment engagement

Shearing et al. (2011)
UK
	SUs (Specialist trauma services)
	N = 7
		Experiences of reliving as part of TF-CBT	TF-CBT	Single event traumas; physical and sexual abuse; road traffic accidents; natural disasters.	Qualitative
					
					Semi-structured interviews
					
					Interpretative Phenomenological Approach
						Superordinate themes:
						
						• Overcoming ambivalence
						  ○ Subordinate themes: desperate for change, fear, trusting the therapist, becoming ready for reliving
						• Painful but achievable
						  ○ Subordinate themes: Feeling like the trauma was happening again, unfounded fears, reliving taking over my life
						• Positive change
						  ○ Subordinate themes: changing symptoms, changing relationship with trauma, regaining sense of agency in the world, worth the pain

Valentine & Smith (1998) US	SUs (Non-specific population) N = 16	Experiences of having imaginal flooding in therapy	Traumatic incident reduction-imaginal flooding	Physical abuse, emotional abuse; abortion; childhood poverty; fire; car accident; psychiatric care	Qualitative Semi-structured interviews Domain Analysis	Emerging domains: • Support • Safety • Structure • Heightened physiological state • Insight • End point

van Gelderen et al. (2020)
The Netherlands
	SUs (Veterans)
	
	N = 10
		SU's experiences of EMDR with Virtual Reality	EMDR with Virtual Reality	Combat Stress	Mixed-method
					
					Semi Structured Interviews
					
					Grounded Theory
						Themes:
						
						• Treatment processes
						  ○ Subthemes: engaging, feeling supported, regulating distress, facing traumatic memories, allowing emotions, associating, disengaging from trauma
						• Treatment effects
						  ○ Subthemes: Openness, closure, new learning, reintegration, self-understanding

Bosch & Arntz (2021) The Netherlands	SUs and Clinicians who delivered TFIs (therapists) N = 19 (10 SUs and 9 therapists	Perspectives of elements of change in imagery rescripting or EMDR, based on a randomised clinical trial	Imagery rescripting and EMDR	Childhood trauma; physical abuse; sexual abuse; witnessing abuse	Qualitative Semi-structured interviews Content Analysis	Agreements between SUs and therapists were found, whereby receiving care from treatment, and confronting the perpetrator, controlling distressing reactions were main factors towards elements of change
Boterhoven de Haan et al. (2021) Australia	SUs and Clinicians who delivered TFIs (therapists) N = 60 (44 SUs and 16 therapists)	Explore patients' and therapists' experiences with trauma-focused treatments in patients with PTSD from childhood trauma, as part of the randomised clinical trial.	Imagery rescripting and EMDR	Physical and sexual abuse (childhood trauma)	Qualitative Semi-structured interviews Thematic Analysis	SUs emphasised gaining a good understanding of the trauma and regaining sense of self and positive future. Therapists emphasised self-confidence, challenges and importance of protocol adherence, and their avoidance in processing trauma with the SUs. Themes: • Focusing on trauma memories ○ Subthemes: Willingness; starting trauma work; going back to the source; going back to the source; enhancing treatment format

						• Nature of change
						    ○ Subthemes: Trauma in context; the changed self
						• Optimising the therapist role
						    ○ Subthemes: Therapeutic relationship; therapist confidence; avoidance, adherence

Meis et al. (2022) US	SUs (veterans) and Clinicians who delivered TFIs (therapists)	Perspectives of poor adherence to PTSD treatment	CPT and PE	Combat Stress	Qualitative Semi-structured interviews Dyadic Analysis Approach	Themes: • Therapists relied on stereotypes while veterans' explanations were nuanced • Therapists were in the dark • What's therapy supposed to do? • Signals, misses, and misfires • Problematic veteran-therapist relationships and interactions ○ Subthemes: Disconnection; invalidating experiences.

SUs = Service Users; PTSD = Post-traumatic Stress Disorder; CBT = Cognitive behavioural Therapy; TF-CBT = Trauma-focused Cognitive Behavioural Therapy; EMDR = Eye Movement Desensitisation Reprocessing; AF-EMDR = Attachment-focused Eye Movement Desensitation Reprocessing; CPT = Cognitive Processing Therapy; PE = Prolonged Exposure; PTSD = Post-Traumatic Stress Disorder; TF-CBTp = Trauma-focused Cognitive Behavioural Therapy for Psychosis; DBT = Dialectic Behavioural Therapy; EBP = Evidence-Based Practice

Quality Appraisal

An overview of the quality assessment ratings is provided in Appendix A. All 19 studies fully met at least eight of the CASP appraisal criteria and were considered adequate for this review, with three studies fully meeting all the 10 criteria (Boterhoven de Haan et al., 2022; Chadwick & Billings, 2022; Shearing et al., 2011). The main limitation across the studies was the lack of reference to researcher-reflexivity.

Aims and Design

All studies had a clear statement of aims and a clear rationale, with appropriate choice of qualitative design. Two studies used a mixed-methods design (Amsalem et al., 2021; Hardy et al., 2022).

Participants and Sampling

Sample sizes varied between 6 and 126 participants for qualitative research. Different qualitative methodologies apply different principles and philosophical perspectives to sampling, which affects the consensus for adequate sample sizes (Vasileiou et al., 2018). Most studies used purposive sampling and mostly recruited from outpatient clinics, which was appropriate in relation to exploring service users' and clinicians' perspectives in clinical contexts. Two of the studies recruited service users and clinicians from RCTs (Bosch & Arntz, 2021; Boterhoven de Haan et al., 2021). Of the nine included studies that addressed clinicians' perspectives, six interviewed clinicians who had delivered TFIs (Amsalem et al., 2021; Bosch et al., 2021; Boterhoven de Haan et al., 2021; Doran et al., 2019; Kemal-Kapten & Brayne, 2021; Meis et al., 2022). The remaining three interviewed clinicians with no clear indication of having TFIs or not (Chadwick & Billings, 2022; Frueh et al, 2006; Hasandedic-Dapo (2021), addressing factors that hindered their delivery of TFIs.

Ethical Considerations

All studies obtained informed consent from their participants. One study stated that they obtained informed consent from therapists, while informed consent by service users was presumed but not explicitly stated (Meis et al., 2022). None of the studies reported how they addressed any potential concerns with distress of participants in their data collection.

Data Collection and Analysis

Details on data collection and analysis varied between studies. One study using focus groups (Frueh at el., 2006) did not provide clarity on how data were recorded. Studies using semi-structured interviews provided details of recordings and transcripts. All studies apart from two (Amsalam et al., 2021; Edmond et al., 2004) clearly described and explained the type of qualitative analysis they used.

Researcher Reflexivity

Only three of the included studies talked about reflexivity, research-participant relationship, and the researcher's position in relation to the study process (Shearing et al., 2011; Boterhoven de Haan, et al., 2021; Chadwick & Billings, 2022).

Validity of Study Findings

The majority of the studies showed a rigorous approach to data analysis, using more than one researcher to analyse data, particularly in theme generation and consensus. Three of the studies looking at both service user and clinician experiences clearly described both groups' perspectives separately within each theme (Bosch & Arntz, 2021; Boterhoven de Haan et al., 2021; Meis et al., 2022). All studies provided adequate insight into the value of their findings in clinical and research contexts regarding the implementation and use of TFIs. In particular, participants' experiences as well as the barriers and facilitators to the use of interventions were drawn from the analyses.

Key Findings

The thematic synthesis generated four analytical themes: 'Core elements needed to heal from trauma', 'readiness', 'therapeutic processes', and 'factors outside of therapy'. Table 4 summarises the analytical themes, subthemes, and contributing studies.

Table 4.

Themes, subthemes, and contributing studies

Theme	Subtheme	Contributing studies
Core elements needed to heal from trauma	Addressing the associated meanings and beliefs with trauma	Clinician perspective Bosch & Arntz (2021); Boterhoven de Haan et al (2021); Chadwick & Billings (2022) Service user perspective Ashwick et al (2019); Bosch & Arntz (2021); Boterhoven de Haan et al (2021); Hardy et al (2022); Hundt et al (2017); Kehle-Forbes et al (2022); Shearing et al (2011); van Gelderen et al. (2020); Valentine et al (1998)
	Promoting control over physical and emotional reactions to trauma	Clinician perspective Amsalem et al (2021); Bosch & Arntz (2021); Boterhoven de Haan et al (2021); Chadwick & Billings (2022); Doran et al. (2019); Edmond et al (2004); Kemal Kapten & Brayne (2021) Service user perspective Ashwick et al (2019); Bosch & Arntz (2021); Boterhoven de Haan et al (2021); Doran et al (2021); Hardy et al. (2022); Hundt et al (2017); Shearing et al (2011); van Gelderen et al. (2020); Valentine et al (1998)
	Stamina to endure and overcome the pain	Clinician perspective None Service user perspective Bosch & Arntz (2021); Doran et al (2021); Hundt et al (2017); Hundt et al (2020); Hardy et al (2022); Kehle-Forbes et al (2022); Shearing et al

		(2011); van Gelderen et al. (2020); Valentine et al (1998)
	Rebuilding life and regaining sense of self	Clinician perspective Boterhoven de Haan et al. (2021) Service user perspective Boterhoven de Haan et al. (2021); Edmond et al. (2004); Hardy et al. (2022); Hundt et al. (2017); Shearing et al. (2011); van Gelderen et al. (2020); Valentine et al (1998)
Readiness	Knowledge and understanding of the intervention	Clinician perspective Ashwick et al (2019); Bosch & Arntz (2021); Chadwick & Billings (2022); Frueh et al. (2006); Kemal Kaptan & Brayne (2021) Service user perspective Bosch & Arntz (2021); Hasandedic-Dapo (2021); Hundt et al. (2020); Kemal Kaptan & Brayne (2021); Meis et al. (2022); Shearing et al., (2011); Valentine et al. (1998)
	Fear and harm expectancy	Clinician perspective Amsalem et al (2021); Boterhoven de Haan et al (2021); Chadwick & Billings (2022); Frueh et al (2006) Service user perspective Ashwick et al (2019); Boterhoven de Haan et al (2021); Hardy et al. (2022); Hundt et al (2020); Kehle-Forbes et al. (2022); Meis et al. (2022); Shearing et al. (2011); Valentine et al. (1998)
	Addressing ambivalence and avoidance	Clinician perspective Amsalem et al (2021); Boterhoven de Haan et al (2021); Chadwick & Bilings (2022); Doran et al. (2019); Frueh et al. (2006); Hasandedic-Dapo (2021); Kemal Kaptan & Brayne (2021); Meis et al. 2022 Service user perspective: Boterhoven de Haan et al (2021); Doran et al. (2021); Hardy et al. (2022); Hundt et al. (2017);

		Hundt et al. (2020); Kehle-Forbes et al. (2022); Meis et al. 2022; Shearing et al (2011); van Gelderen et al. (2020); Valentine et al. (1998)
Therapeutic processes	Confidence and motivation	Clinician perspective Bosch & Arntz (2021); Boterhoven de Haan et al (2021); Chadwick & Billings (2022); Frueh et al (2006); Doran et al. (2019); Hasandedic-Dapo (2021); Kemal Kaptan & Brayne (2021); Meis et al (2022) Service user perspective Ashwick et al (2019); Bosch & Arntz (2021); Boterhoven de Haan et al (2021); Edmond et al. (2004); Doran et al. (2021); Hundt et al. (2017); Kehle-Forbes et al. (2022); Meis et al (2022); Shearing et al. (2011); Valentine et al. (1998)
	Therapeutic Alliance	Clinician perspective Bosch & Arntz (2021); Boterhoven de Haan et al (2021); Chadwick & Bllings (2022); Doran et al. (2019); Meis et al. (2022) Service user perspective Ashwick et al (2019); Bosch & Arntz (2021); Boterhoven de Haan et al (2021); Doran et al., (2021); Edmond et al. (2004); Hardy et al. (2022); Hundt et al. (2017); Kehle-Forbes et al. (2022); Meis et al. (2022); van Gelderen et al. (2020); Valentine et al. (1998)
	Flexibility and client-centred	Clinician perspective Bosch & Arntz (2021); Chadwick & Billings (2022); Boterhoven de Haan et al. (2021); Doran et al. (2019); Frueh et al. (2006); Kemal Kaptan & Brayne (2021); Meis et al. (2022) Service user perspective Ashwick et al (2019); Bosch & Arntz (2021); Boterhoven de Haan et al. (2021); Doran et al. (2021); Hardy et al. (2022); Kehle-Forbes et al (2022); Meis et al. (2022); Shearing et al. (2011); Valentine et al. (1998)

	Timing and duration of the intervention	Clinician perspective Boterhoven de Haan et al (2021); Doran et al (2019); Kemal Kaptan & Brayne (2021) Service user perspective Boterhoven de Haan et al (2021); Doran et al (2021); Shearing et al. (2011)
Factors outside of therapy	Training and supervision for clinicians	Clinician perspective Chadwick & Billings (2022); Frueh et al (2006); Hasandedic-Dapo (2021); Meis et al (2022) Service user perspective None
	Personal life constrains	Clinician perspective None Service user perspective Hundt et al. (2020); Kehle-Forbes et al. (2022); Meis et al. (2022); Shearing et al. (2011)

Core elements needed to heal from trauma

This theme relates to the importance of overcoming the adverse effects of PTSD throughout the therapy process from a clinician and service user perspective. The main drivers identified were related to the person's relationship to, and understanding of, the trauma, having control over the feelings and symptoms of PTSD, the ability to endure the intervention, and ways to rebuild the person's life.

Addressing the associated meanings and beliefs with trauma

Studies exploring service users and clinicians commented on the importance of evaluating the associated meaning and beliefs regarding trauma. Service users reported negative meanings regarding their traumatic memories, and that receiving trauma-focused therapy changed their perspective and their relationship with the trauma, alleviating any negative cognitions of the self, others, and the world.

"And that she has also noticed through the rescripting that it was not unwillingness on the part of mother, but maybe sometimes ignorance. And that that made it easier in contact with mother now." (Clinician; Bosch & Arntz, 2021, p. 8).

"I learned that it was not necessarily my fault; that I could not have changed it if I'd've wanted to because had I stayed another two or three minutes I would've been laying on the floor beside him. And I never thought that train of thought; I only thought that I should have saved him." (Service User; Hundt et al., 2017, p. 12).

Promoting control over physical and emotional reactions to trauma

Helping the service user to cope with the physical and emotional reactions to trauma has a direct impact on their control over the traumatic memory. This includes strengthening their ability to recognise trauma-related reactions and consolidate the skills to reduce distress.

"That when I get a memory of my childhood that I can just rescript in my head. I am going to get in the image myself and I say that it is enough or something. That I can solve it myself when it is ever going to be back. Or should something happen that gives me the same feeling again, that I can do it myself in my head. That I know how to do it. And now I know it helps." (Service user; Bosch & Arntz, 2021, p. 7).

Clinicians in Amsalem et al's (2021) study spoke about service user's discomfort in facing distressing emotions, indicating a need to prepare service users in managing these reactions in TFIs.

"He was starting to feel more anger, which means that the treatment was working, and he didn't like that." (Clinician; Amsalem et al., 2022, p. 583).

Stamina to endure and overcome the pain

Studies on service users found that TFIs were emotionally demanding, and that building the stamina to endure and overcome the distress from trauma was important (Hardy et al., 2022). Interestingly, studies exploring clinicians' perspectives did not comment on this.

In a few studies, service users outlined that although facing the traumatic memory can be emotionally intense, they felt it was needed, and helped build the 'stamina' to overcome the trauma-related distress.

> *"Although it was very, very painful to relive it, umm, I didn't lose control, I didn't scream and cry and lash out."* (Service User; Shearing et al., 2011, p. 464).

Studies also found that those who were able to continue with the intervention anticipated the intense emotions attached to therapy and did not perceive the intervention to be ineffective.

> *"…exacerbation did not signal to them that the treatment was ineffective, allowing them to focus on the anticipated long-term benefit when facing trauma content"* (Authors; Kehle-Forbes et al., 2022, p. 6)

However, some studies have noted the importance of respecting the service user's decision to not talk and process traumas that are too painful to endure. A facilitator was to focus on something less distressing to start the process of 'building stamina', as the authors in Hardy et al. (2022) wrote:

> *"For this participant, some things remained too painful to discuss and required a shift in focus within the sessions to areas that were less emotionally threatening. When reflecting on her therapist's initial encouragement to discuss such "disturbing" events, Jean concluded that the process had been partly beneficial ("it wasn't 100% but it was quite helpful") yet ultimately untenable due to the turmoil it created."* (Authors; Hardy et al., 2022, p. 12).

Rebuilding life and regaining sense of self

Studies also addressed the importance of setting up goals that will help service users to rebuild their life and regaining sense of self. However, only one study on clinician's perspectives commented regarding this important factor (Boterhoven de Haan et al., 2021).

Enabling service users to engage in their meaningful activities and lifestyles, as well as regaining their sense of self after feeling disempowered from trauma (Shearing et al., 2011) can support the engagement with TFIs.

> *"I found myself doing more things. Going to more sporting events with my grandkids, going to more family reunions and stuff…"* (Service User; Hundt et al., 2017, p. 13).
>
> *"I just look at things completely differently now, you know. Like I see my life, like where I was like six months ago, to where I am now, its like, I feel like I'm a completely different person"* (Service User; Shearing et al., 2011, p. 466).

Readiness

This theme describes aspects that support or hinder a person's confidence and motivation in engaging with TFIs. The perceptions of readiness by clinicians and service users overlapped with relation to understanding the intervention, fear of the intervention, and the ambivalence and avoidance.

Knowledge and understanding of the intervention

Unfamiliarity with TFIs was a factor in the uptake of TFIs as well as commencing work on targeting the traumatic memory. This was both reported by clinicians and service users. Clinicians lacking knowledge of the evidence base of TFIs created uncertainty on the effectiveness, creating ambivalence around referring people for TFIs. This included confusing TFIs with trauma-informed interventions.

> *"Significant differences between participants' awareness of and perceptions about psychological interventions indicated ambiguity about the nature and use of interventions."* (Authors; Chadwick & Billings, 2022, p. 549).
>
> *"…she would explain to me why it was important to talk about it, and I just didn't feel that way. . . It was not working for me. I do not want to talk about bad stuff. . . I really*

do not understand CPT. Like what it's supposed to do? I wouldn't really know." (Service user; Meis et al., 2022, p. 7)

Service users, on the other hand, emphasised the unknown as a source of anxiety in starting TFIs. Service users reported that knowing what to expect with the intervention helped them to believe in it and helped them to recognise the preparation needed.

"If I'd have known at the beginning, if they'd have said that 'right, this is the same stuff that's covered in the 6-weeker', I think I'd have been a lot more at ease with stuff as well" (Service User; Ashwick et al., 2019, p.5).

Interestingly, lacking understanding of the intervention can also been misinterpreted as lack of motivation in therapy. It is important for therapists to be transparent about the expectations with the intervention in terms of the intensity, adherence to consolidating the skills, and the process involved with reprocessing the traumatic memory.

"An important group of veterans had basic misunderstandings of the therapy itself, including confusion about why they were asked to face their trauma-related distress or misinformation on how the treatment works, leading to engagement problems. These misunderstandings were largely missed by therapists or misinterpreted as a lack of motivation." (Author; Meis et al., 2022, p. 6).

Fear and harm expectancy

Both clinicians and service users reported having concerns that TFIs would make the trauma symptoms worse. Although evidence has shown that the risk of exacerbating symptoms is minimal (Rusek et al. 2016), clinicians' reluctance in putting service users through intense treatment remains.

"…it was felt that the person would not have been able to, because of how chronic they are with their symptoms and how long-standing their illness has been" (Clinician; Chadwick & Billings, 2022; p. 554).

Some studies showed that when service users anticipated that the fear of facing the traumatic content was necessary, this mitigated against any harm expectancies, and was complemented by their knowledge and understanding of the intervention.

> *"People worry that the process of talking through the trauma will raise so much distress that people with psychosis in particular won't be able to manage that, and therefore that it will have a knock on effect on their other symptoms say"* (Clinician; Chadwick & Billings., 2022, p. 554)

> *"[I]t's like it puts me back in a situation I don't ever want to be back in again. It's not a nice feeling. It's a good feeling to release that energy, but at same time it was negative"* (Service User; Hardy et al., 2022, p. 12)

Some service users reported feeling unable to confidently handle the intense emotions, suggesting the importance of helping them to cope with the distressing experiences during therapy.

> *"I just couldn't do it...it was too much, every time I played it (the recording of the trauma) back or heard it, I felt like I was in it again,"* (Service User; Hundt et al., 2020, p. 6)

Addressing ambivalence and avoidance

Addressing ambivalence was linked to a lack of knowledge and understanding of the intervention; not believing in the efficacy of the intervention, unaddressed expectations with the intervention, and readiness for change.

Trauma-related difficulties or PTSD as the service user's main problem may create uncertainty for clinicians as to whether they will be confident in their abilities. Studies also found that clinicians have their own fears in addressing trauma.

> *"...trauma has acquired a mystique that leaves clinicians fearful of addressing it, and clinicians have little confidence in their ability to help clients with PTSD. Despite*

recognition that trauma is a serious concern within their population of mental health consumers, and one that currently receives insufficient attention, many clinicians also described their own personal fear of addressing trauma directly." (Author; Frueh et al., 2006, p. 1029).

Avoidance can be present both in clinicians and service users as a reluctance to deliver or receive TFIs, specifically the avoidance of engaging in memory work. Clinicians were advised to identify any avoidance seen in service users, which is expected in TFIs.

"I think that is one of the most important part that they are not running away from it and not putting it away in their mind." (Clinician; Boterhoven de Haan et al., 2021, p. 10).

"I'd been avoiding it for ages and ages and ages, I'm just scared of it. That's why I've not faced it anyway, I'm just scared…" (Service user; Shearing et al.., 2011, p. 462).

Clinicians reported challenges in remaining flexible with clients, yet not to encourage confrontation with the avoidance either with the memory work or the therapy process itself. Service users who had engaged in trauma-focused therapy explained the importance of not leaving the memory work too late (Shearing et al., 2011).

Therapeutic processes

Across all the studies, certain therapeutic processes were identified in sustaining the engagement of TFIs. This relates to the promotion of confidence and motivation of clinicians and service users, strong therapeutic alliance, flexibility, and client-centred approaches with stringent protocols in TFIs, and the timing and duration of the intervention.

Confidence and motivation

Therapeutic processes related to confidence and motivation were important drivers of engagement with TFIs, expressed by clinicians and service users. This was also linked to therapists' confidence to believe in the service users' ability to engage with the intervention.

"Don't be afraid to kind of push your client . . . I think there is a lot of possibility going on and look I think,... if you give the client that option, they can do it." (Clinician; Boterhoven de Haan et al., 2021, p. 10)

Service users also appreciated therapists' confidence during the intervention, including the therapist being able to find alternative ways to support engagement.

"She was very bold. 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. And, not just with the finger movement, the hand movement, the terminology, the words she would use to help me weave into whatever was going on" (Service User; Edmond et al., 2004, p. 266).

Sustaining the motivation of service users was reported from both clinicians and service users in terms of their perception and experiences.

"And that I gave her very much encouragement: I'm going to help you, I'm going to pull you through, I'm going to help you, you will succeed." (Clinician; Bosch & Arntz, 2021, p. 7).

Clinicians' own confidence in using the intervention and being able to safely apply the skills with memory work were also voiced. This can also have a direct impact on the service user's confidence, which speaks to the effects of a clinician's therapeutic stance.

"I think that it's important that the therapist is not afraid and can give patients a feeling of confidence . . . like a doctor,... it's important that the doctor gives you the idea that he knows what he or she knows what he does and that it's ok and that he is in control." (Clinician; Boterhoven de Haan et al., 2021, p. 10).

Therapeutic alliance

Both clinicians and service users agreed that a good therapeutic relationship is a common denominator in facilitating a sustained engagement and completion of the intervention. Maximising trust and rapport help to create a safe contained space for service

users to speak openly about their experiences of trauma and gives them confidence in their therapist to continue with the therapy process.

"At the end of the day you really just have to be a good clinician. And that has nothing to do with the protocols or manuals. You have to trust yourself and connect to your patients." (Clinician; Doran et al., 2019, p. 19).

"I think having the support from [therapist] was a big help, cos I trusted her. And I believed if she told me that it was gonna help, cos there was a small part of me that thought this was never gonna help, but then I did, I trusted her so that was a massive thing for me". (Service user; Shearing et al., 2011, p. 463).

Flexibility and client-centred

Although clinicians expressed difficulties in adhering to protocols whilst maintaining service users' needs and expectations, they acknowledged the importance of flexibility, giving service users choice, and adapting the intervention to tailor to service users' needs.

"Sometimes it feels like you are just 'throwing worksheets' at whatever issue they come up with, which works in some cases but not all, and can also feel disingenuous, repetitive, or impersonal." (Clinician; Doran et al., 2019, p. 16).

Similarly, service users talked about the unhelpfulness of therapists being a 'textbook' clinician, emphasising the importance of flexibility within the protocolised intervention.

"You can have a curriculum, but you've got to let loose. . . It was just so impersonal. Maybe it was her first shot at it. Maybe she'll get better" (Service User; Meis et al., 2022, p. 8).

Conversely, one study noted that therapists also found that adherence to the intervention protocol helped to overcome avoidance (Boterhoven de Haan et al., 2021). Keeping to the structure within the protocol during, for example, memory work helped

therapists to feel contained and trust the process. This suggests a balance is needed with adhering to the protocol and remaining flexible.

"That we are used to calm down the client or do some relaxation exercise, but the protocol says, well, you should go on . . . We are used to taking care . . . (patients) can take time out. But afterward, I see well, it was right . . . Just to keep going." (Clinician; Boterhoven de Haan, et al., 2021, p. 10).

Timing and duration of the intervention

At times, service users were not ready for memory work which meant further work in promoting control over the symptoms was needed. Both clinicians and service users talked about the importance of having a sufficient number of sessions.

"The short time frame was also seen as problematic for working with PTSD due to needing time to build an alliance and help veterans open up and face the trauma" (Authors; Doran et al., 2019, p. 20).

"I think if there was a two or four more to just see me through, just to help me just get through the last few doors you know, because I still struggle with things." (Service User; Boterhoven de Haan et al., 2021, p. 7).

Knowing when to target something in therapy (e.g. addressing core beliefs) is important, as wrong timing can impede the therapeutic alliance.

"When people have got such chronically devastating core beliefs about themselves, and they wouldn't be able to conceive themselves with having a positive belief about themselves…It has got to come later if you want the therapeutic relationship to stay strong" (Clinician; Kemal Kaptan & Brayne, 2021, p. 599).

Studies did find that service users who either prematurely dropped out or found TFIs unhelpful had fewer sessions, emphasising the importance of having an adequate number of sessions to meet the important intervention milestones and reflect any measurable changes.

Service users that spoke about dropping out of therapy, particularly in relation to the distress in addressing the trauma, may shed light on the importance of speaking about the processes involved in the intervention during the early stages, as well as thinking about factors to increase motivation.

> *"…veterans had typically completed three to five sessions, which may not have been enough to expect substantial improvement"* (Author; Hundt et al., 2020, p. 7).
>
> *"I just gave up because it wasn't…I wasn't getting anywhere…They were trying to convince me that it's gonna happen. You've just got to give it a little more time, and it wasn't working."* (Service user; Hundt et al., 2020, p. 7).

However, clinicians also emphasised a barrier whereby services do not provide enough time or capacity to deliver TFIs.

> *"I think pretty much everywhere now you have to have a discrete, you offer people discrete therapy contracts that are far too short for what they actually need because that's the NHS context"* (Clinician; Chadwick & Billings, 2022, p. 548).

Factors outside of therapy

This theme describes the systemic barriers that impede the implementation or engagement of TFIs, suggesting that such barriers are beyond the clinician's or service user's control.

Training and supervision for clinicians

Training and supervision availability were a systemic barrier in the implementation of TFIs. Lack of training affects clinicians' ability to communicate with someone severely affected by trauma.

> *"there's probably a training need within the team, uh, around the assessment of trauma and actually understanding the impact of trauma on psychosis"* (Clinician; Chadwick & Billings, 2022, p. 551).

Training and supervision as a barrier or facilitator were not captured in studies exploring service user perspectives, as they would believe therapists would have the adequate skills to help people with PTSD.

"…the participants acknowledged that they had little to no training on how to address trauma or trauma-related difficulties among their consumers. Thus they had little idea about how to ask their clients about it, how to treat it, or how to respond to trauma-related crises or symptom exacerbations, and they had little sense of their ability to effectively handle and help clients manage the impact of PTSD and trauma in their lives" (Author; Frueh et al., 2006, p. 1030).

Hasandedic-Dapo (2021) noted that psychologists commented on how time consuming and costly EMDR training is, alongside getting certification privately, which speaks to wider issues with the affordability of specialist training which clinicians have to fund themselves.

"It's pretty expensive to get certified, and it took a lot of time, usually entire weekends to go through the trainings, which not many people can afford to devote. And the majority of people in Turkey need to travel to another city for the training, which then requires more time and money." (Clinician; Hasandedic-Dapo, 2021, p.21).

Personal life constraints

Personal life constraints related to family, work, finance, and life event disruptions were reported by service users as affecting engagement or the start of TFIs. Studies on clinician perspectives did not report this.

"Non-completers reported using life stressors (real and exaggerated) as reasons for ending treatment early in the face of ongoing ambivalence. One non-completer reported, "I had surgery and it was just convenient not to go. It was like okay, I'll just use that as my excuse." (Authors and service user; Kehle-Forbes et al., 2022, p. 7).

However, studies also showed that finding ways not to overwhelm service users with therapeutic tasks, such as homework setting, can mitigate the impact of their life constraints.

*"I have three little boys. . . and it gets busy. And I forgot all about this homework, so I went back the next time, and he's like, "Oh, he didn't do the homework, so you don't really care." And I was really taken back by [that]. I was like, "Who the f*** do you think you are?" [therapist:]"* (Service user; Meis et al., 2022, p. 7).

Comparisons between clinician and service user perspectives

Strong shared perspectives were found between clinician and service users regarding the uptake and delivery of TFIs. Factors that were unique to service users were personal life constraints and being able to increase their stamina to endure and overcome the distress from their trauma, which were not seen in clinicians' experiences and perspectives. Training and supervision were common factors that were spoken about in all studies addressing clinicians' perspectives of TFIs.

The subthemes mapped to the TDF domains are shown in Table 5. The majority of subthemes mapped to the TDF domains were salient for both clinicians and service users. Notably, 'environmental context and resources' had different subthemes for each group. For service users, this was linked to 'personal life constraints', while for clinicians this was linked to 'training and supervision'. Some subthemes overlapped with multiple TDF domains. For example, 'promoting control over physical and emotional reactions to trauma' was relevant to the TDF domains of 'skills', 'behavioural regulation', and 'emotion'. The subtheme 'training and supervision' was relevant to the TDF domains of 'knowledge', 'skills', and 'environmental context and resources' for clinicians.

Table 5.

Subthemes relevant to service users and clinicians mapped to the TDF Domains

TDF Domains	**Subthemes**	
	Service Users	**Clinicians**
Knowledge	• Knowledge and understanding of the intervention	• Knowledge and understanding of the intervention • Training and supervision for clinicians
Skills	• Promoting control over physical and emotional reactions to trauma	• Promoting control over physical and emotional reactions to trauma • Training and supervision
Memory, attention, and decision processes	• Flexibility and client centred • Timing and duration of the intervention	• Flexibility and client centred • Timing and duration of the intervention
Behavioural regulation	• Promoting control over physical and emotional reactions to trauma • Stamina to endure and overcome the pain	• Promoting control over physical and emotional reactions to trauma
Environmental context and resources	• Personal life constraints	• Training and supervision
Social influences	• Therapeutic alliance	• Therapeutic alliance
Beliefs about capabilities	• Addressing ambivalence and avoidance • Addressing the associated meanings and beliefs with trauma • Fear and Harm expectancy	• Addressing ambivalence and avoidance • Addressing the associated meanings and beliefs with trauma • Fear and Harm expectancy
Optimism	• Confidence and Motivation • Rebuilding life and regaining sense of self	• Confidence and Motivation • Rebuilding life and regaining sense of self
Social/Professional role and identity	• None identified	• None identified

Intentions	• Flexibility and client centred • Timing and duration of the intervention	• Flexibility and client centred • Timing and duration of the intervention
Goals	• Flexibility and client centred • Rebuilding life and regaining sense of self	• Flexibility and client centred • Rebuilding life and regaining sense of self
Emotion	• Promoting control over physical and emotional reactions to trauma • Stamina to endure and overcome the pain	• Promoting control over physical and emotional reactions to trauma • Stamina to endure and overcome the pain
Reinforcement	• Therapeutic alliance	• Therapeutic alliance

Discussion

This review used thematic synthesis to explore both clinicians' and service users' experiences and perceptions of trauma-focused interventions (TFIs) to better understand the barriers and facilitators to the uptake and delivery of TFIs. Mapping these identified factors to the Theoretical Domains Framework (TDF; Cane et al., 2012) may help inform the development of both clinician and service user tailored strategies on the uptake and delivery of TFIs. Nineteen qualitative and mixed-methods studies were identified to address this aim, and four themes were derived from the selected studies with the subthemes mapped to 13 domains of the TDF.

Summary of Findings and Interpretation in the Context of the TDF and Previous Literature

Relevant to the TDF domain of 'beliefs of capabilities', a key facilitator that emerged from the theme, 'core elements to heal from the trauma', was helping service users to address the meanings and beliefs regarding the trauma. Shifting the negative sense of self, others, and the world, are key in creating purposeful changes for the service user (Shearing et al., 2011). The subtheme 'promoting control over the physical and emotional reactions to trauma' was salient across the three TDF domains of 'behavioural regulation, emotion, and skills'. This subtheme was applicable to both clinicians and service users, highlighting promoting control as key to engagement and prevention of dropout in TFIs. The studies addressing service users' perspectives expressed the need to build their stamina in all aspects of trauma-focused therapy. Interestingly, studies exploring clinicians' perspectives did not highlight this as a factor. Service users lacking such stamina may be viewed as unready to engage by clinicians (Cook et al., 2014). Within TFIs, the studies in this review showed that promoting therapeutic alliance encourages service users to believe in change and feel contained during sessions. This suggests applying different therapeutic positionings to promote assurance and safety –

e.g., taking a direct, strong therapeutic stance ("I'm going to help you"; Bosch & Arntz, 2021, p. 7). Notably, both groups reported that trauma can at times be too painful to address. This may necessitate starting with a less distressing trauma material that is more tolerable for service users (Hardy et al., 2022). Relevant to the TDF domains of 'goals' and 'optimism', the subtheme 'rebuilding life and sense of self' was mostly reported by service users, where they were able to re-engage in meaningful activities that were inhibited by PTSD (Hardy et al., 2022). As this facilitator was only found in one study exploring clinicians' perspectives (Boterhoven de Haan et al., 2021), this may suggest that clinicians emphasise outcomes regarding symptom reduction as opposed to quality of life. Informed by the TDF, promoting optimism of TFIs can be enhanced if therapy goals are more aligned to service users' meaningful activities (Hardy et al., 2022).

Regarding 'readiness', the subtheme, 'knowledge and understanding of the intervention', can be seen as both a barrier and a facilitator, matching the TDF domain of 'knowledge'. Similar to the findings of Finch et al (2020), clinicians' limited understanding of TFIs create ambivalence towards it. Disengagement occurred when service users engaged with the trauma-related content in the sessions and did not understand the purpose - e.g., talking about the impact of the trauma or engaging with memory work (Kehle-Forbes et al., 2022). This affected both clinicians' and service users' decision to engage with TFIs.

The subthemes of 'addressing ambivalence and avoidance' and 'fear and harm expectancy' were also related to the TDF domain of 'beliefs about capabilities'. Similar to Smith et al's (2020) systematic review, avoidance of engaging with trauma content was observed in service users as well as clinicians in this review. This suggests potential parallel processes occurring between both groups regarding ambivalence towards the intervention, and avoidance within the therapy processes. Regarding the subtheme 'fear and harm expectancy', addressing this concern with referrers, clinicians, and service users sceptical of

TFIs would help dispel any ambivalence towards TFIs. Clinicians prioritising psychoeducation, developing coping strategies, and being transparent with the processes within TFIs can help alleviate ambivalence (Marques et al., 2016).

Regarding the subthemes of ‘flexibility and client centred’ and ‘timing and duration of the intervention’, these were reflected in the TDF domain of ‘intentions’. Achieving flexibility is a key facilitator that encourages clinicians to use TFIs and tailor them to the individual, similar to the findings in Finch et al’s (2020) review. Flexibility within fidelity (Kendall et al., 2008) has been highlighted in studies addressing the implementation of psychological therapies. However, studies in this review have found ongoing concerns regarding clinicians’ ability to achieve this with protocolised manuals. Conversely, adherence to a protocol also helped clinicians’ confidence in therapy delivery (Boterhoven de Haan et al., 2021). Flexibility may impede on the effectiveness of memory work, due to the importance of the timing of the intervention. As such, balancing flexibility in engaging with service users with achieving the optimal time-point for targeting trauma memories can pose a challenge for both groups. Regarding therapeutic processes, ‘confidence and motivation’ were commonly expressed in studies exploring both clinicians and service users, which speaks to the importance of addressing ‘optimism’ in both groups, as proposed in the TDF. Lack of confidence in clinicians’ and service users’ own skills becomes a barrier to using TFIs (Boterhoven de Haan et al., 2021).

Similar to the findings by Finch et al’s (2022), clinicians reported systemic barriers such as availability of training and supervision, lack of resources, and limited capacity. A barrier outside of clinicians’ or service users’ control is the service constraints in providing an adequate number of sessions, informed by evidence from RCTs, as well as support within the organisation (Finch et al., 2020; Murray et al., 2022). This suggests that barriers to implementing TFIs can be systemic rather than related to client engagement. Conversely,

service users' personal life constraints can also affect their engagement with TFIs. Clinicians and service users with adequate resources within their supporting networks (e.g., families, care coordinators) can augment engagement and progress with therapy. As such, the TDF domain of 'environmental context and resources' related to clinicians and service users differently, highlighting the various systemic constraints around delivery and engagement with TFIs.

Research and Clinical Implications

The overlapping factors affecting the uptake and delivery of TFIs relate suitably to the TDF. For example, clinicians and service users reported needing the 'knowledge' and 'skills' necessary; helping the service user build resilience ('behavioural regulation') can be complemented by therapeutic alliance ('social influences', 'reinforcement'), which is strongly associated with therapy engagement (Fenn & Byrne, 2013); personal life constraints inhibited help-seeking behaviour in service users whereas clinicians felt that their service context posed challenges in facilitating the delivery of TFIs due to lack of training and supervision ('environmental context and resources'). That the present findings integrate comfortably into the TDF domains in turn reinforces its value as a tool for interpreting barriers and facilitators to implementation. This held true for both clinician and service user responses, underlining the value of combining their perspectives when considering implementation. Moreover, the present findings reinforce the value of producing findings that consider implementation strategies at the individual, provider, system, policy, and economic levels (Bauer et al., 2015).

This review provides insight to the factors that clinicians should consider when supporting service users to engage with TFIs. For example, addressing meaningful rebuilding life goals and applying therapeutic processes to strengthen their resilience in tolerating trauma-focused work. Services would benefit from supporting clinicians to access training

and supervision to support their ability to deliver TFIs. Moreover, currently there is limited research investigating how many clinicians can deliver TFIs across different settings, thus further research in this area is warranted. Future research would also benefit from further clarifying the number of clinicians trained in delivering TFIs, but feel ambivalent, to complement the identified barriers and facilitators. Future research should also explore the experiences of service users and clinicians of TFIs within the same population and setting. Only three studies in this review achieved this (Bosch & Arntz, 2021; Meis et al., 2022; Boterhoven de Haan et al., 2021). This would better support in the identification of therapeutic processes facilitating or impeding engagement.

Strengths and Limitations

A strength of this review is that studies on both clinicians' and service users' perspectives were included to identify the commonalities and differences in terms of the barriers and facilitators, which previous systematic reviews lacked. This helped to identify unique aspects of each group. Another strength was that the themes identified were similar across studies, which shows good reliability of the findings. The range of studies that looked at treatment completers and dropouts also helped to better identify themes that spoke to the barriers and facilitators in the uptake and engagement with TFIs.

Regarding limitations, only one researcher conducted the analysis and coding which may have affected themes being missed (Korstjens & Moser, 2018). Importantly, researcher subjectivity should be recognised, as the thematic synthesis involved re-interpreting the findings interpreted by the authors of the reviewed studies (Thomas & Harden, 2008). However, the analysis and interpretation of findings were discussed with the research supervisor as a means to account for this. Another limitation of the review is the variability across studies in terms of TFIs, clinical populations, index traumas, and professional groups. However, there was congruence in the themes identified, echoing those reported in previous

systematic reviews that similarly included a broad range of clinical/professional groups and TFIs (Finch et al. 2020; Smith et al, 2020). Identifying the factors influencing the use of TFIs across different professional groups provides a better understanding of practice needs at different stages of their career (Finch et al., 2020). As mentioned, all TFIs are well suited for any type of trauma (Schnurr, 2017), and share overlapping mechanisms of change despite individual differences in method of delivery (Kangaslampi & Peltonen, 2019). Nonetheless, future research would benefit from investigating whether clinicians' and service users' perspectives related to uptake and delivery are associated with mechanisms of change of specific TFIs.

Conclusion

The present review found multiple factors that support or hinder the uptake and delivery of TFIs, which were relevant to multiple domains in the TDF. Comparing clinician and service user perspectives and experiences, factors such as flexibility of the intervention, readiness, therapeutic processes (related to confidence, motivation, and therapeutic alliance), were reported by both groups. A barrier not reported by clinicians was the service users' hope in strengthening their resilience to support their progress and engagement with therapy. Clinicians should address these aspects throughout the process with TFIs. Clinicians would benefit from receiving support from organisations to address barriers related to training and systemic constraints that hinder successful implementation recommendations of TFI protocols based on RCTs. Future research should explore both clinician and service user experiences within the same population and setting. This will help address the gaps in the facilitators and barriers captured in this review, maximise the effectiveness of the use of TFIs, and support implementation in clinical services.

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Section B

Therapists' experiences of delivering trauma-focused cognitive-behavioural therapy for psychosis (TF-CBTp) in the Study of Trauma and Recovery (STAR) randomised clinical trial (RCT).

Potential journal: British Journal of Clinical Psychology

Word count: 7968 (593)

Abstract

Introduction: Trauma-focused interventions for people with psychosis and PTSD are not widely used due in part to perceived concerns with symptom exacerbation and safety. The present study sought to explore the perceived acceptability, self-efficacy, and expectations regarding trauma-focused cognitive behavioural therapy for psychosis (TF-CBTp) from the therapists' perspective.

Method: A qualitative design with semi-structured interviews was conducted with the trial therapists in the Study of Trauma and Recovery (STAR) randomised clinical trial. Reflexive thematic analysis was used to explore the perspectives and experiences of 17 trial therapists.

Results: Five main themes were generated: i) 'Flexibility is key', ii) 'Perceived stability of service users', iii) 'Addressing the ambivalence and avoidance', iv) 'rebuilding life goals as a main thread, and v) 'Training and supervisory needs'. These themes all or partially encompassed the perceived acceptability of the TF-CBTp, the promotion and maintenance of service user's self-efficacy, and changes in expectations that influenced a change in the acceptability of TF-CBTp.

Conclusion: The acceptability of TF-CBTp was strengthened by the flexible nature of the protocol, service users' stability in social circumstances, and training and supervision. The self-efficacy of service users receiving this intervention can be promoted and sustained by multiple therapeutic processes including addressing ambivalence and avoidance, empowerment, and the shared understanding and rationale behind the intervention. Therapists' initial negative expectations impacted the therapy delivery, although these expectations positively changed through time. Limitations of the study and the research and clinical implications are discussed.

Key words: trauma-focused cognitive behavioural therapy, acceptability, psychosis, trauma, post-traumatic stress disorder.

Introduction

The Study of Trauma and Recovery (STAR) is a randomised clinical trial (RCT) evaluating the effectiveness and cost-effectiveness of a trauma-focused therapy for psychosis (Peters et al., 2022). Only a few studies have explored clinician's experiences of trauma-focused therapy in psychosis, but none have qualitatively captured the perceived acceptability and experiences involved in delivering the intervention. Given perceived risk concerns around using trauma-focused therapies (Farrell et al., 2013), it is important to further investigate the acceptability of this intervention. This includes looking at therapist's experiences of addressing the self-efficacy of service users (SUs) receiving the intervention. This will help clarify the barriers and facilitators to implementation in routine clinical services.

Prevalence of Trauma and PTSD in Psychosis

People with psychosis are approximately five times more likely to develop post-traumatic stress disorder (PTSD) compared to the general population (McLaughlin et al, 2015), the effects of which can severely impact their functioning (Grubaugh et al., 2011; Karam et al., 2014). PTSD includes the following symptoms: intrusive memories (e.g. flashbacks, nightmares), cognitive and/or behavioural avoidance, and hypervigilance (American Psychiatric Association; APA, 2013). In some instances, PTSD symptoms may play an aetiological role in the formation of psychotic experiences (Hardy, 2017). National clinical guidelines for psychosis recommend trauma screening and assessments as standard, but this remains lacking in psychosis services (Sampson et al., 2017). Research has shown that clinicians' reluctance to discuss trauma in psychosis services was associated with perceived concerns with client distress (Read et al., 2007; Walters et al., 2016). SUs have reported the lack of opportunity to discuss trauma (Campodonico et al, 2022), as psychosis often trumps the focus on PTSD in clinical services (de Bont et al., 2015). Such individuals

present with more comorbid difficulties and poor response to antipsychotic medication (Grubaugh et al., 2011; Hassan & de Luca, 2015).

Trauma-Focused Interventions (TFIs) in Psychosis

The National Institute for Health and Care Excellence (NICE) recommends that TFIs (e.g., trauma-focused cognitive-behavioural therapy and eye movement desensitisation reprocessing) and cognitive-behavioural therapy for psychosis (CBTp) should be offered for PTSD and psychosis respectively (NICE, 2018). TFIs differ to trauma-informed interventions, whereby the latter focuses on understanding the impact of trauma on a person's life, and the former specifically targets traumatic memories and their associated post-traumatic stress symptoms (Peters et al., 2022). As the effects of trauma inform the symptomatology in both psychosis and PTSD (Brand et al, 2017), treating the impact of trauma may provide benefit for both presentations and their intertwined difficulties. Despite emerging evidence that TFIs are safe and efficacious for this population, few clinical trials have examined this due to strict exclusion criteria (Brand et al., 2018; Swan et al., 2017).

Evaluating the Acceptability of Interventions

The acceptability of an intervention can be measured quantitatively via outcome measures, or qualitatively through interviews focusing on the experiences of the intervention (Moore et al., 2015). There is a lack of consensus in defining and operationalising acceptability (Sekhon et al., 2017; Staniszewska et al., 2010). This led to the development of Sekhon et al.'s (2017) theoretical framework of acceptability (TFA), which proposes seven components to evaluate the appropriateness of healthcare interventions for the person either delivering or receiving the intervention: affective attitude, burden, ethicality, intervention coherence, opportunity costs, perceived effectiveness, and self-efficacy. This was recently applied to a qualitative study that explored clients' experiences and perceptions of

psychotherapy for suicide prevention for people with non-affective psychosis (Harris et al., 2023).

Self-Efficacy in Psychosis and Trauma

Self-efficacy, defined as the ability to execute tasks, determines the extent to which a person can cope, motivate self, and persevere, particularly in the face of stressful situations (Bandura, 1997; Benight & Bandura, 2004). Developing self-efficacy consists of four domains: ‘social persuasion’, through encouragement and support from others; ‘vicarious experiences’, through observing others or role models succeeding in a task; ‘master experiences’, related to improving self-competency and achieving successes; and ‘somatic and emotional states’, related to changing the feelings or emotional reactions toward a particular task (Bandura, 1986; 2001). Positive self-efficacy was also associated with positive recovery outcomes in people with psychosis and PTSD (Ng et al., 2021; Pratt et al., 2005). Therapeutic factors associated with increased self-efficacy include therapeutic alliance, hope, and psychological mindedness (Tzur Bitan & Abayed, 2020). In psychosis and trauma, overcoming fear of disclosure regarding past experiences, clear goal setting, and increased insight positively correlated with therapy engagement (Switzer & Harper, 2019; Mankiewicz et al., 2018; Álvarez-Jiménez et al., 2009). It is currently unknown how therapists enhance or maintain SU’s self-efficacy in TFIs. Exploring self-efficacy, one of the components in Sekhon et al’s (2017) TFA, will help provide a better understanding of how therapists facilitate SU engagement with TFIs.

Perceptions of TFIs

Qualitative and mixed-methods research has found perceived concerns of exacerbating symptoms, client safety, and expected burden with TFIs (Farrell et al., 2013; Foa et al., 2013; van den Berg et al., 2016). However, evidence indicates that such risks are minimal (Rusek et al., 2016). Negative expectations have shown to affect the overall

effectiveness of the intervention in terms of SU engagement and outcome (Deacon & Farrell, 2013). Boterhoven de Haan et al. (2021) highlighted that confidence and adherence to intervention protocols reduced therapists' ambivalence towards using TFIs.

Only two qualitative studies have investigated clinicians' perspectives of TFIs in psychosis. Gairns et al. (2015) found that the barriers to TFIs in a service supporting young people with first-episode psychosis were associated with workload pressure and poor client engagement. Chadwick & Billings (2022) found that the facilitators were related to shared understanding, structural support of teams, and providing safe spaces. However, none of these studies explored the experiences of delivering TFIs and the ongoing concerns of the intervention among clinicians might be related to a lack of expertise in using TFIs in psychosis. Only one mixed-methods study found that training significantly changed the perceived credibility, expected burden, and harm expectancies in TFIs for psychosis (van den Berg et al., 2016). Given the discrepancy between clinicians' perceived concerns of risk and the promising evidence of TFIs regarding safety and efficacy, evaluating the acceptability and expectations of TFIs in psychosis is warranted.

Study Rationale and Aims

Only a few clinical trials have evaluated TFIs in a psychosis population (van den Berg et al., 2015; de Bont et al., 2016; Steel et al., 2017; Clarke et al., 2022), and therapists' experiences of using these interventions with this population have not been investigated. STAR investigated the clinical and cost-effectiveness of integrating trauma-focused therapy with cognitive behavioural therapy for psychosis (TF-CBTp), compared to treatment as usual, across five sites in England: London, Manchester, Newcastle, Oxford, and Sussex (Peters et al., 2022). As this is the first RCT that integrates trauma-focused and CBTp, it is important to explore therapists' acceptability of using TF-CBTp. The present study sought to explore the experiences of the STAR trial therapists in delivering TF-CBTp to answer the following:

1. What factors impact the acceptability of TF-CBTp?
2. How do the therapists understand and promote SU's self-efficacy when engaging with TF-CBTp?
3. How do the therapists perceive the impact of their expectations on the acceptability of TF-CBTp?

Two NHS values are relevant to the present study: 'commitment to quality of care', and 'Improving lives' (Department of Health and Social Care, 2021). The present study will help provide further insight into better delivery of TFIs to effectively support SUs with psychosis and PTSD.

Method

Design

A qualitative design with semi-structured interviews was used, with a reflexive thematic analysis (TA) approach (Braun & Clarke, 2019). Reflexive TA provides a flexible approach that is not underpinned by a specific philosophical position (Braun & Clarke, 2019). Given that the research aims are to explore the therapists' perceptions and experiences of TF-CBTp, reflexive TA was deemed appropriate to address this, which examines patterns and meanings across the broad data set (Braun & Clarke, 2022). An inductive approach (data-driven) to data analysis was employed given the limited research on clinicians' experiences and perceptions with TFIs in psychosis,

Sampling and Participants

Purposive sampling was employed, recruiting across the five STAR trial sites within the NHS foundation mental health trusts: South London and Maudsley (SLaM); Greater Manchester Mental Health; Cumbria, Northumberland, Tyne and Wear (Newcastle); Oxford Health; and Sussex Partnership. The participants were trial therapists delivering TF-CBTp and had prior experiences delivering psychological therapies for trauma and/or psychosis.

Eighteen participants on the STAR trial were available for interview during the recruitment stage, with 17 being eligible. Interviews were conducted between December 2021 and December 2022. A summary of demographics information is summarised in Table 1.

Table 1.

Demographic Summary

Demographic		N = 17
Age range		31 - 52
Gender	Male	1 (6%)
	Female	16 (94%)
Ethnicity	White British	15 (88%)
	White Asian	1 (6%)
	Mixed Background	1 (6%)
Professional role	Clinical Psychologist	14 (82%)
	CBT Therapist	2 (12%)
	Psychotherapist	1 (6%)
Median number of years qualified		8
Median number of therapy cases seen		5
Median number of years of experience post-qualification	PTSD only experience	3
	Psychosis and general trauma experience	6
	Psychosis and PTSD experience	4.5
Number of trial therapists that have trauma-focused approaches prior to the trial		13 (76%)
Median number of years using trauma-focused approaches		2

Brief Overview of the TF-CBTp Protocol

TF-CBTp applies model-based interventions for PTSD, with adaptations made for a psychosis population, including interventions drawn from CBTp (Peters et al., 2022). TF-

CBTp was delivered over 9-months, with approximately 26 sessions that lasted 60-90 minutes. It adopts a flexible (yet phased) approach, emphasising engagement and stabilisation of distress (Keen et al., 2017; van den Berg et al., 2020). The following four flexible phases are: assessment, psychoeducation, and goal setting; shared formulation; formulation-driven model intervention consisting of promoting control, memory work, and rebuilding life; and consolidation and staying well plan (Peters et al., 2022). See Appendix B for further details on the protocol.

Inclusion Criteria

Participants were eligible for interview after completing therapy with at least one SU from the trial and completed the main phases in the protocol. Initially, an inclusion criterion was for the participants to have completed therapy with at least two SUs in the trial. However, this criterion was amended for therapists who joined STAR late into recruitment, to ensure inclusion within the recruitment window. Eight out of the 17 recruited participants met the amended criterion.

Materials

Interview Schedule

The semi-structured interview schedule consisted of open-ended questions exploring the participants' experiences and perceptions around acceptability, expectations, and self-efficacy regarding TF-CBTp (Appendix C). The structure of the interview schedule was used flexibly, guided by the participant's responses. The interview schedule was initially drafted by members of the STAR research team, including the Principal Investigator (PI), the trial coordinator, and a therapy lead. The interview schedule was further developed by the researcher and was then reviewed and finalised with input from the trial coordinators, PI, therapy leads, and the qualitative lead for the trial. A pilot interview was conducted with one of the trial coordinators, which led to further refinement of the interview schedule.

Participant Background Information Form

Each participant completed an anonymised background information form to capture demographic characteristics, years of experience working with psychosis and trauma/PTSD, number of therapy cases they have seen in the trial, and prior experiences of trauma-focused approaches (Appendix E).

Procedure

The researcher contacted eligible participants about the interview. Prior to the interview, participants completed and signed the informed consent form and provided background information. Due to restrictions imposed by the COVID-19 pandemic, interviews were conducted remotely. Remote interviews have been more widely used since the pandemic, and have been deemed to be safe and adaptable within clinical and research contexts (Dodds & Hess, 2020). Interviews lasted 60-80 minutes, with some interviews split across two appointments due to the therapists' time and capacity. Video calls were recorded and transcribed by the researcher. The participants were aware that they would receive a summary of the findings.

Ethics

Ethical Approval

NHS Research Ethics Committee Review and Research and Development approvals were already gained by the trial when recruitment for the present study began. (Appendix H). The present study gained university approval following submission of the research proposal (Appendix I). Following this, NHS to NHS Letters of Access approvals for each of the five trial sites were obtained (Appendix J).

Ethical Considerations

All participants were given an information sheet, completed the informed consent sheet (Appendix D), and consented to having their interview recorded and transcribed.

Participants were informed about the right to withdraw consent at any time and were reminded before the start of the interview that they had no obligation to answer any questions they did not want to.

Discussing trauma and the impact of delivering interventions can be potentially distressing. Participants were informed that they could take a break at any time, and that the researcher would provide a check-in in the middle of the interview. The researcher closely gauged the participant's emotional reactions and asked the participant if they wished to stop or move on to the next question.

Participants were informed that any information in the transcript would remain confidential and that any identifiable information would be omitted from the transcript. Participants were also advised to be mindful about confidentiality when sharing information regarding their trial therapy cases, but that any disclosure that risked a SU being identified would be anonymised in the transcript. The researcher also suggested participants use pseudonyms and that they would inform the research when this was exercised.

Limitations to confidentiality were emphasised, such as issues of risk to self, others, or from others, as well as issues of malpractice. They were informed that any concerns disclosed would be passed on to the trial coordinators and therapy supervisors. No such issues were reported during the interviews.

Only the researcher had access to the interview recordings and transcripts, which were password protected and stored in an encrypted device.

Data Analysis

Reflexive TA consisted of the following process: (1) data familiarisation; (2) initial coding of the data set; (3) initial generation of themes; (4) reviewing the themes; (5) defining and renaming themes; (6) report production by use of quotes referring to the themes, and interpreting the findings based on the research questions and literature (Braun & Clarke,

2019). The process is not linear, as shifting between the process stages will be expected while refining the codes and themes (Braun & Clarke, 2022).

Epistemological Positioning

The study used a critical realist framework, which assumes that the researcher's understanding of the acceptability of an intervention as well as self-efficacy are not only influenced by the underlying reality and previous theoretical literature, but also co-constructed by the participant's perception and subjective experiences (Vincent & Mahoney, 2018). In the context of reflexive TA, the 'truth' is not contained in the data as it is contingent on the researcher's subjectivity and interpretation (Braun & Clarke, 2022). Therefore, reflexivity can be used to show how the research and knowledge produced was partially shaped by wider social contexts (Braun & Clarke, 2022).

Reflexivity and Quality Assurance

Reflexivity is an important part of the data analysis process and can aid quality assurance (Braun & Clarke, 2022; Dodgson, 2019). Data collection and interpretation of the findings can be influenced by researchers' role, subjectivity, assumptions, and beliefs around the research topic (Carpenter, 2007). In terms of the researcher's position, they identify as a male, British, East Asian, trainee clinical psychologist. The interest in PTSD and psychosis arose from work experiences prior to doctoral training, which influenced their beliefs and knowledge about the value that TFIs in psychosis bring. The researcher also uses CBT in their professional work, but had no prior experience of using TFIs, including TF-CBTp in the STAR trial. The researcher did not have any other role in the STAR trial other than the present study. This helped to limit preconceived assumptions related to the research question, data analysis, and interpretation of the findings. The researcher's exploration of existing literature around the positive and negative experiences of using TFIs in psychosis will likely

influence the analysis. Therefore, the researcher was open to hearing both the positive and negative experiences of the therapists delivering TF-CBTp.

An independent researcher facilitated a bracketing interview with the researcher (Appendix F). It consists of open-ended questions that spoke to the pre-expectations of the research, beliefs, and assumptions regarding TFIs for people with psychosis and PTSD, personal values, and potential conflicts (Tufford & Newman, 2020). A reflective diary was completed by the researcher throughout the process, which documented how their thoughts impacted the research progress (abridged version in Appendix G). For instance, the researcher reflected on the experience of participants reporting mainly positive experiences of their delivery of TF-CBTp, and how the researcher took this into account by considering the drawbacks in the delivery of TFIs in subsequent interviews.

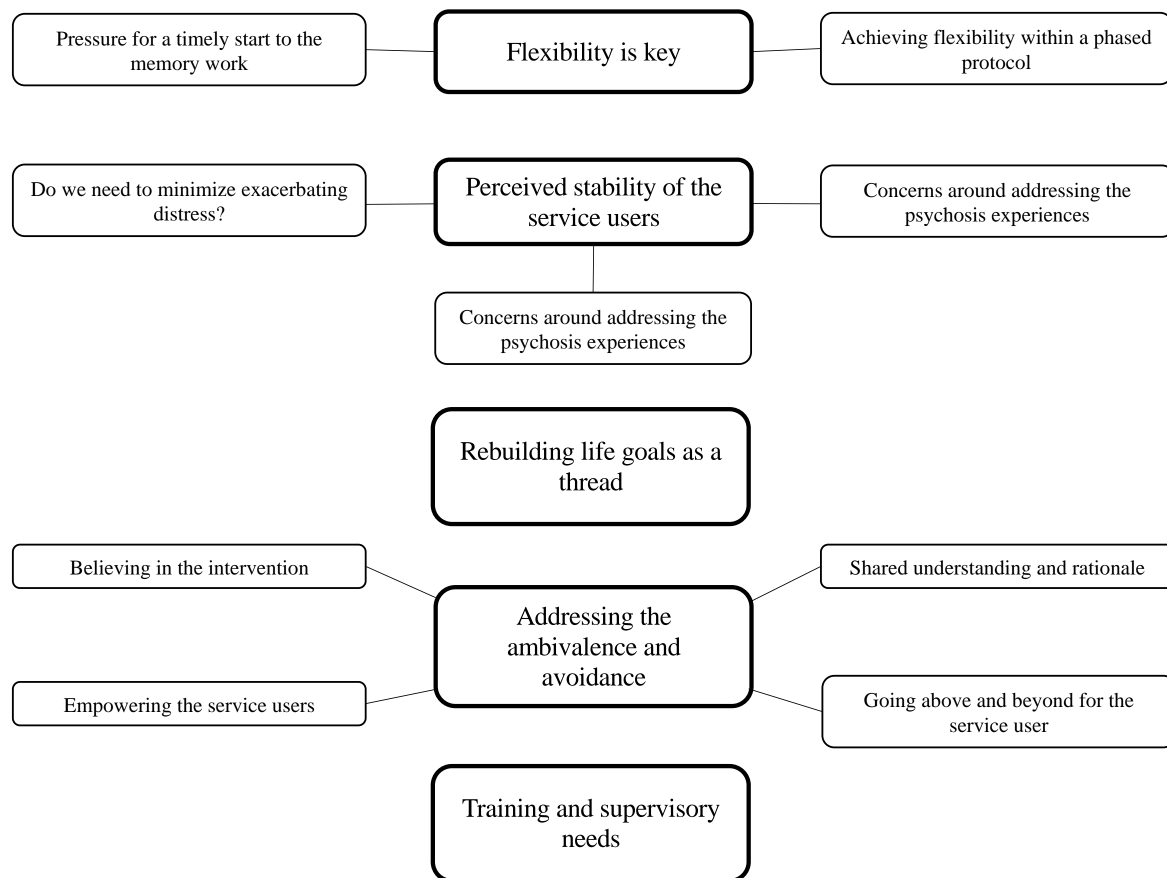
Accuracy of data interpretation was supported by the research supervisor who reviewed the coding of two interview transcripts. This provided additional insights and interpretations in the analysis, which helped the researcher to question any assumptions made and identify areas that were overlooked (Braun & Clarke, 2022). The researcher aimed to receive feedback from the participants to ensure the developed themes accurately represented their experiences. However, this was not achieved due to time constraints.

Results

Figure 1 shows the summary of the generated themes and subthemes. The five themes were the following: ‘Flexibility is key’, ‘Perceived stability of service users’, ‘Addressing the ambivalence and avoidance’, ‘rebuilding life goals as a main thread’, and ‘Training and supervisory needs’. Extracts of coded transcripts, initial coding, and theme development, can be found in Appendices K-L.

Figure 1.

Themes and subthemes



Flexibility is key

Therapists stressed the importance of using the intervention flexibly due to the complexity that the SUs presented with. Therapists also shed light on the acceptability of the intervention, which was driven by the flexible nature of this TF-CBTp protocol. Using TF-CBTp flexibly also positively impacted on the SU's self-efficacy.

Achieving flexibility within a phased protocol

This subtheme refers to the process of the therapists' expectation in finding the balance between adhering to a stringent protocol and remaining flexible in the interest of SUs' needs. Therapists expressed their initial anxiety and pressures adhering to the protocol, particularly for those unfamiliar with trauma-focused approaches. From the trial therapy training, therapists were aware that there was a level of flexibility available in the protocol

due to recognising the complex difficulties people with psychosis and PTSD present with. One therapist described their initial attitude towards the flexible approach in the phased protocol.

> *"My anxiety was that the protocol had been really kind of, this is what you do, this is the techniques you are doing in certain sessions and then obviously there was an outline of kind of techniques…the protocol was very clear that it was very flexible…which is again what you need because every person and every presentation is different but maybe less containing for someone who's is less familiar with the trauma-focused side"* (P5[1]).

Some therapists expressed that juggling this balance impacted their delivery of the intervention. P4 described how it impacted the pacing of the delivery:

> *"…made me think really carefully about adhering to kind of the phases and the speed of the pace of therapy to try and ensure that within the 26 sessions we have available that it could be covered. So I think it probably impacted my pacing a little bit"* (P4).

Protocol adherence was at times challenging for the therapists, where it conflicted with concerns around the SU's clinical needs.

> *"What made it harder is having the protocol on the back of my mind thinking, oh, you know, we're taking things way slower than the guide suggests…should I push on or actually is it more clinically indicated that we take our time?"* (P7).

Therapists reported that becoming familiarised with the intervention increased their confidence, which created better flow in their delivery with regards to flexibility. Therapists eventually appreciated interweaving between the phases in the protocol.

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[2] 'P' refers to Participant.

"*I would see that I would get better at managing that flexibility and knowing when to push it a bit more and knowing when to draw back from maybe particularly the memory work, you know…so I think the flexibility is important"* (P11).

As such, this suggests that lack of flexibility would impede the strength of the perceived acceptability of TF-CBTp for therapists, as P11 explained:

"I think it's not going to work if it's with this client group, it has to be flexible" (P11).

Pressure for a timely start to the memory work

This subtheme relates to nearly all the therapists' concerns around meeting the milestones in the trial by supporting SUs to engage in memory work within an ideal timeframe.

"I guess I felt a bit of pressure to try and get the memory work, you know, underway as soon as possible because I'm aware of the focus of the trial being about that." (P9)

Therapists had to balance the concern for a timely start to the memory work with other priorities. For example, jumping to the memory work too early might impede on the overall engagement of the SU. This may also affect the progress of promoting or sustaining their self-efficacy, as the SU may not have yet developed the ability to cope with the distress of memory work and would risk perceiving this as a setback. Therapists faced a dilemma between maintaining the rapport and dealing with the SU's avoidance of memory work, which speaks to concerns with alliance ruptures as an unintended consequence.

"If they changed their mind, cancel the session, or say in a session they're not gonna do it, you have to be supportive of that. And that in some ways was good because it built the trust and the engagement, but in other ways was bad because ultimately they avoided memory work on the more significant traumas" (P16).

Some therapists acknowledged their own avoidance in starting memory work, indicating a parallel process of avoidance between the therapist and SU, which suggests that

addressing self-efficacy was important for both in achieving mastery. One therapist reported times when they focused on what content the SU brought in the session, putting the memory work on hold.

"I think sometimes my experience was that people would avoid it and come in with some other things going on, and suddenly the session would be over, and then you didn't have time to do it. So I do think there's a there's a level of avoidance, probably therapist avoidance as well" (P11).

Some therapists reflected that they could have started with the memory work earlier in hindsight.

"I actually think in hindsight maybe I could have got gone into the memory work quicker with her, but I sort of fluffed around doing promoting control for the sake of ticking it off" (P7).

Encouragingly, therapists found that this pressure was reduced when realising that engagement with the SU was paramount throughout the therapy process, and that protocol flexibility supported this. This became more apparent for therapists once they experienced using the intervention and acknowledged the complexity of the SU's experiences. As P2 explained:

"It's just not possible when it's such a range of complexity…as we've progressed in the trial…the kind of like my perception of that has changed and the essence of the trial is that this protocol has to be flexible in order for people to engage. For some people, those milestones work perfectly, and you can get through it …but that's just not the case for every single person coming through…you can't put that pressure on yourself to get that perfect milestone with every person within this client group" (P2).

Perceived stability of service users

This theme refers to the expectations around the SU's stability, and how it influenced the perceived acceptability of TF-CBTp. Stability in this context relates to the SU's psychosis and/or PTSD symptoms as well as their socioeconomic context.

Do we need to minimise symptom distress?

Some therapists expressed having initial concerns around the need to minimise symptom exacerbation and, as such, there was an expectation around needing to prioritise helping the SUs promote control over distressing experiences. This concern was important for therapists to consider when determining the acceptability of TF-CBTp.

> *"I thought of hypothesising that, what if we do the trauma work and it makes her voices worse, then this could elevate the risk from the command voices to harm herself and sometimes harm their children so I thought it might make sense to do more CBTp work"* (P5).

SUs achieving symptom stability provided therapists with reassurance that self-efficacy was strengthened and were then ready to engage in memory work. As such, several therapists spent more time on stabilisation work.

> *"At the beginning I have faffed a bit more in the first phase in terms of doing more stabilisation, actually because I needed the reassurance things were going to be okay in terms of the symptoms"* (P1).

When perceived risks and need for symptom stability remained, some therapists acknowledged that addressing the trauma memories would also help the SU to develop stability. This in turn strengthened their self-efficacy through resilience building.

> *"Of course, we work on those to try and minimise those and get people to a place of safety as much as we can, but the whole point is that we don't have to wait till those things have completely, you know, normalised…those things are responses to the*

trauma symptoms. So if we don't help them with the trauma symptoms, how can we help them to resolve those issues" (P9).

Concerns around addressing the experiences of psychosis

Some therapists highlighted the expectation of focusing on SU's distressing experiences of psychosis, and whether these experiences would disrupt the therapeutic work, particularly for therapists who were less familiar with working with psychosis. The integration of trauma-focused and psychosis work in TF-CBTp led therapists to question how this would be achieved. These initial expectations affected the therapists' perceived acceptability of TF-CBTp. For example, some therapists reported being preoccupied with the experiences of psychosis during their early cases.

"I think I got really hung up initially on, am I doing enough with unusual experiences? And I spent a long time, kind of doing extra reading and making sure I was aware of that…so that might have influenced early sessions where I was constantly trying to put it on the agenda because I didn't want to miss it just because I don't have that natural skill" (P1)

Therapists also expressed the importance of staying on track when focusing on SU's trauma memories, despite on occasion feeling compelled to focus on the experiences of psychosis. This conflicted with having to be flexible with the protocol and maintaining engagement.

"I think it can be difficult not to get pulled into other areas that are distressing for the clients such as voice hearing or other psychosis difficulties…but it's also really important that you're flexible and respond to the client's needs" (P13).

However, therapists also acknowledged that, at times, the experiences of psychosis were helpful to address. This also meant ensuring that SUs self-efficacy was enhanced by being supported to strengthen their skills around coping with distressing content.

"We'd sort of done some work on psychosis, or enough at least to kind of manage it and keep it at bay. So, it was kind of like, OK, that's OK, let's focus on this because this is, this is, you know, the reason that we're doing this" (P16).

What supported the therapists with this dilemma was recognising trauma and psychosis as intertwined experiences, and trusting in the therapeutic process that addressing PTSD experiences will also positively impact on the experiences of psychosis. This recognition and change in expectations enhanced the perceived acceptability of TF-CBTp.

"We're trying to get to the memory work and it's about like not feeling compelled to do that psychosis work that, you know, you could keep that on the backburner and keep targeting the memories with the view that targeting those memories is going have a secondary impact on the psychosis symptoms" (P2).

P8 explained how their initial perception, from seeing trauma and psychosis as two distinct experiences, changed.

"…at the beginning I was seeing things very black and white. This is separate from trauma. We're going in to see if we can reduce psychosis from treating trauma. But I think what I've realised is that they're not so distinct" (P8).

Service users having adequate personal resources

The perception of stability was also associated with the SU's social and living context and whether this would influence overall engagement and readiness in therapy, which led therapists to question the acceptability of TF-CBTp for SUs with less social stability.

"What I mean by readiness is you know some degree of stability in the living situation and in their social context and because you know when people are homeless or having lots of social services involvement or other stuff going on they just can't physically attend sessions" (P5).

Therapists felt that lack of social stability meant that the person's basic needs were a priority before they could engage in the intervention, given the duration and intensity of TF-CBTp. Lack of social stability also seemed to be a barrier in promoting self-efficacy due to personal circumstances that may hinder their opportunity to fully engage with TF-CBTp. As P15 explained:

> *"…being a single mum with children who get poorly and really struggling financially. So they quite often cancelled the appointment because they needed to get a food parcel and that obviously trumps seeing me because they need to feed their family. So it's harder for people to engage when they don't have those basic things…"* (P15).

Interestingly, some therapists took on a role outside of the boundaries of a typical therapist to help minimise social barriers, particularly for SUs without care coordinators. P9 shared this conflict in clinical supervision.

> *"I think the other thing has actually been stepping slightly outside of my role as a therapist. She doesn't have a care coordinator and I have ended up doing some care coordinator type things where I feel that…and I've always discussed in supervision first where I feel that it is relevant to what we're doing"* (P9).

This could mean that the acceptability of TF-CBTp may be dependent on systemic factors such as being under, or have good connections with, a multidisciplinary team, particularly for SUs with complex needs.

> *"I think it would be useful to be embedded within a team…just so that you're less stand alone and then your position is clearer"* (P1).

Rebuilding life goals as a main thread

According to participants, SUs were more likely to engage with TF-CBTp when their important values were linked to meaningful therapy goals. This was developed collaboratively by the therapists and SUs during the rebuilding life phase. Having this

threaded throughout the intervention sustained hope and motivation for the SU, thus promoting self-efficacy.

> *"You have rebuilding life goals right from the onset that run alongside through every session and that's really helpful. As you know, participants could see the progress they're making and and changes in their day-to-day life"* (P13).

The intervention was perceived to be more acceptable when it provided a platform for developing therapy goals centred around reclaiming their life.

> *"It [the intervention] can make a huge difference to people's lives. You know, this is a difference between somebody being kind of fearful and at home to kind of getting back into work and relationships and life"* (P14).

Addressing the ambivalence and avoidance

The four subthemes below speak to the therapeutic processes that therapists found helpful in addressing ambivalence and avoidance, which helped enhance the acceptability of TF-CBTp for the therapists as well as promoting the SU's self-efficacy. Therapists highlighted that this was challenging, yet important, for the initial engagement with the intervention and with therapeutic tasks, such as engaging with memory work or homework tasks to consolidate the skills in therapy.

> *"I guess the avoidance of the therapy… they wanted that input, but what they didn't want to do or what they didn't feel ready to do was go there in terms of actually doing the memory work in the session for example. So that was a difficulty"* (P16).

Believing in the intervention

This subtheme explains how the therapists' own confidence and positive expectations regarding the acceptability of TF-CBTp impacted on the therapeutic processes and outcomes. The therapists' belief about the intervention reportedly influenced how the SUs responded to it.

"I think if you weren't brought into it or if you were feeling really anxious or hesitant about doing it, then you wouldn't have the same outcomes or experience at all." (P9).

P12 talked about how it promoted hope for the SU:

"I'm very passionate about integrating TF-CBTp, I think that does influence kind of my enthusiasm for the approach…maybe that does instil some hope in clients because I have confidence in this will work, this will be helpful" (P12).

Therapists reported that displaying confidence to the SU enabled the SU to also believe in the intervention and thus be more willing to engage, promoting SU's self-efficacy.

"I think it's a general sense that I can feel confident that it works. So, I feel like I'm communicating that to them and that comes across in the way I'm you know, I can't, I can't promise anybody it's going to work but I think probably my sense of confidence and my reduced anxiety…I'm not scared of the work and that's really helping I think" (P5).

Shared understanding and rationale

An important aspect of any intervention is to support the person to feel able to engage and consolidate the knowledge and understanding of the tasks involved. By knowing the 'ins and outs' of the intervention, this strengthened the acceptability of TF-CBTp for the therapists. Furthermore, adapting the formulation to the SU's own experiences enhanced their self-efficacy by developing a rationale for tackling avoidance.

"So there might be a little bit avoidance or a little bit reluctance and I think on reflection targeting that early on and formulating that avoidance with patients has been really helpful" (P6).

Discussions regarding the transparent processes involved in TF-CBTp was one aspect that therapists found useful in addressing ambivalence experienced by SUs. This helped to

support SUs' informed decision-making process and anticipated outcomes. As P15 explained when a SU felt understandably anxious with the memory work:

"People are, I guess anxious about doing the memory work, but that's why that whole rationale and making sure that they're informed and they understand and they have a really clear formulation of why we're doing it is so important" (P15).

Highlighting the link between trauma and psychosis also helped in creating this shared understanding.

"... making sense of psychosis symptoms as a kind of unprocessed memory or you know an unprocessed experience linked to the trauma so the formulation is very helpful in terms of a conceptual merger of those things with them" (P2).

Empowering the service users

This relates to the importance of therapists promoting SU empowerment to address avoidance of engaging in therapy tasks, thus hoping to increase self-efficacy. All therapists reported that a strong therapeutic alliance facilitated the engagement of SUs with TF-CBTp, as well as maximising SU's confidence and trust with the therapy tasks. For example, as P13 explained:

"Unless you've got a good strong therapeutic relationship with your therapist, I think it would be incredibly difficult to do the memory work, it needs to feel like a safe enough space to work on that together" (P13)

Therapists also found that highlighting achievements to SUs promoted and sustained their self-efficacy, recognising their progress and sustaining the efforts made.

"...when a person achieves something that they've struggled to do or they've made an attempt at doing that and being able to kind of really reflect on any change that's been made and that they have made it. So I guess there's a kind of a sense of really recognising the work that they're doing as well within the session." (P11)

Therapists were aware of SUs wanting to identify positive changes. They felt that engendering 'quick wins' early in the therapy process helped to enhance the SU's self-efficacy – for example, by setting up small, achievable tasks.

"I think that idea of quick wins to start with for people is really helpful. People want some change. People want I think early on, when they're in that much distress, some ideas for how to help them as much as they want" (P2).

Another approach that therapists applied to promote empowerment in SUs was giving them choices in the decision-making process.

"I offered it as a choice point and so I kind of said we can do more work on this and we can move on to this and have explained what memory work involves and use metaphors and explained it I mean good idea videos at that point but we with erm offered a choice point" (P5).

Normalising experiences was also powerful, involving therapists using resource materials to help services users understand and manage the common effects of trauma in psychosis.

"I guess having really clear resources to draw on and including kind of videos but also material to kind of very quickly normalise experiences for people. You know, this stuff isn't just you and being able to kind of pull out resources to help people really kind of engage with that process" (P14).

Normalising setbacks was also a helpful facilitator when SU's progress was negatively impacted. This positively affected their self-efficacy, as they recognised setbacks as a learning opportunity.

"…having a setback sometimes can be a positive in the sense that you had an opportunity to learn that you know at times, flashbacks or trauma memories might

increase or you might feel more distressed but it's, you're in a different place now in terms of how you can manage that and what you could put in place" (P13).

Going above and beyond for the service user

An important aspect of promoting and sustaining SUs' self-efficacy was the therapists being proactive in maintaining engagement with, and consolidation of, therapy tasks (e.g., therapy homework). Therapists reported doing more 'checking in' between sessions, which meant devoting extra time to their SUs.

"It's just hard work for everybody and there's a lot of checking in between sessions. It's a lot on the therapist I think in that time and the client obviously… so it just takes a lot out of you resource wise I think" (P1).

Despite the additional time dedicated, therapists felt it was essential to support SUs who lacked a supportive network or resources to apply the therapy tasks outside the sessions. This was partially linked to the perception that the intervention was less acceptable for SUs with inadequate personal resources.

"I've been much more proactive and flexible with working with this client group who often don't have many other supporters around them…I'll do a lot more checking in… text in between sessions, prompt them, send little reminders, we'll make little cards like just anything that captures them so they see the point in doing it" (P4).

Training and supervisory needs

Receiving good training and supervision was associated with the perceived acceptability of TF-CBTp. Being trained in the intervention helped therapists to have a positive expectation in terms of its impact on the SU.

"I think the training really helps us to have positive expectations as well because many of the people who are training us have got lots of this experience and

communicated a sense of positive expectation and communicating the sense that it really helped people" (P5).

Therapists expressed challenges with the implementation of this intervention in clinical services related to training and supervision for clinicians.

"…that people would have training and that people would have access to regular supervision. So I think those would be the things that I would be hopeful for it going out to clinical practice…I think the resources and the protocol are very helpful…but would people be able to access the training" (P10).

Therapists also expressed how delivering TF-CBTp emotionally impacted them due to the potential intensity when addressing traumatic memories and their associated difficulties. This highlighted the importance of therapists using clinical supervision to process this impact, and that lack of clinical supervision would also adversely affect the acceptability of TF-CBTp.

"Because this is quite taxing work emotionally and it can have a personal impact. So I think that's an additional requirement of the supervision and you know that being a safe place to have those conversations alongside conversations about the delivery of therapy for example" (P16).

However, therapists acknowledged the potential constraints with implementing TF-CBTp in routine clinical services, impacting on the acceptability of the intervention outside of the clinical trial.

"The frequency of supervision currently in service settings is I think probably monthly for large caseloads. I think also managing the level of complexity and risk could be quite difficult unless you've got a really sort of good strong team approach" (P13).

P9 expressed whether such supervision arrangements are possible given that the expertise with TFIs in psychosis in clinical services is lacking.

"I think my biggest concern about implementing it outside of the trial is the supervision. I think that you can train people up quite well to do it, but it's probably finding people who already have expertise with psychosis or PTSD…but I don't know about supervisors" (P9).

Discussion

The present study is the first to explore therapists' experiences of delivering a trauma-focused intervention (TFI) for psychosis. Therapists were interviewed about their experiences of delivering trauma-focused cognitive-behavioural therapy for psychosis (TF-CBTp) in the Study of Recovery and Trauma (STAR), a randomised clinical trial (RCT) evaluating the clinical and cost-effectiveness of TF-CBTp. The aim was to explore the factors that impact the acceptability of TF-CBTp, how the therapists promoted and understood service user's (SU's) self-efficacy, and how their expectations impacted on the perceived acceptability of TF-CBTp. Five main themes were generated: i) 'Flexibility is key', ii) 'Perceived stability of service users', iii) 'Addressing the ambivalence and avoidance', iv) 'rebuilding life goals as a main thread', and v) 'Training and supervisory needs'.

The findings suggest that the protocol's flexibility enhanced the acceptability of TF-CBTp. Stringent protocols from TFIs acts as a barrier for clinicians, as it is perceived to limit the clinician in responding to the service user's (SU's) clinical needs (Finch et al., 2020). Kendall et al. (2008) highlighted that flexibility within fidelity is strongly recommended for evidence-based interventions to tackle this barrier. Other factors in the findings that strengthened the acceptability of TF-CBTp were the therapists believing in the intervention and the shared rationale behind the processes involved. This relates to Sekhon et al.'s (2017) theoretical framework of acceptability (TFA) regarding 'affective attitude' and 'intervention coherence'. Additionally, the findings suggest that therapists' perceived acceptability of TF-CBTp was determined by the SU's social circumstances, as therapists reported that this factor

posed challenges for SUs' engagement and readiness for TF-CBTp. Furthermore, the therapists' additional 'care coordinator' duties, to minimise social constraints to support engagement, was perceived as appropriate given the social inequalities that people with psychosis face (Dean, 2017). This suggests a significant amount of time and commitment is required for using this intervention effectively. Sekhon et al's (2017) TFA components of 'burden' and 'opportunity costs' relate to this issue, where the trial therapists perceive SUs' ability to engage with TF-CBTp can be impeded by SUs' difficult social circumstances and/or lack of personal resources. Training and supervision were an important factor in therapists' overall confidence in the acceptability and expectation of outcome of the intervention, which echoes the findings from van den Berg et al. (2016). Therapists also shared the personal impact of delivering TF-CBTp, and how using supervision to discuss challenging experiences supported their wellbeing and delivery. Research has shown that clinicians experience vicarious trauma working in various clinical settings (Jordan, 2010). The present study comports with this view, highlighting the importance of facilitating reflective spaces to support clinicians in managing the emotional demands of delivering TF-CBTp.

As positive self-efficacy is associated with positive recovery in psychosis (Ng et al., 2021), addressing self-efficacy may help SU's confidence and engagement with TF-CBTp. The therapists felt addressing ambivalence and avoidance played a key role in SUs' positive self-efficacy, as well as strengthening the perceived acceptability of TF-CBTp. Aligned with Tzur Bitan & Abayed's (2020) findings, normalising experiences and strong therapeutic alliance were key facilitators that empowered SUs by strengthening their motivation and confidence. This aligns with the concept of 'social persuasion' in self-efficacy (Bandura, 1986). Similar to the findings of Mankiewicz et al. (2018), therapists also reported that highlighting achievements and keeping rebuilding life goals present throughout sessions helped to promote 'mastery experiences' associated with self-efficacy (Bandura, 1986; 2001).

Overall, a combination of therapeutic approaches is needed to overcome the challenges presented by setbacks, avoidance, motivation, and perseverance associated with self-efficacy (Benight & Bandura, 2004).

Regarding the expectations of delivering TF-CBTp, therapists expressed challenges with balancing their flexibility and adherence to the protocol because of the limited timeframe, which initially influenced the therapists to question the acceptability of TF-CBTp (i.e., whether flexibility could be fully achieved). These concerns were reduced by better consolidation of the protocol through experience. Of note, being a trial therapist differs from working in clinical services, regarding the level of scrutiny with competence and adherence to the protocol in clinical trials (Kendall et al., 2008). Moreover, the findings showed that therapists' initial concerns around symptom stability and psychotic experiences affected their pacing of sessions and delayed memory work. Therapists initially expected that TF-CBTp would be more acceptable if symptom stability could be achieved and sustained. This accords with previous findings regarding clinicians' ambivalence towards TFIs concerning client safety and symptom exacerbation (Farrell et al., 2013; Foa et al., 2013). Interestingly, the findings described a parallel process of avoidance occurring between the therapist and SU with memory work, thus both the therapist and SU needed to strengthen their own self-efficacy. This might be associated with the intolerance of uncertainty proposed by studies exploring clinicians' reluctance to using exposure therapies (Turner et al., 2014; Waller & Turner, 2016). Conversely, negative expectations changed for therapists following better familiarity of the intervention, and trust in the effects of memory work on distressing symptoms. The change towards positive expectations influenced a reduction in their concerns around delivering TF-CBTp, and may have strengthened the perceived acceptability of TF-CBTp as well as SU engagement. This relates to previous findings where therapists' positive

expectations predicted SU engagement and therapy outcome (Connor & Callahan, 2015), while negative expectations predicted the opposite (Deacon & Farrell, 2013).

Overall, the components of 'affective attitude, 'intervention coherence' and 'self-efficacy' in the TFA (Sekhon et al. 2017) seem to be interrelated by the knowledge and understanding of the processes involved with TF-CBTp. Therapists reported that their positive beliefs and better understanding of TF-CBTp, as well as their role in helping SUs to better understand the intervention, helped in strengthening confidence and engagement with the intervention, highlighting another parallel process occurring.

Researcher's Reflexivity on the Findings

The present findings drew on factors that enhanced or impeded the acceptability of TF-CBTp and SUs' self-efficacy, based on the therapists' experiences. The researcher's trainee status may have enabled the therapists to feel safer and less judged during the interviews. The researcher also noted how initially the therapists focused on the positive aspects of delivering TF-CBTp, which led the researcher to adapt their interview strategy by including questions around the challenges faced by the therapists. The researcher acknowledged that the way they read the transcripts and interpreted the findings was shaped by familiarity with the therapeutic processes and relating to the therapists' experiences with their own experiences (e.g., the challenges of achieving flexibility in manualised therapies). Given that there is a dominant narrative around the risks of delivering TFIs in psychosis (Burger et al., 2023), the findings interpreted may have been partially influenced by the researcher's hope to promote a better perception of TF-CBTp. These were managed by critical discussions with the research supervisor during the coding and themes development, and further in-depth reading on the therapeutic approaches for psychosis and PTSD.

Strengths and Limitations

This is the first study to explore the experiences of therapists using a novel, integrated TFI in psychosis. Seventeen participants were interviewed, which can be deemed a good sample size for data saturation for qualitative studies (Hennink & Kaiser, 2022).

Regarding limitations, participants were employed as trial therapists to deliver TF-CBTp, potentially resulting in selection bias. Participants may have felt compelled to advocate for TF-CBTp, so the validity of the research may be affected. However, participants' background and experiences varied prior to the trial. For example, not everyone had expertise either in using trauma-focused or CBTp interventions and not everyone was experienced both in PTSD and/or psychosis. The participants were new to using the integrated approach and the findings captured a range of experiences.

Participants recalling their experiences retrospectively may have affected the accuracy when capturing their expectations prior to being trained, and their views may have been clouded by having already used the intervention. Longitudinal interviews could have better explored how their expectations changed over time (Carduff et al., 2015), by comparing participants' perceptions and expectations prior to and after delivery. Nonetheless, participants were candid in reporting their prior anxieties regarding the intervention and how this changed over time, indicating a subjective recognition that their perspectives had shifted over time.

It is uncertain whether the approaches that the therapists shared in addressing self-efficacy reflected the actual experiences of the SUs. A study of SU's experiences in STAR is currently underway, which will help determine whether its findings will be complementary to the present findings.

Research and Clinical Implications

Limited research on therapists' experiences of using TFIs in psychosis may reflect a relatively low uptake of TFIs in psychosis by clinicians. Investigating how often this is used in clinical services (e.g., via surveys) can help clarify this. Further exploration of therapists using TF-CBTp and other TFIs outside of clinical trials is recommended, to help evaluate the current acceptability of the intervention within routine clinical services, and factors that can improve its acceptability. Another approach to evaluate the acceptability is evaluating both the therapists' and SUs' experiences of TF-CBTp, using the Sekhon et al's (2017) TFA to translate and improve implementation.

The findings indicate that effective training would help to strengthen the acceptability of TF-CBTp. For implementation purposes, supervised training is vital to the quality of treatment delivery (Schoenwald et al., 2013). Due to the potential long duration of TF-CBTp, this questions the extent to which clinical services can facilitate this due to systemic constraints on service provision in the UK (Finch et al., 2020). Adequate supervision by therapists with expertise in trauma and psychosis would be warranted. Supervision should also involve space for therapists to process the potential emotional impact of delivering TF-CBTp. Consideration should be given to the number of cases and time commitment to minimise negative consequences, such as staff burnout and potential vicarious trauma (Ward-Brown et al., 2018). Informing clinical services regarding the effectiveness and low risk of symptom exacerbation in TFIs for psychosis should be a priority in addressing systemic barriers to implementation. This would also help defuse preconceptions and promote better understanding for SUs when recommending the treatment.

Conclusion

This study provided insight into therapists' perception of the acceptability of TF-CBTp. It also provided useful insights into how they promoted SUs' self-efficacy when

delivering an intensive therapy. Positive changes in initially negative expectations were influenced by therapists' experiences of delivering the intervention as well as the recognition of flexibility in the TF-CBTp protocol. The findings highlight the complexity of evaluating the acceptability of interventions, given the multiple domains involved in acceptability for clinicians and SUs. Future research should include further exploration of therapists' experiences in delivering TFIs for psychosis to evaluate their acceptability and related therapeutic processes in addressing self-efficacy, as these remain under-investigated. This can help complement the quantitative findings of RCTs in terms of its effectiveness and improve the implementation and delivery of the intervention in routine clinical services.

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Section C: Appendices and Supporting Materials

Appendix A: Critical appraisal of 19 studies reviewed using the CASP (2018) framework

Authors	Clear statement of aims?	Appropriate methodology	Appropriate design	Appropriate recruitment strategy?	Appropriate data collection method?	Adequate consideration of researcher – participant relationship?	Consideration of ethical issues?	Rigorous data analysis?	Clear statement of findings?	How valuable is the research?
Amsalem et al (2021)	Yes	Yes	Yes	Yes	Yes	No	Yes	Unsure	Yes	Yes
Ashwick et al (2019)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Bosch et al (2021)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Boterhoven de Haan et al (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Chadwick & Billings (2022)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Doran et al (2021)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Doran et al (2019)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Edmond et al (2004)	Yes	Yes	Yes	Yes	Yes	No	Yes	Unsure	Yes	Yes
Frueh et al (2006)	Yes	Yes	Yes	Yes	Partially	No	Yes	Yes	Yes	Yes
Hardy et al (2022)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Hasandedic-Dapo (2021)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Hundt et al (2020)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

Hundt et al (2017)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Kehle-Forbes et al (2022)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Kemal Kaptan et al (2021)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Meis et al (2022)	Yes	Yes	Yes	Yes	Yes	No	Partially	Yes	Yes	Yes
Shearing et al (2011)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Valentine et al (1998)	Yes	Yes	Yes	Yes	Yes	No	Partially	Yes	Yes	Yes
van Gelderen et al (2020)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

Appendix B: STAR Therapy Protocol

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Appendix C: Interview Schedule

The STAR (Study of Trauma and Recovery) project: Follow-up qualitative interview topic guide for therapists

The order and exact content of the questions will be determined by the structure and progress of the interview. The following topics and prompts serve as an initial interview guide only. Prompts will be used flexibly.

- *Introduce self, thank participant for attending.*
- *Explain purpose of interview (i.e., acceptability and feasibility of STAR therapy from therapists' perspective), stressing interest in both positive and negative views/experiences, and recommendations for future implementation.*
- *Outline relevant issues around use of data, including confidentiality and right to withdraw, issues around information sharing in the event of risk (i.e., when it may be necessary to break confidentiality)*

Could you tell me about your experiences working with people with both psychosis and PTSD prior to the trial?

- *What interested you in working in this area?*

What were your expectations of delivering the intervention?

- What were your hopes and concerns about integrating the two approaches of CBTp and trauma-focused work?
- *In what ways, if any, did your expectations impact on the therapy process?*
- *How did your expectations compare to the experience of actually delivering it?*
- *In what ways, if any, have your thoughts changed over time?*

What were your experiences of delivering the intervention?

- How did you find the integration of trauma-focused and psychosis work?
- What benefits and challenges did this raise?
- How did you manage the challenges?

Could you tell me about your experience with the service users engaging with the therapeutic tasks?

- *How did you promote their confidence in the face of aversive experiences?*
- *How did you help them to sustain the efforts made?*
- *What setbacks, if any, were there with the participant's progress in therapy?*
- *What were the facilitators and obstacles to this work?*
- *What challenges did you face?*
- *How do you make sense of these challenges?*

What was your experience with the therapeutic relationship?

- *What challenges did you face?*
- *How do you make sense of these challenges?*
- *What did you do to respond to these challenges?*

What was your experience of the impact of TF-CBTp?

- *What about its impact on the service users?*
- *How did your views influence the way you delivered the therapy?*
- *What about the impact of on the service user's experiences of psychosis?*
- *What about its impact on you as a therapist?*
- *In what ways can the intervention be made tolerable?*
- *Any views on its implementation outside the trial?*

(NB. If the participant self-introduced any of the above prompts, further prompt: "Could you tell me more about…")

Appendix D: Participant information sheet and informed consent form

The STAR Trial (Study of Trauma And Recovery): My experience of delivering TF-CBTp

My name is Gary Ngai, Trainee Clinical Psychologist (gn108@canterbury.ac.uk) and my supervisors are Dr Raphael Underwood, Lead Investigator and STAR Trial Coordinator (raphael.underwood@slam.nhs.uk), and Dr Alan Hebben-Wadey, Salomons Internal Supervisor (Alan.Hebben-Wadey@canterbury.ac.uk). We would like to invite you to take part in our research study about your experiences of delivering trauma-focused cognitive behavioural therapy for psychosis (TF-CBTp) in the STAR trial.

Aim of the study
We are interested to hear your experiences in delivering TF-CBTp in helping people with trauma and psychosis in the STAR trial. We would like to hear the processes involved that helped you to deliver the therapy, including the challenges you faced. This will help us have a better understanding of the acceptability of TF-CBTp and your views about using this integrated approach for people in the future.

Do I have to take part?
It is entirely up to you to decide whether you want to take part. Even after you agreed to take part, you are still free to withdraw at any time, and you don't need to give a reason.

What will happen if I take part?
If you choose to take part, you will be invited to attend an interview meeting with myself. You will have the opportunity to find out more about the study, go through this information sheet, and sign a study consent form if you agree to take part.

During the interview, I will ask about your experience of delivering the therapy in the STAR trial. All questions are optional, and you do not have to answer anything you do not want to. You can also stop the interview at any time and are free to specify if you would like anything you have said to be deleted or replaced. The interview will last for around one hour.

The interview will be conducted remotely through online video call, and it will be recorded using encrypted recording devices. Only specific members of the research team can access them.

All of the information that you share will remain confidential. However, if there are any concerns with your safety or someone else's safety, including issues around malpractice, we may need to share the disclosed information to others. You will be fully informed of the process should this event occur.

What happens after the interview?
The interviews will be transcribed and analysed. The transcripts will be anonymised, meaning no information that could identify you personally will be included. We will anonymise quotes in the transcripts by removing all names and information that could link to you personally. Supervisors of this research project will not have access to the full transcripts, although some of the quotes may be looked at by them in the data analysis. Quotes from the interviews may be included in STAR trial scientific papers, at conferences, on the STAR trial website and promotional materials. It will not be possible to identify anyone from these quotes. We will also make a summary of the results available to everyone who has taken part.

How will my information be kept secure?
Your data will be processed in accordance with the General Data Protection Regulation 2018. All information we collect for the study will be kept securely and anonymously on password-protected

computers on a secure University or NHS network. It will be identifiable by a participant number, not your name. A document with your name and participant number will be kept securely and entirely separately from recording and typed interview.

With your agreement, we will keep anonymised research data (i.e., data that cannot be traced back to you) indefinitely for future ethically approved research but you will not be identified at all. Your personal details (i.e. your name and job role) will be kept in a separate place for up to 10 years in line with information governance guidelines, and then will be confidentially destroyed.

What are the advantages of taking part?
Sharing your experiences will help shape and improve the therapy. It will also help us evaluate the acceptability of TF-CBTp and how this integrated approach can be best delivered.

What are the disadvantages of taking part?
We appreciate that talking about your experiences of delivering TF-CBTp may cause some discomfort or distress. However, you do not have to disclose anything that you are not comfortable with and you can terminate the interview and withdraw your consent at any time. You can also take a break from the interview if any discomfort or distress arise. If you need further support, please speak to your trial supervisor or manager who will help advise the supporting procedures in place. Please also see 'What if there is a problem?' section below.

As the lead investigator may also access the transcript, you may be concerned that the transcript will be recognisable. Any personal information that is identifiable such as names of people and places will be completely anonymised to maximise confidentiality.

As mentioned, there are limitations to confidentiality. Any concerns regarding your safety, someone else's safety, or concerns with malpractice will be shared to the STAR trial team.

What if there is a problem?
If you have a concern about any aspect of this study, you can get in contact with me or Raphael Underwood and we will do our best to address your concerns. You can email us to arrange a suitable time to speak to one of us. If you remain dissatisfied and wish to complain formally, you can do this by contacting Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology (fergal.jones@canterbury.ac.uk).

What if I would like more information or want to get in touch?
If you would like to ask any questions or receive more information about the study, please contact:

Researcher:	Gary Ngai (gn108@canterbury.ac.uk)
Project Lead Investigator:	Dr Raphael Underwood (raphael.underwood@slam.nhs.uk)
STAR Principal Investigator:	Dr Emmanuelle Peters (Emmanuelle.Peters@kcl.ac.uk)
Salomons Internal Supervisor:	Dr Alan Hebben-Wadey (alan.hebben-wadey@canterbury.ac.uk)

Thank you for reading. Please keep a copy of this information sheet.

Participant Informed Consent Sheet

Please add initials in each box if you agree to each statement

1. I confirm that I have read and understand the Information Sheet for the above study. I have had the opportunity to consider the information and ask questions. I have had these answered to my satisfaction. ☐

2. I understand that my participation is my choice and that I am free to withdraw at any time without giving any reason. My legal rights will not be affected. The research team will keep the data I have provided if I am to withdraw. ☐

3. I understand that some of the data in the transcript may be looked at by my supervisors, although they will not have access to the full transcripts ☐

4. I understand that all identifiable information in the transcript will be fully anonymized ☐

5. I understand that the anonymised direct quotes from my interview may be used for publication of the research. ☐

6. I agree to any relevant adaptations to my involvement in the study being put in place to ensure my health and safety during the COVID-19 pandemic ☐

7. I agree to take part in the above study. ☐

OPTIONAL: ***Please add initials in each box if you agree to each statement***

I agree for the anonymised direct quotes from my interview can be used to support other research in the future and may be shared with other researchers. ☐

_______________________	_______________________	_______________________
Name of therapist	Date	Signature
_______________________	_______________________	_______________________
Name of person taking consent	Date	Signature

Appendix E: Participant background information form

Participant no:

<table>
<tr><td colspan="3">Age:</td></tr>
<tr><td colspan="3">Gender</td></tr>
<tr><td colspan="2">Female
Male
Non-binary
Other</td><td>Prefer not to say</td></tr>
<tr><td colspan="3">Ethnicity</td></tr>
<tr><td>Asian, Asian British, Asian English, Asian
Bangladeshi
Indian
Pakistani
Any other Asian background - please specify:</td><td>Black, Black British, Black English, Black Scottish or Black Welsh
African
Caribbean
Any other Black background – please specify:</td><td>Mixed
White & Asian
White & Black African
White & Black Caribbean
Any other Mixed background – please specify:</td></tr>
<tr><td>White
British - English
British – Scottish
British – Welsh
Any other British (white) background – please specify:

Irish
Any other White background – please specify:</td><td>Other Ethnic Background
Chinese
Middle Eastern/North African
Any other background – please specify:</td><td>Prefer not to say</td></tr>
<tr><td colspan="3">Professional role:</td></tr>
<tr><td colspan="3">Number of years qualified:</td></tr>
<tr><td colspan="3">Current number of cases seen for the trial:</td></tr>
<tr><td colspan="3">Years of clinical experience (post-qualification) working with the following presentations prior to the trial:

PTSD only:

Psychosis and general trauma:

Psychosis and PTSD:</td></tr>
<tr><td colspan="3">Have you ever used trauma-focused approaches working with people with psychosis and PTSD prior to the trial?
Yes/No

If yes, how many years of experience?</td></tr>
</table>

Appendix F: Abridged bracketing interview

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Appendix G: Abridged research diary

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Appendix H: NHS Ethics and SLaM Research and Development Approvals

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Appendix I: University Approval

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Appendix J: Letters of Access for each of the five NHS Foundation Trusts

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Appendix K: Extracts of coded transcripts

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Appendix L: Theme development processes

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Appendix M: Summary Report to Ethics Committee

Therapists' experiences of delivering trauma-focused cognitive-behavioural therapy for psychosis (TF-CBTp) in the Study of Trauma and Recovery (STAR) randomised clinical trial (RCT)

Background

Only a few studies have explored clinician's experiences of trauma-focused therapy in psychosis, but none have qualitatively captured the perceived acceptability and experiences involved with delivering the intervention for people with psychosis. Given the perceived risk concerns around using trauma-focused therapies in psychosis, it is important to further investigate the acceptability of this intervention. This includes looking at therapist's experiences of addressing the self-efficacy of service users receiving the intervention. This will help clarify the barriers and facilitators to implementation in routine clinical services.

Aim

The study sought to explore the experiences of STAR trial therapists' delivery of TF-CBTp in the STAR RCT and investigate the factors that impact on the acceptability of the intervention. The study also aimed to explore how the therapists promoted service users' self-efficacy and how the therapists' expectations impacted their perceived acceptability of TF-CBTp.

Method

Semi-structured interviews were conducted with 17 trial therapists. Data was analysed using reflexive thematic analysis.

Findings

Five themes were generated from the data: ‘Flexibility is key’, Perceived stability of service users’, ‘Rebuilding life goals as a main thread’, ‘Addressing the ambivalence and avoidance’, and ‘Training and supervisory needs’.

Therapists reported that the acceptability of TF-CBTp was enhanced by the flexible nature of the protocol, the effective training received, and the opportunity to use clinical supervision to process the emotional impact of delivering the intervention. The acceptability of the intervention was also partially determined by the social stability of service users, as service users with less personal resources and challenging social circumstances may hinder their readiness engaging with the therapy. According to the trial therapists, the key facilitator that helped promote the service users’ self-efficacy was addressing the ambivalence and avoidance throughout the therapy process, which included empowering the service users, strong therapeutic alliance, sharing knowledge and understanding of the intervention and its therapy tasks. Although therapists’ negative expectations (related to the pressure of protocol adherence, concerns in managing distressing symptoms) initially impacted their pacing and delivery of the intervention, this changed through the course of delivering the intervention.

Research and Clinical Implications

The findings indicate that effective training would help to strengthen the acceptability of TF-CBTp. For implementation purposes, supervised training is vital to the quality of treatment delivery. Adequate supervision by therapists with expertise in trauma and psychosis would be warranted. Supervision should also involve giving space for therapists to process the emotional impact that may come with delivering TF-CBTp. Informing clinical services regarding the effectiveness and low risk of symptom exacerbation in TFIs should be a priority

in addressing systemic barriers with implementation. This would also help defuse preconceptions and promote better understanding for SUs when recommending the treatment. Future research should include further explorations of therapists' experiences in delivering TFIs to evaluate their acceptability and related therapeutic processes in addressing self-efficacy, as these remain under-investigated. This can help complement the quantitative findings of RCTs in terms of its effectiveness and improve the implementation and delivery of the intervention in routine clinical services.

If you would like further information, please contact me (g.ngai108@canterbury.ac.uk) or Dr Raphael Underwood, STAR Trial Coordinator (raphael.underwood@slam.nhs.uk).

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Appendix N: Author Guidelines for Submission to the British Journal of Clinical Psychology

Aims and Scope

The *British Journal of Clinical Psychology* publishes original research, both empirical and theoretical, on all aspects of clinical psychology:

- clinical and abnormal psychology featuring descriptive or experimental studies
- aetiology, assessment and treatment of the whole range of psychological disorders irrespective of age group and setting
- biological influences on individual behaviour
- studies of psychological interventions and treatment on individuals, dyads, families and groups

For specific submission requirements, read the Author Guidelines.

The Journal is catholic with respect to the range of theories and methods used to answer substantive scientific problems. Studies of samples with no current psychological disorder will only be considered if they have a direct bearing on clinical theory or practice.

The following types of paper are invited:

- papers reporting original empirical investigations;
- theoretical papers, provided that these are sufficiently related to empirical data;
- review articles, which need not be exhaustive, but which should give an interpretation of the state of research in a given field and, where appropriate, identify its clinical implications;
- Brief Reports and Comments.

Manuscript Categories and Requirements

Papers describing quantitative research should be no more than 5000 words (excluding the abstract, reference list, tables and figures). Papers describing qualitative research (including reviews with qualitative analyses) should be no more than 6000 words (including quotes, whether in the text or in tables, but excluding the abstract, tables, figures and references). Brief reports should not exceed 2000 words and should have no more than one table or figure. Any papers that are over this word limit will be returned to the authors. Appendices are included in the word limit; however online appendices are not included.

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Refer to the separate guidelines for **Registered Reports**.

All systematic reviews must be pre-registered and an anonymous link to the pre-registration must be provided in the main document, so that it is available to reviewers. Systematic reviews without pre-registration details will be returned to the authors at submission.

Preparing for submission

Free Format Submission

British Journal of Clinical Psychology now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer (If you do submit separate files, we encourage you to also include your figures within the main document to make it easier for editors and reviewers to read your manuscript, but this is not compulsory). All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

Important: the journal operates a double-anonymous peer review policy. Anonymise your manuscript and prepare a separate title page containing author details. *(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)*

- An ORCID ID, freely available at https://orcid.org. *(Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)*

To submit, login at **https://wiley.atyponrex.com/journal/BJC** and create a new submission. Follow the submission steps as required and submit the manuscript.