Narrative Exposure Therapy in Early Intervention in Psychosis services: Expert by experience and clinician views

Rachel Sparrow

D.Clin.Psy Thesis (Volume 1) 2022

University College London

UCL Doctorate in Clinical Psychology

Thesis declaration form

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

Signature:

[redacted]

Name: Rachel Sparrow

Date: 16th June 2022

Overview

Traumatic events (in particular, multiple and repeated traumatic events) have been linked with an increased risk of developing psychosis. Clinical guidance recommends the use of interventions recommended for post-traumatic stress disorder (PTSD) for trauma-focused work with people experiencing psychosis. As an intervention developed specifically for use with people reporting multiple trauma histories, Narrative Exposure Therapy (NET) may be an appropriate and beneficial intervention for this group.

Part 1 is a qualitative meta-synthesis. Thirty two qualitative studies of first-hand accounts of psychosis were reviewed and synthesised, with the aim of exploring connections made by Experts by Experience (EbE) between their experiences of traumatic events and of psychosis. Findings indicate that people link a broad range of traumatic events and life stressors to the onset of psychosis, and outline some of the pathways by which EbE link past events with subsequent psychosis experiences.

Part 2 is a qualitative study exploring EbE and clinician experiences of NET in an Early Intervention in Psychosis (EI) service. Interviews were conducted with four EbE and eight clinicians, and analysed using thematic analysis. The findings suggest that NET is a meaningful and emotionally-demanding intervention which can help people create a new ‘unburdened’ relationship with traumatic memories. Considerations are shared related to the preparation for and monitoring of distress during the intervention, as well as psychosis-specific factors relevant to the implementation of NET in EI services.

Part 3 is a critical appraisal of the research process. It explores dilemmas and reflections related to the conceptualisation of trauma in clinical work and research, experience of the role transition from ‘clinician’ to ‘researcher’, and reflections related to power and social identity.

Impact statement

While clinicians and researchers have contributed psychological perspectives on the nature of links between traumatic events and psychosis, there has not to date been a synthesis of how Experts by Experience (EbE), themselves, make sense of such links. The findings of Part 1 of this thesis attempt to bridge this gap by synthesising trauma-psychosis links mentioned in first-hand accounts of psychosis. These findings may hold relevance to the following groups:

1. **Academics and researchers:** Themes related to trauma-psychosis links may inform future research and developments in explanatory models. Widespread lack of demonstration of researcher reflexivity may identify this as a future research need, especially in research exploring EbE subjective experiences.
2. **Clinicians working in psychosis services:** Increased understanding of themes important to EbE can inform the process of assessing, formulating, and intervening with traumatic and psychosis-related experiences. A deeper understanding of themes important to EbE can help these to be prioritised, alongside those privileged in existing psychological models.
3. **People accessing psychosis services:** Access to themes and ideas important to EbE through research can help inform interventions offered to people currently accessing psychosis services.

Given the particular association between multiple/repeated traumatic events and psychosis, Narrative Exposure Therapy (NET) may be an appropriate and effective intervention for use in Early Intervention in Psychosis (EI) services; to date, there has not yet been a qualitative exploration of experiences of NET in this setting. As a naturalistic study, the findings of Part 2 of this thesis reflect real-world challenges and experiences encountered in a live clinical setting. The findings may benefit the following groups as described:

1. **Academics and researchers:** EbE and clinician experiences can inform psychosis-specific adaptations to NET, which may be useful for future effectiveness studies (such as randomised

controlled trials). Research may consider the emotional and cognitive demands of the intervention, and what adaptations may mitigate these.

2. **Healthcare providers:** This thesis suggests that NET is valued by EbE and clinicians in EI settings. Given the importance placed on specialist training and supervision, healthcare providers may consider provision of this more widely. Moreover, service providers may consider how to mitigate the barriers to NET implementation identified by clinicians (e.g. time in job plans, whole-team understanding).
3. **Clinicians working in EI services:** An increased understanding of EbE experiences of NET may support clinicians to tailor the intervention to meet the needs of EbE- for example, monitoring distress throughout the intervention, and increased awareness of helpful trust-building processes. Shared understanding of common clinician experiences and barriers may help clinicians contribute to service-level thinking about mitigating these barriers.
4. **People accessing EI services:** A developing body of NET research may inform future guidance around trauma-focused interventions in EI services, which may increase the availability of these in the future. Improved clinician understanding of EbE experience of NET, plus further research into adaptations, may improve the acceptability and effectiveness of NET for EbE.

Table of Contents

Acknowledgements

I would first like to acknowledge the generosity of everyone who participated in this research. Thank you for the time and experiences you shared with me- without them, this project could not have taken place. I have been inspired by your openness and willingness to share so much of yourselves, and hope that I have done justice to your stories. I am also extremely grateful to all the Early Intervention clinicians who supported the recruitment process and helped me muddle through various practicalities.

Thank you to Prof. Chris Barker and Dr Katy Robjant for sharing your respective qualitative and NET wisdom in the process of developing the project and the interview schedules. Thank you also to the UCL Experts by Experience who were incredibly generous with their time and support in developing the research documents.

To my friends and family- thank you for bearing with my disappearances, stresses and panics, and for sharing in my highs and celebrations. Your cheerleading has carried me through late nights, early mornings and existential crises, especially during this final stretch (and especially in the final days). To my DClinPsy cohort; there are so many memories from the last three years that I will treasure and many more to make- thank you for the fun and friendship which has made this training journey all the more meaningful.

Finally, a massive thank you to Dr Miriam Fornells-Ambrojo. Your patience, boundless knowledge, kindness and humour has made what has often felt like a mountain… still feel like a mountain (!), but a much sunnier one. Thank you.

Part I: Systematic review

Trauma and psychosis: A qualitative meta-synthesis of expert by experience views

Introduction

Recent developments in the theoretical understanding of psychosis recognise the risk posed by adverse life events in the development of anomalous experiences (e.g. Morrison et al., 2003). Higher rates of adverse life events are reported by people diagnosed with psychosis compared to the general population (Bonoldi et al., 2013; Kessler et al., 2010), and childhood adversity has been strongly associated with increased risk of psychosis (Varese et al., 2012). People may be at an increased risk when exposed to repeated or multiple traumatic events, suggesting a dose-type relationship (Croft et al., 2018; Shevlin et al., 2007).

Models of post-traumatic stress disorder (PTSD) propose that memory encoding is affected by stress-induced neurobiological changes during an adverse event; this results in memories high in emotional salience but lacking contextual information related to the 'when' and 'where' of the event which can emerge intrusively as 'flashbacks' (Brewin & Burgess, 2014). Given the overlap between psychosis-related experiences (e.g. voices and fixed beliefs) and PTSD-related experiences (e.g. flashbacks and hypervigilance), some suggest psychosis can be explained similarly, though with a greater focus on external appraisal with psychosis, versus internal with PTSD (Hardy, 2017; Morrison et al., 2003). The mechanism may vary depending on the form of the anomalous experience; a recent meta-analysis suggest that emotional dysregulation, hyperarousal, avoidance and dissociation mediate the relationship between traumatic events and the development of hallucinations, whereas negative schemata does so between traumatic events and delusions or paranoia (Bloomfield et al., 2021).

Existing models of psychosis have been criticised as privileging biological and neurological factors, at the expense of psychosocial factors and personal meaning (Boyle, 2002; Johnstone, 2011). Individuals have unique, multi-faceted explanatory models for experiences of distress, informed by cultural, familial, spiritual and socio-political narratives (Bhikha et al., 2012; Boydell et al., 2010; Owiti et al., 2015). Qualitative research enables the exploration of subjective experiences and meaning, which can subsequently inform formulation and intervention developments (Barker et al., 2016). Syntheses of qualitative research into Experts by Experience (EbE) understanding of psychosis have highlighted positive and distressing impacts; the difficulty (for some) in making sense of such experiences; and variation in EbE and family perspectives (Griffiths et al., 2019; Jordan et al, 2018; Noiriel et al., 2020).

To the authors' knowledge there are no qualitative syntheses directly exploring how EbE understand the potential impact of traumatic events on the development of psychosis. This review, therefore, aims to investigate connections drawn (or not) by individuals between past traumatic events and their subsequent experiences of psychosis.

Methods

Inclusion and exclusion criteria

Inclusion and exclusion criteria (Table 1) were developed in collaboration with the research supervisor (MFA). The researchers included studies focused on anomalous experiences of any classification (i.e. diagnosed and self-identifying 'non-clinical' populations). This is in line with continuum models of psychosis, which propose that the anomalous experiences reported by people diagnosed with psychosis are at increased severity, frequency and/or conviction than those reported by non- and sub-clinical populations, rather than being structurally distinct (DeRosse & Karlsgodt, 2015; van Os et al., 2008). The definition of 'traumatic events' adopted went beyond that provided in Criterion A of the DSM-V (APA, 2013) in terms of event type in order to capture a range of adverse life experiences in childhood and adulthood which have been linked to psychosis, such as bullying, victimisation, separation and bereavement (Carr et al., 2018; Kelleher et al., 2013; Read et al., 2009; Trotta et al., 2015).

The meta-synthesis focused on self-drawn connections between past traumatic events and subsequent experiences of psychosis. Papers were initially included if past traumatic events were mentioned in relation to subsequent experiences of psychosis, and were retained if they provided sufficient qualitative content for re-analysis; thus the aim was to prioritise inclusion to ensure enough studies for a meaningful analysis, but not too many as to compromise on the conceptual richness of the analysis, as has been observed in larger synthesis (Lewin et al., 2015; Soilemezi & Linceviciute, 2018). It was beyond the scope of the review to explore the traumatic impact of psychosis itself as the current review focuses on expert by experience understandings of the role of traumatic events in the development of psychosis, though this is an area of growing interest and importance and has been reviewed and synthesised elsewhere (Buswell et al., 2021; Fornells-Ambrojo et al., 2016).

Table 1. Inclusion and exclusion criteria

Studies were included if:	Studies were excluded if:
1) The study was a piece of qualitative research.	1) They were systematic reviews, literature reviews, meta-analyses or meta-syntheses.
2) They recruited people reporting anomalous experiences (operationalised by formal psychosis diagnoses, or self-identification [e.g. sub-clinical voice-hearing])	2) They reported insufficient qualitative content about past traumatic events and psychosis for re-analysis in the meta-synthesis (e.g. no participant quotations, limited elaboration of themes).
3) There was qualitive content available related to traumatic events and experience of psychosis	3) They were case studies which did not report expert by experiences' own views
a. History of traumatic events preceding the onset of psychosis was mentioned as part of explaining or understanding its causes.	4) They were book chapters, abstracts, protocols or theory-oriented papers with no analysis of participant experience of psychosis.
4) Full-text, English-translated versions of the articles were available.	

Search terms

Studies were identified through searches in three electronic databases (PsychINFO; Medline; Web of Science), and two further databases focused on grey literature (PsychEXTRA; Proquest Theses and Dissertations). Searches were conducted on 31st December 2021, retrieving references from the earliest record available until present day. Search terms focused on four topics central to the research question- psychosis, trauma, qualitative methodology and lived experience (Table 2). The search terms were refined with the research supervisor and subject librarian, to ensure suitability and rigor.

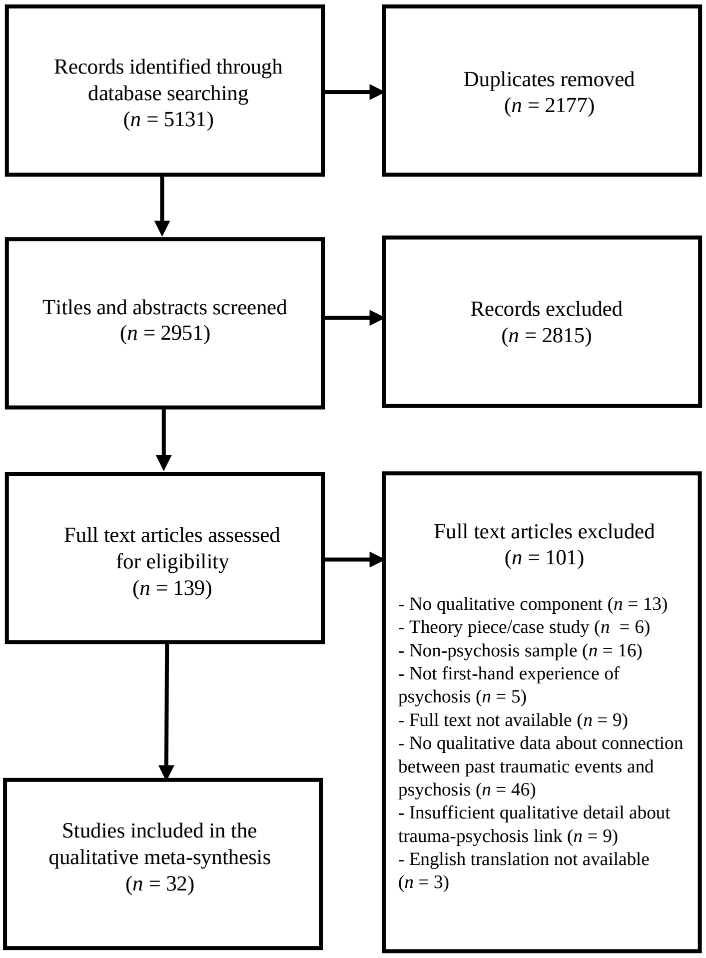
Table 2. Search terms

Psychosis	***AND***	**Trauma**	***AND***	**Qualitative methods**	***AND***	**Lived experience**
psychosis OR psychoses OR schizophren* OR hallucinat* OR delusion* OR paranoi* OR voice hear* OR OR hear* voices		trauma* OR posttraumatic OR post-traumatic OR PTSD OR abus* OR discriminat* OR adversit* OR past experience*		qualitative OR interpretative OR IPA OR grounded theory OR focus group* OR narrative* OR ethnograph* OR mixed method*		service user* OR client* OR patient* OR consumer* OR inpatient* OR outpatient* OR lived experience* OR first hand OR first person

Procedure

Relevant papers were identified using PRISMA guidelines (Moher et al., 2015; Figure 1). Searches were conducted across the five electronic databases and 5131 references; 2177 duplicated entries were removed, and titles and abstracts of the remaining 2951 references were screened, taking an inclusive approach. The remaining 139 full texts were read, and the 32 papers meeting the inclusion criteria were retained. Authors were contacted for all references for which full texts were not available. The research supervisor was consulted throughout the study selection process where the suitability of studies was not clear. Included articles are marked in the references with an asterisk.

Figure 1. PRISMA flowchart



Data extraction

Key information about the studies was extracted including details about the study and sample. Details about any therapy undertaken by participants were also extracted to provide context for the connections drawn between traumatic events and psychosis.

Text directly related to the research question (i.e. connections between past traumatic events and subsequent experiences of psychosis) was extracted as data for the meta-synthesis in consultation with the research supervisor; this was retrieved from the main body of the results section and from tables. ‘Connections’ was operationalised as any part of the qualitative data in which EbE referred to traumatic events in relation to the development of psychosis (including where this was discussed and noted that the participant believed there to be no connection). The extracted data was imported into NVivo for analysis (QSR International Pty Ltd, 2020).

Analysis

The data was analysed following Lachal and colleagues' qualitative meta-synthesis method, a phenomenological adaptation of Thomas and Harden's thematic synthesis approach (Lachal et al., 2017; Thomas & Harden, 2008). This involved repeated reading of the data and line-by-line coding, followed by comparison and categorisation of the generated themes. Lastly, analytical themes were produced which proposed a more conceptual analysis of the data, going beyond the content of the original studies. To ensure rigor, credibility and transparency of the analysis, the coding and themes were discussed with the research supervisor throughout the analytical process; inconsistencies and overlaps were addressed, and a final theme-structure was agreed (Lachal et al., 2017).

Reflexive statement

The author is a trainee clinical psychologist with experience of working with individuals experiencing psychosis in a community setting, but with little experience of using trauma-focused interventions with this client group. She has no personal lived experience of psychosis. By nature of her training, clinical experience and world-view, she views anomalous experiences as phenomena which fall on a continuum of human experiences (DeRosse & Karlsgodt, 2015) rather than experiences distinct to people diagnosed with psychosis. She also believes these emerge in response to past and/or current life difficulty, and has an awareness of existing psychological models of psychosis and PTSD. As such, she paid attention to her preconceptions about the links between traumatic events and psychosis- e.g. that links between trauma and psychosis are important in first-hand explanatory models- and her existing knowledge of cognitive-behavioural models of psychosis. Bracketing these preconceptions was important in minimising the risk of biased misrepresentation of the experiences of people with first-hand experience of psychosis during analysis, the views of whom are often silenced or ignored.

The researcher approached the research question from a critical-realist epistemological stance (Willig, 2012); as such, while she acknowledges that there may be structures and processes that link traumatic events and psychosis ontologically, these cannot be independently accessed or examined outside of the context of the perceptions and experiences of the participants. As such, she is interested in the self-made meaning participants create about experiences traumatic events and psychosis.

The author identifies as a white British female, and thus was aware that the review as a result would be constructed and conducted through a white, Western lens. Conscious that people with minoritised identities are often excluded from research, the author aimed to pay particular attention to the ethnic and cultural demographics of the sample, actively considering these factors when assessing the quality of studies and when synthesizing the research.

Results

Study summary

Key information about each study is presenting in Table 3. Most studies took place in the UK (*n* = 21; 66%), with three based in the USA (9%), and one each in India, Israel, Finland, Australia, Nicaragua, Poland and Sweden (3% respectively). Of the 462 participants across the studies, 215 were female (47%), 238 were male (52%), 1 was transgender (0.2%), and data was not provided for 8 (2%). The age of participants (where reported) ranged from 18 – 79 years. Sample sizes ranged from 3 to 43 and recruited from a range of settings, including community-based mental health teams (*n* = 12; 38%); UK-based Early Intervention in Psychosis services (*n* = 6; 22%); unspecified mental health teams (*n* = 4; 13%); other research projects (*n* = 4; 9%); inpatient wards (*n* = 3; 9%); and third-sector organisations (*n* = 3; 9%). 27 studies recruited participants with specific diagnoses (predominantly schizophrenia or psychosis; 84%), with 4 (13%) focusing on first-episode psychosis. 6 studies (19%)

recruited people who self-identified as having been affected by psychosis, or anomalous experiences associated with psychosis.

Eleven studies (34%) reported aims connected specifically to both trauma and psychosis; these are highlighted in grey in Table 3, and were predominantly based in the UK or USA (n = 9; 82%). Across all of the references included, all but one mentioned the types of traumatic events encountered by participants. Although the timing of the event was absent in some studies, 22 referenced events occurring in childhood (69%), whereas events occurring in adulthood were still a feature but mentioned less frequently (k = 13; 41%). Interpersonal trauma was at the core of traumatic events elicited, with trauma-focused papers more frequently reporting abuse or intentional harm from others (k = 9; 91%) than studies not specifically investigating trauma (k = 14; 67%). A reverse pattern was noted in relation to loss events (e.g. bereavement, family breakdown), which were more likely to be noted in non-trauma-specific studies (k = 18; 86%) than trauma-specific studies (k = 6; 55%). A minority of events mentioned were not interpersonal by nature (e.g. sudden physical illness).

Table 3. Descriptive features of studies included in qualitative meta-synthesis (grouped by trauma/non-trauma focused aims).

Type	Study	Aims	Sample demographics	Psychosis experience	Methodology
Studies aiming to investigate trauma	Anketell, Dorahy & Curran (2010) Northern Ireland	To explore voice-hearing and dissociation in PTSD at a deeper, subjective level	3 males Age not reported Ethnicity not reported Therapy history not reported	Chronic PTSD with auditory hallucinations	Interview Framework analysis
	Campodonico, Varese & Berry (2021) UK	To explore service users' experiences of trauma and discuss their perspectives on how trauma and disclosure have affected participants' life and current mental health condition	6 male, 5 female Age range: 18-59 8 White, 3 Mixed-race Therapy history not reported	Experience of psychosis and difficult life event (identified by TALE checklist; Carr et al., 2018)	Semi-structured interview Thematic analysis
	Dickson et al. (2016) UK	To explore, from a first-hand perspective, how early adversity is seen to contribute to the development of persecutory delusions	6 male, 1 female Mean age: 34; Age range: 18-43 No ethnicity reported Therapy history not reported	Experience of persecutory delusions	Semi-structured interviews IPA
	Misra et al. (2020) United States	To investigate how individuals diagnosed with schizophrenia perceive the role of early life adversities on later life family interactions	10 male, 9 female, 1 transgender person Mean age: 49.5; Age range: 23-69 9 White, 6 Black, 4 Asian, 1 Multiracial Therapy history not reported	Diagnosis of schizophrenia or schizoaffective disorder	Semi-structured interviews Grounded theory
	O'Neill (2010) England	To explore how women have experienced sexual abuse in childhood and psychosis in adulthood	4 female Mean age: 37.5; Age range: 32-48 Ethnicity not reported All participants had psychotherapy	Psychotic disorder and CSA	Semi-structured interviews IPA

Type	Study	Aims	Sample demographics	Psychosis experience	Methodology
Studies aiming to investigate trauma (cont.)	Rhodes, Parrett & Mason (2016) UK	To better understand the personal experience of refugees and asylum-seekers in the UK who have suffered traumatic events and subsequently experience hallucinations	6 male, 1 female Mean age: 34.7; Age range: 26-43 6 Sub-Saharan African, 1 North African Therapy history not reported	Asylum seekers subject to at least one traumatic event involving political violence, diagnosed with psychotic symptoms	Semi-structured interviews IPA
	Rhodes, O'Neill & Nel (2017) UK	To explore how service users report their difficulties and possible symptoms, and further explore how these cohere. To examine connections of any type between CSA and suffering in adulthood.	7 women Mean age: 35.9; Age range: 26-48 3 white, 2 Black British, 1 mixed race, 1 Asian British 'Some' had therapy	Experience a form of psychosis and CSA	Semi-structured interviews IPA
	Rosen et al. (2017) USA	To inform our understanding of the complex relationships and patterns of trauma and adversity, and symptoms as they unfold over time	20 male, 14 female Mean age: 43.7 23 African American, 5 Caucasian, 2 Hispanic, 4 other/mixed Therapy history not reported	Schizophrenia spectrum disorders/bipolar disorder with psychotic features	Individual and focus group interviews Modified grounded theory approach
	Vallath et al. (2018) Location not clear	To explore the impact of negative life events (NLEs) on the form and content of voices	7 male, 14 female Age not reported Ethnicity not reported Therapy history not reported	Schizophrenia conditions involving hearing voices	Semi-structured interviews/case note review Inductive analysis
	Vallath et al. (2020) India	To understand patient perspectives on the impact of psychological trauma on their experience with psychotic disorders	20 female Mean age: 44.28 Ethnicity not reported Therapy history not reported	Psychosis spectrum conditions and homelessness	In-depth interviews IPA

Type	Study	Aims	Sample demographics	Psychosis experience	Methodology
Studies aiming to investigate trauma (cont.)	Wheeler (2019) England	To explore how individuals who access services for first episode psychosis (FEP) make sense of their experiences of bullying in childhood, and whether/how they consider these experiences to be relevant to their experiences of psychosis	4 male, 4 female Mean age: 22.1 Age range: 18-31 2 British Asian, 2 White British, 3 Black British, 1 European Therapy history not reported	FEP and experience of childhood bullying	Semi-structured interviews IPA
Studies with a non-specific trauma focus	Araten-Bergman et al. (2015) Israel	To explore how ageing people with schizophrenia give meaning to their illness through self-etiology in their current lifeworld	11 males, 7 females Age range: 61-69 No ethnicity reported Therapy history not reported	Older adults with schizophrenia	Phenomenological interviews Reflective lifework approach
	Bergstrom et al. (2019) Finland	To explore how people give meanings to experience which are often interpreted as psychosis, and how these experiences are included in life stories	12 male, 8 female Mean age: 45 No ethnicity reported Open dialogue approach	Chronic psychosis	Narrative enquiry Thematic analysis
	Brown (2016) UK	To identify life events significant to the participants interviewed; to explore the sense made of those experiences; to explore how these are connected to the development of psychosis	7 male, 6 female Mean age: 25.9; Age range: 17-37 13 Black-Caribbean Therapy history not reported	Black-Caribbean individuals with FEP	Life story interview Template analysis
	Butcher, Berry & Haddock (2020) UK	To understand how individuals subjectively experience negative symptoms	17 male, 3 female Mean age: 52; Age range: 35-62 12 White British, 8 Black African Therapy history not reported	Diagnosis of schizophrenia with negative symptoms	Semi-structured interview Thematic analysis

Type	Study	Aims	Sample demographics	Psychosis experience	Methodology
Studies with a non-specific trauma focus (cont.)	Campbell (2007) UK	To find out about people’s subjective experience of paranoia	6 male, 6 female Mean age: 30.9 No ethnicity reported Therapy history not reported	Experience of paranoia (6 schizophrenia, 6 non-patient)	Semi-structured interview IPA
	Chakraborty, McKenzie & King (2009) UK	To explore the experience of perceived unfair treatment (discrimination) in people with psychosis, and to compare this between Black and White participants	Black participants 5 male, 5 female Age range: 27-59 Mean age: 39.3 White participants 5 male, 5 female Age range: 26-64 Mean age: 39.3 Therapy history not reported	Diagnosis of psychosis	Ethnographic interview Analysis unclear
	Chiu et al. (2015) Australia	To explore the lived experience of sleep problems in people with schizophrenia-spectrum disorders	7 male, 7 female Age not reported Ethnicity not reported Therapy history not reported	Diagnosis of schizophrenia, plus past/present problems with sleep	Focus groups Thematic analysis
	Hutchins, Rhodes & Keville (2016) UK	To investigate how participants experienced their emotions before, during and after psychotic experience	6 male, 2 female Age range: 19-35 6 White British, 1 White Hungarian Therapy history not reported	First-episode psychosis	Semi-structured interviews IPA
	Laithwaite & Gumley (2007) Scotland	To present a service user perspective of what constitutes recovery for people with psychosis in maximum security	12 male, 1 female Mean age: 29.2; Age range: 22-60 No ethnicity reported Therapy history not reported	Diagnosis of psychosis or bipolar disorder (resident in maximum security hospital)	Semi-structured interviews Grounded theory

Type	Study	Aims	Sample demographics	Psychosis experience	Methodology
Studies with a non-specific trauma focus (cont.)	Langley (2020) UK	To explore the impact of peer-led Hearing Voices Network (HVN) meetings as experienced by voice-hearers	5 male, 4 female Mean age: 50.3; Age range: 20-71 7 White British, 1 White Other, 1 British Asian Therapy history not reported, but all attending peer-led HVN meetings	Voice-hearing	Semi-structured interviews Grounded theory
	Leavey et al. (2007) England	To elicit illness narratives of Turkish patients with a history of psychosis	8 male, 1 female Age range: 19-41 9 Turkish Therapy history not reported	First-episode psychosis	Interview Analysis unclear
	Lyons et al. (2012) Nicaragua	To gain an in-depth understanding of the lived experience of psychosis in Nicaragua from the perspective of service users	11 male, 17 female Mean age: 41.8; Age range: 18-79 Ethnicity not reported Therapy history not reported	Experience of psychosis	Focus groups Inductive and deductive analysis
	Milligan et al. (2012) England	To examine voice-hearers' retrospective accounts of what it is like to live with voices over time	5 men, 1 woman Age range: 17-30 Ethnicity not reported 'Some' participants mentioned therapy, no details	First-episode psychosis with auditory verbal hallucinations (AVH)	Semi-structured interviews IPA
	Owiti et al. (2015) England	To explore patient explanatory models of mental distress	16 female, 15 male Mean age: 38.5 12 Asian/British Bangladeshi, 5 British/Black Somali, 6 Arab, 3 Iraqi, 1 Yemeni, 1 Iranian, 1 Egyptian, 2 African/Black British, 2 Black/British Caribbean, 1 Asian/British Pakistani, 1 Mixed white and Black Caribbean, 1 Brazilian, 1 white (other), 1 declined 'Some' had therapy	'Serious mental illness (SMI- all with psychotic features)	Barts Explanatory Model Inventory Framework analysis

Type	Study	Aims	Sample demographics	Psychosis experience	Methodology
Studies with a non-specific trauma focus	Pietkiewicz, Klosinska & Tomalski (2021) Poland	To analyse the experiences of possession in patients diagnosed with schizophrenia	2 male, 2 female Age range: 21-30 Ethnicity not reported Therapy history not reported	Schizophrenia	Clinical interviews IPA
	Rice (2009) USA	To seek a deeper understanding of the nature of meaning of life with a diagnosis of schizophrenia and violence	9 women Age not reported Ethnicity not reported Therapy history not reported	Women with a history of experiencing violence and a diagnosis of schizophrenia	Semi-structured interviews IPA
	Schofield et al. (2019) UK	To explore how BME mental health service users perceive ethnic differences in psychosis and what their explanations are for these differences	24 male, 17 female Age not reported 41 Black Therapy history not reported	Black adults diagnosed with psychotic illness	Focus groups Thematic analysis
	Strand, Ohlin & Tidefors (2015) Sweden	To explore how individuals with psychosis make sense of the content of their symptoms	7 male, 5 female Mean age: 42.6 Age range: 29-63 8 Swedish, 2 European, 1 Middle Eastern, 1 South American 3 participants were in psychotherapy	People with past/present experience of psychosis	Interviews IPA
	Taylor (2005) Scotland	To explore the role of interpersonal processes in young people's understanding of the psychosis prodrome	8 participants Age range: 18-23 Ethnicity not reported Therapy history not reported	Early-onset psychosis (no longer acutely psychotic)	Interviews IPA

Type	Study	Aims	Sample demographics	Psychosis experience	Methodology
Studies with a non-specific trauma focus (cont.)	Thornhill (2002) UK	To explore psychological and emotional themes which emerged across accounts of recovery from psychosis, and examine the kinds of stories individuals told about their recovery	6 male, 9 female Age range: 30s-70s 12 white British, 1 British Asian, 1 Asian, 1 White non-British Therapy history not reported	Recovered or recovering from psychotic episodes	Semi-structured interviews IPA & narrative analysis
	Turton (2015) UK	To understand the lived experience of living with psychosis as a longer term health condition	4 male, 6 female Mean age: 44.4; Age range: 24-58 10 white British 1 participant had done CBTp	Psychosis	Interviews IPA

Quality assessment

The quality of the included studies was assessed using the Critical Appraisal Skills Programme (CASP) checklist (CASP, 2013). Due to the influence of culture on explanatory models of distress (Bhikha et al., 2012), a minimum level of reporting of demographic data (i.e. age; gender; ethnicity/culture) was imposed as an additional quality criterion. A second rater external to the research group rated the quality of 25% (n = 8) randomly selected references (Cohen's Kappa = .78) and discrepancies in scoring were discussed.

The utility of quality analyses is debated, especially when used to identify papers to be excluded from analyses (Atkins et al., 2008; Walsh & Downe, 2005). For example, PhD and DClinPsy theses- in having more generous word limits- tended to meet more of the CASP criteria. An a priori decision was made not to exclude papers based on the quality assessment, but to use it to contextualise the extracted data. Overall, the quality of the included references was good; all but one reference scored higher than 75% of the maximum 22 points available.

The researcher either failed to explicitly demonstrate consideration their own impact on the research design, data collection and analysis- or only partially achieved this criterion- in 15 studies (47%). Where partially-met, authors either mentioned keeping a reflective journal but did not include reflections in the report, or did not adequately reflect on the impact of their personal or professional identity in the research process. Moreover, researchers in 78% of studies failed to report any information about their own ethnic background (*n* = 25), with three papers describing the ethnic or cultural background of external interviewers but not those involved with analysis. Of the four studies for which researcher demographic information was available, all were white.

Minimum demographic data was not reported in 14 papers (44%), in most cases due to not reporting information about the ethnicity or culture of participants. Only seven (22%) studies mentioned whether participants had undertaken therapy or other formal support approaches (e.g. Open Dialogue).

Table 4. CASP ratings for included studies

	(Anketell et al., 2010)	(Araten-Bergman et al., 2015)	(Bergstrom et al., 2019)	(Brown, 2016)	(Butcher et al., 2020)	(Campbell, 2007)	(Campodonico et al., 2021)	(Chakraborty et al., 2009)	(Chiu et al., 2015)	(Dickson et al., 2016)	(Hutchins et al., 2016)	(Laithwaite & Gumley, 2007)	(Langley, 2020)	(Leavey et al., 2007)	(Lyons et al., 2012)	(Milligan et all., 2012)	(Misra et al., 2020)	(O Neill, 2010)	(Owiti et al., 2015)	(Pietkiewicz et al., 2021)	(Rhodes et al., 2016)	(Rhodes et al., 2017)	(Rice, 2009)	(Rosen et al., 2017)	(Schofield et al., 2019)	(Strand et al., 2015)	(Taylor, 2005)	(Thornhill, 2002)	(Turton, 2015)	(Vallath et al., 2018)	(Vallath et al., 2020)	Wheeler, 2019)
1. Statement of aims	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩
2. Appropriateness of qualitative method	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩
3. Appropriateness of design	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩
4. Appropriateness of recruitment strategy	🟧	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟧	🟩	🟩	🟩	🟩	🟩	🟧	🟩	🟩	🟩	🟩	🟩	🟩
4a. Inclusion of minimum demographics	🟥	🟩	🟥	🟩	🟩	🟥	🟩	🟩	🟥	🟥	🟩	🟥	🟩	🟩	🟥	🟥	🟩	🟥	🟩	🟥	🟩	🟩	🟥	🟩	🟩	🟩	🟥	🟩	🟩	🟥	🟥	🟩
5. Appropriateness of data collection method in relation to research issue	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟧	🟩	🟩	🟩	🟩	🟧	🟩	🟧	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩
6. Consideration of relationship between researcher and participants	🟥	🟧	🟩	🟩	🟥	🟩	🟩	🟩	🟥	🟧	🟩	🟩	🟩	🟥	🟥	🟩	🟥	🟩	🟥	🟥	🟧	🟩	🟧	🟧	🟩	🟩	🟩	🟩	🟩	🟥	🟥	🟩
7. Consideration of ethical issues	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟥	🟩	🟥	🟩	🟩	🟩	🟧	🟩	🟩	🟧	🟩	🟩	🟧	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟧	🟩
8. Rigor of data analysis	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟧	🟧	🟩	🟩	🟩	🟩	🟧	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩
9. Clear statement of findings	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟧	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩
10. Value of research	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩

Sensitivity analysis

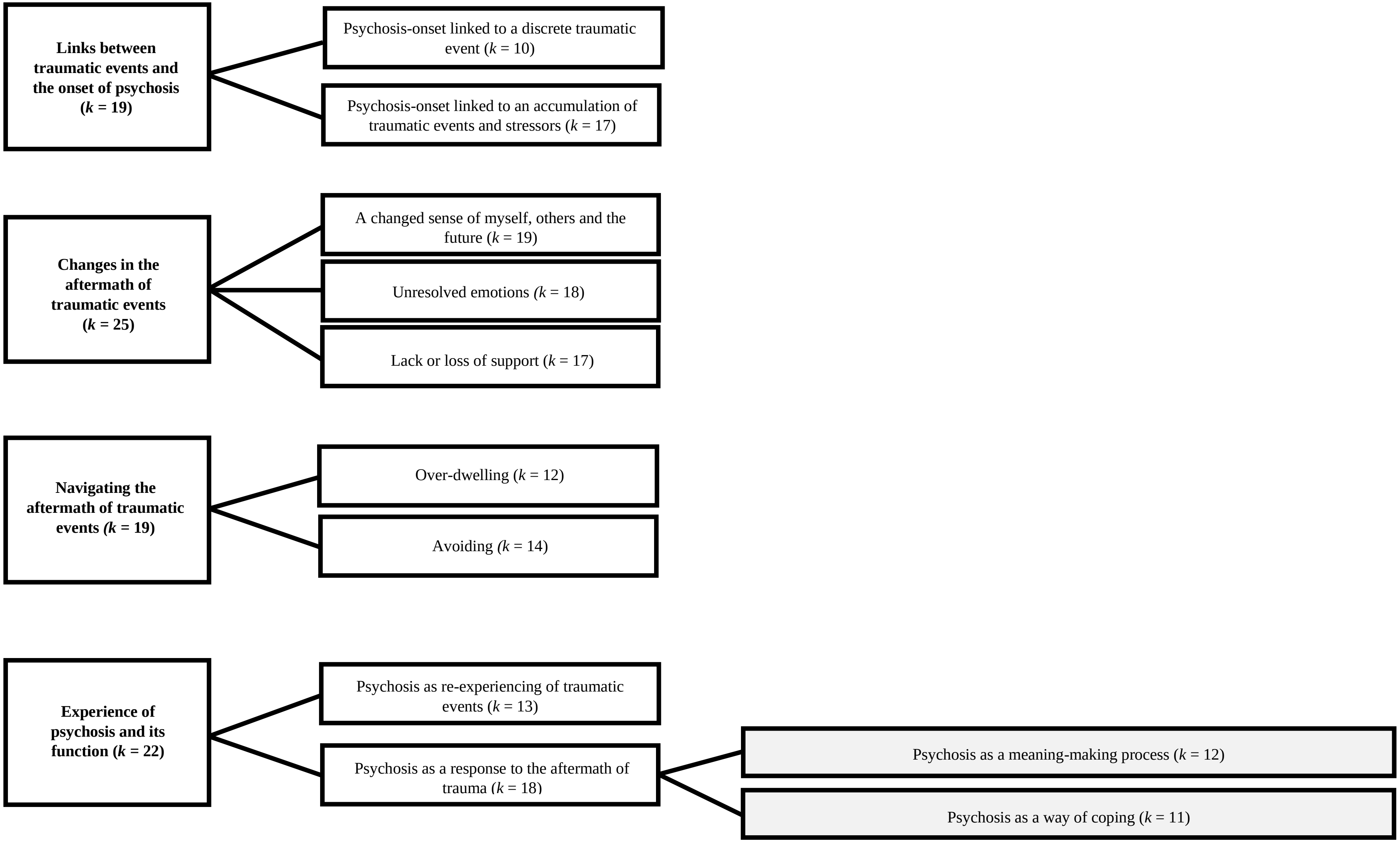
Despite not excluding any studies based on quality, the sensitivity of the synthesis was assessed by checking support for the themes having discounted the only study scoring below 75% on the CASP (Pietkiewicz et al., 2021). Support for the themes remained largely unchanged following this removal, with six of the eleven sub-themes supported by at least 50% of the references in the full sensitivity analysis, even after having removed the paper by Pietkiewicz and colleagues.

Sixteen (50%) of the included studies supported at least half of the themes from the analysis. Closer analysis showed that studies supporting fewer themes tended to focus on more specific phenomena within the psychosis experience (e.g. sleep problems, dissociation, hearing voices groups), whilst those with greater support for themes aimed to explore experiences of psychosis more broadly. Similarly, studies with the lowest support for themes were also the studies from which the least amount of data was extracted. As the review set out to be inclusive of any qualitative papers referencing links between past traumatic events and psychosis, variance in the level of data extracted and subsequent support for constructed themes was expected. Support for themes was comparable between studies with trauma-focused aims, of which six (55%) supported over half the themes, and studies not explicitly focusing on trauma, of which ten (48%) supported over half the themes.

Qualitative meta-synthesis

The analysis generated four superordinate themes related to links drawn between traumatic events and psychosis-onset; changes after the traumatic events; responding to the aftermath of traumatic events; and sense made around the subjective experience of psychosis in relation to traumatic events. These encompassing nine themes, two of which comprised two smaller sub-themes (Figure 2).

Figure 2. Structure of superordinate themes, themes and sub-themes



Superordinate theme 1. Links between traumatic events and the onset of psychosis

When mentioning a traumatic event in relation to the onset of psychosis, whilst this was sometimes described as a ‘trigger’ occurring temporally close to psychosis-onset, it was often also described as part of an accumulation of multiple life stressors and/or traumatic events.

While participants often had clear ideas about links between past events and psychosis-onset, some were uncertain about such links, or had not considered them before. Some mentioned traumatic events in relation to psychosis but also expressed scepticism about them directly linking to the onset of psychosis specifically, suggesting either that the traumatic event led to a more general vulnerability to distress, or was unrelated.

It was often unclear how participants were asked about traumatic events and the possible influence on psychosis. Whilst some studies stated general aim related to exploring such links, others shared example questions (e.g. ‘What led up to the psychosis?’ or ‘What caused the psychosis?’) which may respectively lend themselves to answers relaying events as directly triggering versus cumulatively contributing to the onset of psychosis. There were no obvious trends to this effect, though it was often unclear how or whether participants were asked directly about this. Illustrative quotes supporting all themes are shown in Table 5.

Table 5. Illustrative quotes for themes and sub-themes

Superordinate theme	**Theme**	**Sub-themes**	**Illustrative quotes**
Links between traumatic events and the onset of psychosis ($n = 19$)	Psychosis-onset linked to a discrete traumatic event ($k = 10$)		Q1: I was attacked when I was out with my friend by a group of… well, by a gang, and I was hit on the head with a machete, in the back of the head and I went to hospital… there was no major damage, I've got a scare and that and I went home that night and that's when I started hearing voices. (Milligan et al., 2012). Q2: It was after my Dad died in 1998, that's when I started getting them (voices). (Langley et al., 2020).
	Psychosis-onset linked to an accumulation of traumatic events and stressors ($k = 17$)		Q3: [I fell] on my head from a tree when I was about 12 years old. [When I was 14 years old I] witnessed my mother being raped and then murdered. My father then forced me to marry an older man. I later ran away from the man but I was pregnant by him… [but] later miscarried… I joined my father in the UK, but his new family rejected me… I had to look for my accommodation… In one of the flats, a man attempted to rape me… I am now homeless… [and] isolated. (Owiti et al., 2015) Q4: You have to deal with your own personal issues, so for example whether it's a marriage breakdown, whether it's a pregnant, a divorce, a funeral. Which everyone goes through, but you're picking up the daily stresses combined with the ones that come from our ancestors. (Schofield et al., 2019).
Changes in the aftermath of traumatic events ($k = 25$)	A changed sense of myself, others and the future ($k = 19$)		Q5: (The event) shaped my thoughts about me… on a self-esteem level it just really ground me down… (I thought) I was worthless and just there was something fundamentally wrong with me that I couldn't cope (Dickson et al., 2016). Q6: What I mean by that is that the path was no longer clear… the future was unknown and em, (pauses) I would have to look round the corner myself with no protection. (Laithwaite & Gumley, 2007).
	Unresolved emotions ($k = 18$)		Q7: I've been abused in the past… have those emotions within me; um, perhaps they are there.. (Butcher et al., 2020). Q8: Yeh, I was saying it was crippling… That feeling I had as a child. Of being crippled. Sort of downtrodden. I've had that in mental illness. (Rhodes et al., 2017)

Superordinate theme	Theme	Sub-themes	Illustrative quotes
Changes in the aftermath of traumatic events (cont; *k* = 25)	Lack or loss of support (*k* = 17)		Q9: Well, basically, because of the abuse and stuff, like, that I went through, it's, like, I did find my foster mom, but it's like, okay, I know where she's at, if I really want to talk to her, but it's like, I don't want to talk to her because of the abuse I was in with her. (Misra et al., 2020) Q10: Eric: I don't think that could happen to a white person, that they could have a mental health problem like mine Interviewer: How is their experience different? Eric: Because they know their backgrounds. They know where they're from, know how to cope with it, know how to use the resources they have, and things like that. Interviewer: What's preventing you from knowing how to use all the resources? Eric: Well I'm new here, you know? (Chakraborty et al., 2009).
Navigating the aftermath of traumatic events (*k* = 19)	Over-dwelling (*k* = 12)		Q11: Natalia described how she was constantly thinking about her homesickness and possible associated sadness linked with this experience. 'Very bad homesick, and I always wanted to go home, and, you know, I didn't want to be here, and I was carrying on and on and on about it, and I was turning inside, you know, like I was really quiet and just constantly thinking about it.' (Hutchins et al., 2016) Q12: So I'd be going to bed thinking, thinking, thinking about how to handle the emotionally abusive environment I was in as a child, and how to fight my parents who were doing the emotional abuse. So I have never been able to relax, and that includes at night when I'm sleeping. (Chiu et al., 2015)
	Avoiding (*k* = 14)		Q13: Again I think now on reflection that that was about my inability to resolve it by thinking it through. Because I've refused to think about it. And I think if we refuse to think about things, we refuse to sort of face things, then we suppress them and eventually the pressure gets too great and it's got to come out somehow. (Thornhill, 2002). Q14: I think everything that I've been through in my life has contributed a bit to my psychosis, because I didn't deal with situations when they happened really, I kept them locked inside when I should have really dealt with them. (Brown, 2016)

Superordinate theme	**Theme**	**Sub-themes**	**Illustrative quotes**
Experiences of psychosis and its function (*k* = 22)	Psychosis as a re-experiencing of traumatic events (*k* = 13)		Q15: Participant: I hear these voices saying “Stop, arrest him. Kill him. Kill him.” Like the soldiers used to say in my country. (Rhodes, Parrett & Mason, 2016). Q16: I was experiencing being raped and being sexually abused, but there wasn’t anybody there to say… They just aid “It’s paranoid schizophrenia” which means I was imagining it. But there wasn’t anybody there who said to me “Well have you in your childhood ever experienced these things? That might explain why at this point in time you’re experiencing things happening like something outside of you, that you’re being raped by something outside of you”. (Thornhill, 2002).
	Psychosis as a response to the aftermath of trauma (*k* = 18)	Psychosis as a meaning-making process (*k* = 12)	Q17: Once I worked through the fact... of the abuse...and the biggest issue of abuse for me was finding myself innocent um...and once I'd found myself innocent then the whole reason that the voice had power was gone. The voice's power was rooted in the fact that I was guilty. But once I'm innocent, where's the power of the voice? The voice can still be there, but it has no power. (Thornhill, 2002). Q18: My grandfather came to me and said he did what he did, he sexually abused me because he was sexually abused himself. (Rhodes et al., 2017)
		Psychosis as a means of coping (*k* = 11)	Q19: They ask me whether I ate or if I’ve rested well. They say they miss me and look forward to meeting me soon… it’s nice that there is someone to ask me these things after all these years. (Vallath et al., 2020). Q20: Of course it’s scary when you constantly see those characters flying around you and hear those voices. But on the other hand it was a constant fight with my parents about what was real and what was not, even though the real world was precisely what I was afraid of. (Bergstrom et al., 2019).

Theme 1.1. Psychosis-onset linked to a discrete traumatic event

Psychosis-onset was linked by some to a discrete traumatic event, which was usually portrayed as having occurred temporally close to the psychosis starting. Such links were often narrated with a sense of clarity- with participants explaining that a specific event, seemingly in isolation, triggered the onset of psychosis soon after (Q1; Q2; Table 5).

Some authors (e.g. Butcher et al., 2020) also acknowledged that some participants drew clear links between an earlier traumatic event and the onset of psychosis, despite these being temporally distant (e.g. 'knowing' that a traumatic event contributed to psychosis without it being a temporally-close trigger).

Theme 1.2. Psychosis-onset linked to an accumulation of traumatic events and stressors

Psychosis-onset was also linked to an accumulation of traumatic experiences and/or social stressors, beyond the impact of one discrete event. This included both repeated instances of a similar event over time (e.g. bullying and victimisation) and an accumulation of distinct-but-interconnected events and stressors, temporally distinct from the psychosis-onset (Q3; Table 5). A chain of events, with an emphasis on loss-events, occurred consequentially following a traumatic event; this worsened the primary problem, depleted resources to cope, and increased the likelihood of future stressors.

While some stressors and losses linked directly to traumatic events, many participants also described accumulative stressors linked to broader systems of social disadvantage. Poverty, homelessness and employment difficulties were mentioned in almost all studies that linked accumulative stressors with the onset of psychosis, particularly in studies with a high proportion of participants from minoritised ethnic backgrounds. Social inequality and discrimination (e.g. racism; language and cultural barriers; immigration policies) contributed to the accumulation of social stressors, exacerbating distress and obstructing access to resources. One Black participant described this as an intergenerational accumulative process (Q4; Table 5).

Superordinate theme 2: Changes in the aftermath of traumatic events

The second superordinate theme comprises three sub-themes associated with the disruption caused by traumatic events. This was characterised by unwanted, distressing internal conflicts, emotions and/or changes in relationships, resulting in a changed internal and external landscape which was described by participants as being at odds with their previous ways of understanding the world.

Theme 2.1. A changed sense of myself, others and the future

In coming to terms with the traumatic event(s) and their aftermath, participants made new meaning about themselves, other people, the world and their futures. This change was narrated as distressing and difficult to negotiate.

Some people faced internal conflicts related to the negative impact trauma had on their sense of self. Feelings of worthlessness and self-hatred and confusion about one’s identity were expressed in relation to the aftermath of the traumatic event, and contributed to a sense of not being able to cope with future hardship (Q5; Table 5). Morality was another common theme within this; where shame or self-blame were identified, some participants expressed a sense of themselves as ‘bad’.

For others, the conflict centred on their sense of others and/or the world around them. Some participants described conflicting feelings about specific relationships, such as a complicated relationship with a father who was once caring, and later sexually abused a participant (Vallath et al., 2018). Other participants described grappling with newfound lack of safety in the world, and a general ‘shattering’ of their trust in others.

Uncertainty about the future was another common conflict; traumatic events were often narrated as having disrupted an expected life course, whether due to the detrimental impact of the traumatic event, or a significant loss or bereavement. This resulted in difficulty in envisioning what ‘new’ future they were embarking upon. Across these conflicts was a sense of traumatic events and their aftermath as diverging from personal and/or cultural expectations about how things could or should have been (Q6; Table 5).

Theme 2.2. Unresolved emotions

Powerful and overwhelming emotional experiences (e.g. sadness, guilt, shame and anger)- described in diagnostic terms by some (e.g. depression, anxiety, suicidality)- occurred in the aftermath of traumatic events. Sadness was mentioned particularly in relation to loneliness and loss.

For many there was a sense of entrapment linked to the emotions- the emotions being trapped in their bodies, or participants feeling trapped by the emotions. One participant, in a study exploring experiences of 'negative symptoms' of psychosis, described how these emotions stayed with him in the aftermath of abuse (Q7; Table 5). For some, this was an embodied experience more than a specific emotion- one participant described how a bodily feeling of 'crippled-ness' linked to childhood abuse (Q8; Table 5). These emotions were often described as remaining 'unresolved' into adulthood.

Theme 2.3. Lack or loss of support

Participants spoke to changes in their relationships- either as a direct result of the traumatic event, or through the aftermath- which were generally characterised by a lack or loss of support. For many, the loss of support was linked directly to the traumatic event- such as bereavement, relationship loss or forced migration. For others, the lack or loss of support was more gradual in the aftermath of traumatic events, with participants themselves withdrawing, or distance created (intentionally or not) by friends and family. This loss of support not only left participants with less social resource with which to navigate the aftermath of traumatic event(s), but, for some, was also a source of distress in itself (Q9; Table 5)

Additional barriers to support were faced by people from minoritised ethnic backgrounds (e.g. confusing healthcare systems, asylum status, racism), which also reduced a sense of 'belonging' (Q10; Table 5).

Conversely, some participants described feeling supported in the aftermath of traumatic events, with some authors commenting on the importance of relationships and access to support in promoting wellbeing.

Superordinate theme 3: Navigating the aftermath of trauma

The third superordinate theme covered two processes participants used to cope with the distressing aftermath of traumatic events, which may have been helpful at a time, but which participants described also contributed to a sense of being stuck in the trauma. These processes were shared seemingly spontaneously by participants, as there were no studies actively aiming to explore people's ways of responding to traumatic events. Though describing polarised processes, these did not seem mutually exclusive- instead, it seemed that people may adopt different approaches at different times, and in response to different sources of distress.

Theme 3.1. Over-dwelling

Some participants described over-attending to thoughts, emotions and embodied sensations related to the traumatic event (Q11; Table 5)- Hutchins and colleagues termed this 'over-dwelling' (Hutchins et al., 2016). Some people identified as having 'always been over-thinkers', whilst for others, the process was borne from the traumatic circumstances.

For some, overthinking appeared to serve a function of trying to process past events- either to make sense of them- especially where 'over-thinking (Q12; Table 5). Other people spoke about over-dwelling as feeling out of their conscious control, and more as a process of being bombarded by their experiences. Generally, over-dwelling was narrated retrospectively as a having increased distress.

Theme 3.2. Avoiding

Participants also described an avoidance of thoughts, emotions and/or embodied sensations linked to traumatic events and their aftermath (Q13; Table 5). Similar to over-dwelling, there was variation in the control participants had over avoiding, with some describing it as a process of actively 'shutting out', and others a perceived inability to face thoughts and emotions from the past (Q14; Table 5).

Studies mentioned different methods of avoidance- some intrapersonal such as blocking or suppressing unwanted thoughts and emotions, and others described throwing oneself into work or using alcohol or drugs (especially cannabis) as a means of blocking emotions and memories.

Where participants described attempts to suppress, block or avoid unmanageable emotions, many then narrated the onset of psychosis as an ‘emotional over-spill’ or ‘collapse’, suggesting that the re-emergence of overwhelming emotions coincided with the onset of psychosis. Accounts of avoiding differed from accounts of over-dwelling in this way; the onset of psychosis following avoidance of thoughts and emotions was narrated as sudden and explosive, whereas over-dwelling seemed to tip into psychosis more gradually.

Superordinate theme 4: Experience of psychosis and its links with traumatic events

The final superordinate theme relates to how traumatic events were linked to the subjective experience of psychosis. Most studies spoke to phenomenological links between traumatic events participants had experienced in the past, and the content of their subsequent experiences of psychosis; as such, this superordinate theme comprises two themes- a) accounts of psychosis being a more concrete re-experiencing of traumatic events, and b) psychosis as a more abstract response to the changed post-traumatic landscape. For some, identifying links between traumatic events and the content of their psychosis- alone or in therapy- was important in moving forward with their recovery.

Unlike the other themes in this review, there were many references actively seeking to understand participants’ subjective experience of psychosis.

Theme 4.1. Psychosis as a re-experiencing of traumatic events

Some participants described their experiences of psychosis as involving a ‘re-experiencing’ of past traumatic events. The degree to which experiences of psychosis reflected traumatic events seemed to occur on a spectrum. Some described reexperiencing whole memories, such as being ‘thrown back in time’ by powerfully re-experiencing traumatic experiences similar to trauma-induced flashbacks.

Fragmented components of the memory were relived, by some, in aspects of anomalous experiences such as voices. For example, one man described hearing the voices of soldiers who had attempted to arrest him (Q15; Table 5).

Similarly, some spoke about re-experiencing emotions (especially suspiciousness) or sensations reminiscent of traumatic experiences. Notably, two studies linked the re-experiencing of somatic sensations with childhood sexual abuse; whilst the participant drew a clear link between the two in one study (Q16; Table 5), in the other it was unclear if the participant made a coherent link about these experiences (Pietkiewicz et al., 2021).

Theme 4.2. Psychosis as a response to the aftermath of trauma

In contrast to the previous theme which encapsulates more direct translations of traumatic events into the content of psychosis, this theme discusses more abstract transformations of traumatic content. Trauma-focused studies more often reported phenomenological links between traumatic events and psychosis than psychosis-only studies, making it difficult to conclude whether participants spontaneously focus on such links in their explanatory models. In half of the studies supporting this theme it was unclear whether the links were made by participants or were interpretations of authors.

Sub-theme 4.2.1. Psychosis as a meaning-making process

Psychosis was narrated by some as a process by which sense was made of traumatic experiences; this could be helpful- e.g. by reducing the power voices held (Q17; Table 5)- but could also be confusing and distressing. For some, the meaning-making occurred through an active process of combing through past events ‘like a detective’ in the hope of finding ‘answers’ (e.g. Thornhill, 2002), or could be a less active process through which voices or visions would provide meaning for traumatic events (Q18; Table 5).

Psychosis was also narrated as being as a vehicle for engaging with themes and conflicts in the aftermath of trauma related to participants changed sense of self, others or the world, e.g. a sense of worthlessness resulting from traumatic experience(s) being reflected in voice content (e.g. Wheeler, 2019); an externalisation of conflicting feelings about an abusive father (Vallath et al., 2018); a wish to have been able to defend oneself from abuse externalised into a vision of a policeman (Vallath et al., 2018).

The meaning-making process was sometimes described as an embodied process rather than a cognitive one. One participant shared that re-experiencing somatic hallucinations linked to childhood sexual abuse helped her connect with anger related to the incident, which then led to a sense of connection with women more broadly, in the context of gender-based violence (Rice, 2009).

Some people described psychosis as a helpful transformation of traumatic themes or conflicts, for example voices providing reassurance or providing support when faced with difficulty.

Sub-theme 4.2.2. Psychosis as a means of coping

Some authors and participants spoke about psychosis providing a means of coping with the aftermath of trauma.

Anomalous experiences- especially voices- provided some participants with opportunity for connection or re-connection; this was described particularly in response to relationship loss, bereavement and loneliness. ‘Seeing’, ‘hearing’, ‘feeling’ or ‘speaking to’ a deceased loved-one, for example, fostered a sense of connection with them which often, but not always, helped people feel supported and guided (Q19; Table 5). Connection was also developed through anomalous experiences related to other people, such as neighbours, celebrities, spiritual entities, or extra-terrestrials.

Anomalous experiences served a function of protecting participants from feared future harm, based on their previous experiences of adversity. Paranoia was described at an attempt at maintaining safety, which was later perceived as an over-generalisation of concern stemming from specific negative experiences. Some participants also described voices as actively trying to ‘protect’ them, for example by advising they refrain from discussing traumatic events to protect from pain (Campodonico et al., 2021). Anomalous experiences were also described as serving as a means of taking people away from difficult realities or emotions in the present, e.g. by escaping into ‘imaginary’ relationships or worlds, or serving as a distraction (Q20; Table 5).

Some coping functions of psychosis were described such that it was difficult to conclude whether the links were made by participants, or were authors’ interpretations of participants’ experiences. Two authors also described a process whereby psychosis involved the reversal of negative self-concepts, leading to an exaggerated sense of self-worth as a means of coping (Strand et al., 2015; Dickson et al., 2016).

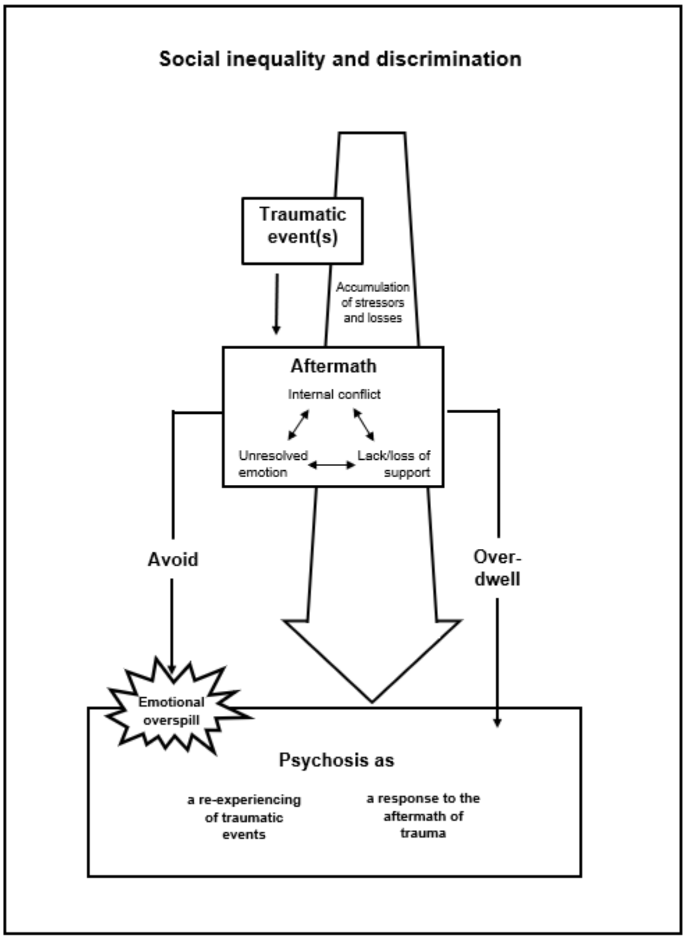
Discussion

This is the first review to synthesise qualitative first-hand accounts of psychosis with an aim of examining links made between traumatic events and subsequent experiences of psychosis. Thirty two qualitative studies had examined the perspectives of people affected by psychosis; most had focused on subjective experiences of psychosis or the link between traumatic events and psychosis, with a minority focusing on other related phenomena (e.g. sleep, recovery, Hearing Voices Network groups, discrimination, emotions).

Traumatic events were linked to psychosis in isolation and as part of an accumulation of stressors. In the aftermath of psychosis, people experienced significant intrapersonal and interpersonal changes and overwhelming, unresolved emotion; these changes differed greatly from people’s expected life paths and required significant adjustment. ‘Avoidance’ and ‘over-dwelling’ were two processes identified to help cope with the aftermath of the traumatic event, which were described as eventually ‘tipping into’ psychosis (characterised as a sudden overspill of emotion, when following avoidance). Anomalous experiences linked to psychosis were described by some as a re-experiencing of parts of the traumatic memory (ranging from literal to fragmented), whilst for others seemed to form more abstract processes of making sense of or coping with difficult life experiences.

The themes, as described above, are visually represented as a process below (Figure 3). This is not intended to represent a definitive pathway from traumatic event to psychosis-onset, rather to illustrate links drawn by participant accounts included in the current review. The model sits within a context of social inequality and discrimination, in light of the role of broader structures of inequality and oppression in the traumatic events and life stressors shared by participants.

Figure 3. Visual representation of the themes drawn between past traumatic events and experiences of psychosis.



Notably, some participants were either uncertain about links between traumatic events and psychosis-onset, had not considered these, or related past adversity to general life suffering rather than psychosis specifically. As such, this process represents an integration of themes related to connections where they had been drawn, whilst acknowledging that trauma may not be central to the explanatory models of all whom have experienced it. Moreover, explanatory models of psychosis for people who do not identify as having experienced traumatic events will, again, generate different explanatory models around their experiences (e.g. Johnson & Orrell, 1995). Reviews of existing literature have pointed to complex and pluralistic explanations of psychosis, including models based on supernatural and/or religious events, psychosocial stress and biomedical factors (Bhikia et al., 2012).

The weight of trauma: Accumulation and the role of loss

Traumatic events were linked to the onset of psychosis both when temporally-close to the psychosis-onset (i.e. a ‘trigger’; Arseneault et al., 2011) and when temporally-distant (as part of an accumulation of stressors; Varese et al., 2012), with the latter featuring more heavily in participant accounts. This accumulation of events was narrated as a process of being ‘worn down’ by a series of traumatic events, and life stressors, the relentlessness of which depleted participants’ resources, leading to a sense of hopelessness and being unable to cope. For some, this depleted resources to a point that even daily tasks contributed to this ‘wearing down’ process.

The range of adverse events identified as significant by participants is in keeping with research identifying associations between psychosis risk and events such as loss, economic deprivation and familial separation (Harrison et al., 2001; Read et al., 2009; Trotta et al., 2015). Quantitative studies linking traumatic events and psychosis vary in their inclusion of events that fall outside of Criterion A of the PTSD diagnosis (APA, 2013; Vila-Badia et al., 2021). The challenge of balancing inclusivity of adverse events with brevity and accessibility of routine measures has been noted in the literature (Carr et al., 2018). Given that traumatic events as categorised by diagnostic manuals have been linked only with slightly higher PTSD symptoms compared to non-traumatic stressors (Hyland et al., 2021; Larsen & Pacella, 2016), an inclusive approach to the assessment of traumatic events and life stressors should be taken, led by the meaning and importance client place on events in their own life stories (Campodonico et al., 2021).

Loss

In particular, Vallath and colleagues propose that loss is central in how EbE link traumatic events and psychosis (Vallath et al., 2020). Loss was mentioned in 16 studies, and was the subject of a theme in three of these (Laithwaite et al., 2007; Langley, 2020; Vallath et al., 2020). Loss events were more often linked spontaneously to psychosis-onset in participant accounts; in the present review loss emerged in participants' accounts of precipitative traumatic events (e.g. significant bereavement), inner conflicts (e.g. a sense of losing one's prior self or expected future), and as a loss of support following traumatic events. Vallath and colleagues linked this association to Conservation of Resources theory, which proposes that adverse events threaten and/or deplete coping resources, leading to 'traumatic stress'; the theory therefore characterises all adverse life events as 'loss events' at their core, proposing that regaining these resources supports 'recovery' (Hobfoll et al., 1995).

While there is some literature linking loss events such as parental separation and death with risk of psychosis (Ayerbe et al., 2020; Misra et al., 2019), this is a relatively under-researched area. In qualitative literature, one review exploring identity change in psychosis identified loss of relationships and roles as one of five significant contributors to identity change related to psychosis, and that identify change in itself is typically narrated as a loss (Conneely et al., 2021). An expert by experience-led qualitative review also commented on the importance placed on a series of personal loses in the lead up to psychosis-onset (Fusar-Poli et al., 2022).

Cumulative impact: For whom is this most likely?

This 'wearing down' process was particularly evident in accounts from studies of participants from minoritised racial backgrounds and/or who were non-native to the research country, and was linked both to the elevated life stressors posed by systemic discrimination such as racism, and inaccessibility of formal support structures (e.g. Brown, 2016; Leavey et al., 2007). This is in line with research identifying ethnic minority position and migrant status as risk factors for psychosis (Leaune et al., 2019; Selten et al., 2019). Social disadvantage, linguistic distance and disempowerment resulting from structural, identity-based exclusion have been proposed as reasons for this increased risk (Jongsma et al., 2020; 2021).

Given that participants in the current study drew links between their experiences of adversity and development of psychosis, intervention is required at a socio-political level (e,g. through research, education, funding and policy change) as well as an individual one (Anglin et a., 2020). Employment and housing support, for example, might be considered a preventative, public health intervention in itself through the mitigation of risk of psychosis posed by accumulative traumatic events and life stressors. This aligns with research suggesting that social factors such a housing and employment are important therapeutic priorities for people diagnosed with psychosis (Douglas et al., 2021; Wood et al., 2013).

Mechanisms of impact: A struggle to manage the aftermath of traumatic events

Many accounts in the present review described internal conflicts related to oneself, others, the world and the future, which were rooted in the traumatic event and brought about changes which significantly deviated from past experiences or expected norms. Schema-based models of PTSD propose that ‘traumatic intrusions’ arise from a lack of integration of traumatic experiences into existing organisations of information related to oneself, others and the world (e.g. Brewin & Holmes, 2003; Janoff-Bulman, 1989; Rafaeli et al., 2011; Strachan et al., 2022). From an attachment perspective, expectations about self/other/world can emerge through early caregiving relationships; therefore when traumatic events involving a breach of parental trust occur in childhood, there is a greater risk of attachment insecurity (Raby et al., 2017). Disruption to the sensitivity and attunement of caregiving relationships has been found to mediate the relationship between traumatic events and anomalous experiences in psychosis (Sitko et al., 2014; Wickham et al., 2015)

Disruption to identity and 'self-hood' is highlighted in phenomenological accounts of psychosis (e.g. Hamm et al., 2018; Mishara et al., 2014; Sass & Parnas, 2003). Such models suggest that disruption to a clear sense-of-self and -other can impact the coherence of personal narratives, and give rise to anomalous experiences. Identity-related topics were spontaneously mentioned in over 80% of open-ended interviews with young adults at clinical high risk for psychosis compared to 38% of interviews with controls, suggesting that identity-related topics are pertinent to this group (Sarac et al., 2022). Alongside the present review, this suggests that identity-related conflicts pertaining to a changed sense of oneself/others/the world/the future may be relevant and valued focuses of therapeutic intervention for people affected by psychosis and traumatic events.

The impact of traumatic events on relationships also featured in participant accounts. Participants described an altered sense of other people and/or the world in the aftermath of traumatic events, often characterised by mistrust, fear or anger directed specifically and/or generally towards others. A lack or loss of support also featured in accounts of the aftermath of traumatic events, and have been linked to psychosis-onset in existing literature (Gayer-Anderson & Morgan, 2012). Rates of childhood traumatic events and reduced social support have been found to be elevated in individual at high risk for psychosis compared to controls (Huang et al., 2019). Social isolation is a commonly reported challenge for people experiencing psychosis (Eglit et al., 2018), with some theorising this may contribute to the development and maintenance of anomalous experiences by reducing opportunities for reality testing (Lim & Gleeson, 2014).

Avoidance and over-dwelling- processes described by participants of the current review- are also implicated in models and research related to trauma and psychosis (Ehlers & Clark, 2000; Freeman et al., 2001; Hardy, 2017). Psychological models of PTSD propose that avoidance and thought suppression (driven by fear) leads to thoughts and emotions returning more strongly. Rumination is associated with a greater risk of PTSD, and is thought to strengthen unhelpful beliefs linked to traumatic events (Ehlers et al., 1998; Ehlers & Clark, 2000). Models of psychosis have identified avoidance as a common safety behaviour (Freeman et al., 2001), with Hardy's model of post-traumatic stress in psychosis (Hardy, 2017) identifying both rumination (similar to over-dwelling) and avoidance as coping strategies adopted which may ultimately prove unhelpful, and maintain experiences of psychosis. Avoidant coping has been found to mediate the relationship between childhood trauma and psychosis, and has been linked in particular to negative symptoms (Powers et al., 2016; Raffard et al., 2010). Rumination and cognitive self-consciousness ('the tendency to focus on one's thought processes'; Cartwright-Hatton & Wells, 1997, p. 387) have been linked to the experience of hallucinations for people diagnosed with schizophrenia (Baker & Morrison, 1998; Sterling et al., 2007). Interestingly, accounts of 'over-dwelling' in the current review seemed to relate to a broader spectrum of experiences (e.g. emotions, embodied sensations) rather than a purely cognitive process.

Richness in the meaning of psychosis

Psychosis was characterised as an experience rich in meaning; historically, beliefs considered anomalous in the context of psychosis have been regarded as 'empty speech acts' (Berrios, 1991). Moreover, participants drew links between anomalous experiences and traumatic events; this contrasts with psychological models which suggest the transparency of links between life events and 'symptom content' may be a differentiating factor between PTSD and psychosis (Morrison et al., 2001). Moreover, beyond thematic connections, anomalous experiences often served functions to participants in relation to traumatic experiences in relation to generating understanding of past events, or coping with the aftermath of them. This functional conceptualisation of anomalous experiences aligns with recovery-oriented models of psychosis, which present a more hopeful construction of psychosis as an understandable human experience (Leonhardt et al., 2015; 2020). It also fits with research suggesting that post-traumatic growth in psychosis is mediated by meaning-making (Mazor et al., 2016).

Participants in several studies noted that understanding the link between traumatic events and subsequent psychosis was 'central' to their recovery. Others expressed a wish that they had been given an opportunity to explore such links sooner- or at all- while accessing services. As well as the routine screening of traumatic events for people presenting with experiences of psychosis (Carr et al., 2018), having an opportunity to make new meaning around significant changes in one's life (traumatic events, experiences of psychosis, and their impacts) can be a meaningful and hopeful aim for intervention, and of psychosis services broadly (Ng et al., 2021).

Limitations

There are a number of limitations of the current review to consider. A core finding of the current review, and a limitation of the studies reviewed, is an absence of explicit consideration of the impact of researcher bias and the role of personal characteristics on the research process; this was demonstrated in only 53% of studies. Given the inevitability of the influence of researchers' own positions over the research process (Buetow, 2019; Norris, 1997), demonstration that researchers have considered their own lenses and biases that could impact the collection and interpretation of data is essential in increasing the credibility of the findings, and enhancing understanding of the work (Berger, 2015). As such, this limits the extent to which conclusions can be considered to represent the views of participants, as opposed to that of the researchers (Poggenpoel & Myburgh, 2003). For example, researchers may hold an expectation of participants' answers to fit with existing psychological models linking trauma and psychosis (Ponterotto, 2002). As such, comparisons were made throughout the analysis between support for themes by studies with trauma-specific aims, and those focusing on psychosis more broadly, to ascertain whether ideas related to trauma seemed to be raised spontaneously (i.e. in general psychosis studies) as well as in trauma-specific studies. Theme 4.2. (related to more abstract reflections of traumatic events in anomalous experiences) had more support from trauma-specific studies, raising questions about the extent to which the conclusion represents the views of EbE. Furthermore, only 22% of studies mentioned whether participants had undertaken therapy; this further limits interpretation of the extent to which ideas shared were influenced by therapists (and therefore psychological theory), versus representing self-developed explanatory models (e.g. Carter, 2002; Johnson & Orrell, 1995).

Similarly, both the author and research supervisor of the present review are white European clinical psychologists working in healthcare systems. Our clinical psychology training may bias us towards interpretations of the data that fit with existing psychological models (Ponterotto, 2002).

Western culture, clinical psychology training programmes and healthcare systems are individualist by nature, so despite paying attention to this, this may also have influenced our interpretation of the data in favour of individualist processes (Hwang, 2019). This may also be true of the included studies, the vast majority of which took place in Europe and the United States and did, indeed, speak more to individualist processes within psychosis. The combination of the lack of researcher and participant demographic information available limits the extent to which cultural bias in the data can be assessed; for example, if both researchers and participants were from predominantly Western cultures then cultural bias may be low but the results may have reduced generalisability, whereas if participants were from predominantly non-Western cultures then the research design and analysis may not capture culturally-pertinent themes (e.g. Does et al., 2018). Furthermore, the pragmatic exclusion of studies for which an English-translated version was not available may have further biased the data available towards studies representing more Western, individualised perspectives; this may go some way to explain, for example, the lack of focus on collectivist processes and spirituality in the analysis (Carter, 2002; Menezes Jr & Moreira-Almeida, 2010).

Half of studies failed to report age, gender, and ethnicity as minimum demographic data, with 47% specifically omitting information about participant’s racial identity; this is slightly more optimistic than findings by DeJesus and colleagues (2019), which found that 73% of 1149 articles in 11 journals between 2015 and 2016 did not report the racial identity of participants, but still limits the depth to which findings can be interpreted and understood. Social identity can consciously and unconsciously shape the way people think, behave and experience the world, and therefore significantly influences the interpretation of research (Does et al., 2018; Ellmers, 2012). The existing psychosis research base- and the psychosocial models developed from it- disproportionately focuses on Western countries, and often fails to include a representative proportion of African-American participants relative to the populations samples are drawn from (Buckhard et al., 2021). Given that many forms of traumatic events (particularly abuse and violence) are grounded in systems of oppression (e.g. Goodman, 2014), information about the social identities of participants is integral in understanding the experiences shared in context. Future research would benefit from researchers reporting age, gender and ethnicity as minimum demographics (with consideration given to additional demographic information which may help situate the data) as well as involving representatives of the study population in the development and implementation of research (Staniszewska et al., 2018).

It was beyond the scope of the present review to explore the experience of psychosis as a traumatic event in itself, as has been highlighted as a common phenomenon and important research focus (e.g. Buswell et al., 2021; Fornells-Ambrojo et al., 2016). In the present review, some studies (e.g. Bergstrom et al., 2019; Hutchins et al., 2016; Taylor, 2005) identified consequences of psychosis (e.g. unimaginable emotion, deviance from life as it was once known) that were comparable to features of the aftermath of traumatic events shared by participants, an observation is supported by existing literature (Firmin et al., 2020). As such, psychosis-onset may build on and maintain existing cycles born from traumatic events, and contribute further to the cumulative impact of trauma .

Conclusion

This review synthesises qualitative studies related to first-hand experiences of psychosis, and provides a detailed analysis of what connections people make (and do not make) between traumatic events and the onset and subjective experience of psychosis. The results provide insights into areas of focus in clinical practice related to the assessment of life events that may be significant in psychosis-onset, and to possible avenues of intervention. It also highlights directions for future research, in particular related to considerations of researcher reflexivity and minimum demographic data reporting.

References

* Anketell, C., Dorahy, M. J., & Curran, D. (2011). A preliminary qualitative investigation of voice hearing and its association with dissociation in chronic PTSD. *Journal of Trauma & Dissociation*, *12*(1), 88-101. https://doi.org/http://dx.doi.org/10.1080/15299732.2010.514844

Anglin, D. M., Galea, S., & Bachman, P. (2020). Going Upstream to Advance Psychosis Prevention and Improve Public Health. *JAMA Psychiatry, 77*(7), 665-666. https://doi.org/10.1001/jamapsychiatry.2020.014

* Araten-Bergman, T., Avieli, H., Mushkin, P., & Band-Winterstein, T. (2016). How aging individuals with schizophrenia experience the self-etiology of their illness: A reflective lifeworld research approach. *Aging & Mental Health*, *20*(11), 1147-1156. https://doi.org/http://dx.doi.org/10.1080/13607863.2015.1063110

Arseneault, L., Cannon, M., Fisher, H. L., Polanczyk, G., Moffitt, T. E., & Caspi, A. (2011). Childhood trauma and children’s emerging psychotic symptoms: A genetically sensitive longitudinal cohort study. *American Journal of Psychiatry, 168*(1), 65-72.

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology, 8*. http://dx.doi.org/10.1186/1471-2288-8-21

Ayerbe, L., Pérez-Piñar, M., Forguet-Boreu, Q., & Ayis, S. (2020). Psychosis in children of separated parents: A systematic review and meta-analysis. *European Psychiatry, 63*(1), 1-9. https://doi.org/10.1192/j.eurpsy.2019.15

Baker, C. A., & Morrison, A. P. (1998). Cognitive processes in auditory hallucinations: attributional biases and metacognition. *Psychological medicine, 28*, 1199-1208.

Barker, C., Pistrang, N., & Elliott, R. (2016). *Research Methods in Clinical Psychology: An Introduction for Students and Practitioners (3rd ed.).* Chichester, UK: John Wiley & Sons.

* Bergstrom, T., Seikkula, J., Holma, J., Maki, P., Kongas-Saviaro, P., & Alakare, B. (2019). How do people talk decades later about their crisis that we call psychosis? A qualitative study of the personal meaning-making process. *Psychosis: Psychological, Social and Integrative*

Approaches, 11(2), 105-115. https://doi.org/http://dx.doi.org/10.1080/17522439.2019.1603320

Berrios, G. e. (1991). Delusions as 'Wrong Beliefs': A Conceptual History. *British Journal of Psychiatry, 159*(14), 6-13.

Bhikha, A. G., Farooq, S., Chaudhry, N., & Husain, N. (2012). A systematic review of explanatory models of illness for psychosis in developing countries. *International Review of Psychiatry, 24*(5), 450-462. https://doi.org/10.3109/09540261.711746

Bloomfield, M. A., Chang, T., Wood, M. J., Lyons, L. M., Cheng, Z., Bauer-Staeb, C., Hobbs, C., Bracke, S., Kennerley, H., Isham, L., Brewin, C., Billings, J., Greene, T., & Lewis, G. (2021). Psychological processes mediating the association between developmental trauma and specific psychotic symptoms in adults: a systematic review and meta-analysis. *World Psychiatry, 20*(1), 107-123. https://doi.org/10.1002/wps.20841

Bonoldi, I., Simeone, E., Rocchetti, M., Codjoe, L., Rossi, G., Gambi, F., Balottin, U., Caverzasi, E., Politi, P. & Fusar-Poli, P. (2013). Prevalence of self-reported childhood abuse in psychosis: A meta-analysis of retrospective studies. *Psychiatry Research, 210*(1), 8-15. https://doi.org/10.1016/j.psychres.2013.05.003

Boydell, K. M., Stasiulis, E., Volpe, T., & Gladstone, B. (2010). A descriptive review of qualitative studies in first episode psychosis. *Early Intervention in Psychiatry, 4,* 7-24. https://doi.org/10.1111/j.1751-7893.2009.00154.x

Boyle, M. (2002). It's all smoke and mirrors: How to create the illusion of a schizophrenic brain disease. *Clinical Psychology, 12,* 9-16.

Brewin, C. R., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk facts for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology, 68,* 748-766.

Brewin, C. R., & Holmes, E. A. (2003). Psychological theories of posttraumatic stress disorder. *Clinical Psychology Review, 23*. 33-376. https://doi.org/10.1016/S0272-7358(03)00033-3

Brewin, C. R. & Burgess, N. (2014). Contextualisation in the revised dual representation theory of PTSD: A response to Pearson and colleagues. *Journal of Behavior Therapy and Experimental Psychiatry, 45*(1), 217-219. https://doi.org/10.1016/j.jbtep.2013.07.011

* Brown, L. J. (2016). *A psychological understanding of the elevated incident rates of psychosis, within specific ethnic minority populations* (Publication Number 10588877) [DClinPsy, University of Birmingham (United Kingdom)]. ProQuest Dissertations & Theses Global. https://www.proquest.com/dissertations-theses/psychological-understanding-elevated-incident/docview/1885878019/se-2?accountid=14511

Buckhard, C., Cicek, S., Barzilay, R., Radhakrishan, R., & Guloksuz, S. (2021). Need for Ethnic and Population Diversity in Psychosis Research. *Schizophrenia Bulletin, 47*(4), 889-895. https://doi.org/10.1093/schbul/sbab048

Buetow, S. (2019). Apophenia, unconscious bias and reflexivity in nursing qualitative research. *International Journal of Nursing Studies, 89,* 8-13. https://doi.org/10.1016/j.ijnursstu.2018.09.013

Buswell, G., Haime, Z., Lloyd-Evans, B., Billings, J. (2021). A systematic review of PTSD to the experience of psychosis: prevalence and associated factors. *BMC Psychiatry, 21*(9). https://doi.org/10.1186/s12888-020-02999-x

* Butcher, I., Berry, K., & Haddock, G. (2020). Understanding individuals' subjective experiences of negative symptoms of schizophrenia: A qualitative study *British Journal of Clinical Psychology, 59*(3), 319-334. https://doi.org/http://dx.doi.org/10.1111/bjc.12248

* Campbell, M. L. C. (2007). *Bridging the Gap Between Psychosis and 'Normality': The Influence of Interpersonal Trauma and Unhelpful Appraisals* (Publication Number 13841214) [PhD, The University of Manchester (United Kingdom)]. ProQuest Dissertations & Theses Global. https://www.proquest.com/dissertations-theses/bridging-gap-between-psychosis-normality/docview/2178824636/se-2?accountid=14511

* Campodonico, C., Varese, F., & Berry, K. (2021). Trauma and Psychosis: A Qualitative Study Exploring the Perspectives of People with Psychosis. Preprint. https://doi.org/10.21203/rs.3.rs-568000/v1

Carr, S., Hardy, A., & Fornells-Ambrojo, M. (2018). The Trauma and Life Events (TALE) Checklist: development of a tool for improving routine screening in people with psychosis. *European Journal of Psychotraumatology, 9*(1). https://doi.org/10.1080/20008198.2018.1512265

CASP. *Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist* (2013). Available from http://docs.wixstatic.com/ugd/dded87_25658615020e427da194a325e7773d42.pdf

Carter, J. H. (2002). Religion/spirituality in African-American culture: an essential aspect of psychiatric care. *Journal of the National Medical Association, 94*(5), 371.

Cartwright-Hatton, S., & Wells, A. (1997). Beliefs about worry and intrusions: the meta-cognitions questionnaire and its correlates. *Journal of Anxiety Disorders, 11*, 279-296.

* Chakraborty, A. T., McKenzie, K., & King, M. (2009). Discrimination, ethnicity and psychosis- A qualitative study. *Ethnicity and Inequalities in Health and Social Care, 2*(1), 18-29. https://doi.org/http://dx.doi.org/10.1108/17570980200900004

* Chiu, V. W., Ree, M., Janca, A., & Waters, F. (2016). Sleep in schizophrenia: Exploring subjective experiences of sleep problems, and implications for treatment. *Psychiatric Quarterly, 87*(4), 633-648. https://doi.org/http://dx.doi.org/10.1007/s11126-015-9415-x

Croft, J., Heron, J., Teufel, C., Wolke, D., Thompson, A., Houtepen, L. & Zammit, S. (2018). Association of trauma type, age of exposure and frequency in child and adolescence with psychotic experiences in early adulthood. *JAMA Psychiatry, 34,* 193-199. https://doi.org/10.1093/schbul/sbm069

Conneely, M., McNamee, P., Gupta, V., Richardson, J., Priebe, S., Jones, J. M., & Giacco, D. (2021). Understanding Identity Changes in Psychosis: A Systematic Review and Narrative Synthesis. *Schizophrenia Bulletin, 47*92), 309-322. https://doi.org/10.093/schbul/sbaa124

DeJesus, J. M., Callanan, M. A., Solis, G., & Gelman, S. A. (2019). Generic language in scientific communication. *Proceedings of the National Academy of Sciences, 116*(37). https://doi.org/10.1073/pnas.1817706116

DeRosse, P., & Karlsgodt, K. H. (2015). Examining the Psychosis Continuum. *Current Behavioral Neuroscience Reports*, *2*, 80-89. https://doi.org/10.1007/s40473-015-0040-7

* Dickson, J. M., Barsky, J., Kinderman, P., King, D., & Taylor, P. J. (2016). Early relationships and paranoia: Qualitative investigation of childhood experiences associated with the development of persecutory delusions. *Psychiatry Research, 238,* 40-45. https://doi.org/http://dx.doi.org/10.1016/j.psychres.2016.02.006

Does, S. Ellemers, N., Dovidio, J. F., Norman, J. B., Mentovich, A., van der Lee, R., & Goff, P. A. (2018). Implications of Research Staff Demographics for Psychological Science. *American Psychologist*, *73*(5), 639-650, https://doi.org/10.1037/amp0000199

Douglas, C., Wood, L., & Tagart, D. (2021). Recovery priorities of people with psychosis in acute mental health in-patient settings: a Q-methodology study. *Behavioural and Cognitive Psychotherapy, 50*(1), 1-14. https://doi.org/10.1017/S135246580000892

Eglit, G. M., Palmer, B. W., A'verria, S. M., Tu, X., & Jeste, D. V. (2018). Loneliness in schizophrenia: Construct clarification, measurement, and clinical relevance. *PLoS ONE, 13*(3), e0194021.

Ehlers, A., Mayou, R. A., & Bryant, B. (1998). Psychological predictors of chronic posttraumatic stress disorder after motor vehicle accidents. *Journal of Abnormal Psychology, 107,* 508-519.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy, 38,* 319-345.

Ellemers, N. (2012). The group self. *Science, 336,* 848-852. https://doi.org/10.1126/science.1220987

Firmin, R. L., Zalzala, A. B., Hamm, J. A., Luther, L., & Lysaker, P. H. (2020). How psychosis interrupts the lives of women and men differently: a qualitative comparison. *Psychology and*

Psychotherapy: Theory, Research and Practice, 94(3), 704-720. https://doi.org/10.1111/papt.12317

Fornells-Ambrojo, M., Gracie, A., Brewin, C. R., & Hardy, A. (2016). Narrowing the focus on the assessment of psychosis-related PTSD: a methodologically orientated systematic review. *European Journal of Psychotraumatology, 7*(1). https://doi.org/10.3402/ejpt,v7.32095

Freeman, D., Garety, P. A., & Kuipers, E. (2001). Persecutory delusions: developing the understanding of belief maintenance and emotional distress. *Psychological Medicine, 31*, 1293-1306. https://doi.org/10.1017/S003329170100455X

Fusar-Poli, P., Estradé, A., Stanghellini, G., Venables, J., Onwumere, J., Messas, G., Gilardi, L., Nelson, B., Patel, V., Bonldi, I., Aragona, M., Cabrera, A., Rico, J., Hoque, A., Otaiku, J., Hunter, N., Tamelini, M. G., Machião, L. F., Puchivailo, M. C. (…) Maj, M. (2022). The lived experience of psychosis: a bottom up review co-written by experts by experience and academics. *World Psychiatry, 21*(2), 168-188. https://doi.org/10.00/wps.20959

Gayer-Anderson, C., & Morgan, C. (2012). Social networks, support and early psychosis: a systematic review. *Epidemiology and Psychiatric Sciences, 22*(2), 131-146. https://di.org/10.1017/S2045796012000406

Goodman, R. D. (2014). A Liberatory Approach to Trauma Counselling: Decolonizing Our Trauma-Informed Practices. In: R. D. Goodman, & P. C. Gorski (Eds.), *Decolonizing "multicultural" counselling through social justice* (pp. 55-72). Springer, New York

Griffiths, R., Mansell, W., Edge, D., & Tai, S. (2019). Sources of Distress in First-Episode Psychosis: A Systematic Review and Qualitative Metasynthesis. *Qualitative Health Research, 29*(1), 107-123. https://doi.org/10.1177/1049732318790544

Hamm, J. A., Leonhardt, B. L., Ridenour, J., Lysaker, J. T., & Lysaker, P. H. (2018). Phenomenological and recovery models of the subjective experience of psychosis:

discrepancies and implications for treatment. *Psychosis: Psychological, Social and Integrative Approaches, 10*(4), 340-350. https://doi.org/10.1080/17522439.2018.1522540

Hardy, A. (2017). Pathways from Trauma to Psychotic Experiences: A Theoretically Informed Model of Posttraumatic Stress in Psychosis. *Frontiers in Psychology, 8*. https://doi.org/10.3389/fpsyg.2017.00697

Harrison, G., Gunnell, D., Glazebrook, C., Page, K., & Kwiecinski, R. (2001). Association between schizophrenia and social inequality at birth: case-control study. *The British Journal of Psychiatry, 179*(4), 346-350.

Hobfoll, S., Dunahoo, C. A., & Monnier, J. (1995). Conservation of Resources and Traumatic Stress. In J. R. Freedy, & S. E. Hobfoll (Eds.), *Traumatic Stress: From Theory to Practice* (pp. 29-47). Springer Science & Business Media.

Huang, Z. H., Hou, C. L., Huang, Y. H., He, Z-Y., Wang, Q-W., Chen, X., Zhoug-Lei, W., Shi-Bin, W., & Fu-Jun, J. (2019). Individuals at high risk for psychosis experience more childhood trauma, life events and social support deficit in comparison to healthy controls. *Psychiatry Research, 273*, 296-302.

* Hutchins, J., Rhodes, J., & Keville, S. (2016). Emotional earthquakes in the landscape of psychosis: an interpretative phenomenology. *Cognitive Behaviour Therapist*, *9*, Article e30. https://doi.org/10.1017/s1754470x16000167

Hyland, P., Karatzias, T., Shevlin, M., McElroy, E., Ben-Ezra, M., Cloitre, M., & Brewin, C. (2021). Does requiring trama exposure affect rates of ICD-11 PTSD and complex PTSD? Implications for DSM-5. *Psychological Trauma: Theory, Research, Practice and Policy, 13*(2), 133.

Janoff-Bulman, R. (1989). Assumptive worlds and the stress of traumatic events: Applications of the schema construct. *Social Cognition, 7*(2), 113-136. Htps://doi.org/10.1521/soco.1989.7.2.113

Johnson, S., & Orrell, M. (1995). Insight and psychosis: a social perspective. *Psychological Medicine, 25*(3), 515-520.

Johnstone, L. (2011). Can traumatic events traumatize people? Trauma, madness and ‘psychosis’. In M. Rapley, J. Moncrieff, & J. Dillon. *De-medicalising Misery* (pp. 99-109). London: Palgrave Macmillan UK

Jongsma, H. E., Gayer-Anderson, C., Tarricone, I., Velthorst, E., van der Ven, E., Quattrone, D., di Forti, M., Menezes, P. R., Del-Ben, C. M., Arango, C., Lasalvia, A., Berardi, D., La Cascia, C., Bobes, J., Bernado, M., Sanjuan, J., Santos, J. L., Arrojo, M., de Haan, L. (…) & EU-GEI WP2 Group. (2020). Social disadvantage, linguistic distance, ethnic minority status and first-episode psychosis: results from the EU-GEI case-control study. *Psychological Medicine, 51*(9), 1536-1548. https://doi.org/10.1017/S003329172000029X

Jongsma, H. E., Karlsen, S., Kirkbride, J. B., & Jones, P. B. (2021). Understanding the excess psychosis risk in ethnic minorities: the impact of structure and identity. *Social Psychiatry and Psychiatric Epidemiology, 56,* 1913-1921. https://doi.org/10.1007/s00127-021-02042-8

Jordan, G., MacDonald, K., Pope, M. A., Schorr, E., Malla, A. K., & Iyer, S. N. (2018). Positive Changes Experienced After a First Episode of Psychosis: A Systematic Review. *Psychiatric Services, 69,* 84-99. https://doi.org/10.1176/appi.ps.201600586

Kelleher, I., Keeley, H., Corcoran, P., Ramsay., H., Wasserman, C., Caril, V., Sarchiapone, M., Hoven, C., Wasserman, D. & Cannon, M. (2013). Childhood trauma and psychosis in a prospective cohort study: Cause, effect and directionality. *The American Journal of Psychiatry, 170*(7), 734-741. https://doi.org/10.1176/appi.ajp.2012.12091169

Kessler, R. C. McLaughlin, K. A., Green, J. G., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., Aguilar-Gaxiola, A. O. Alhamzawi, J., Angermeyer, C., Benjet, E., Bromet, S., Chatterji, G., de Girolamo, K., Demyttenaere, J., Fayyad, S., Florescu, G., Gal, O., Gujere, J. M., Haro, C. Y. (…) Williams, D. R. (2010). Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. *British Journal of Psychiatry, 197,* 378-385. https://doi.org/10.1192/bjp.bp.110.080499

Lachal, J., Revah-Levy, A., Massimiliano, O., & Moro, M. R. (2017). Metasynthesis: An Original Method to Synthesize Qualitative Literature in Psychiatry. *Frontiers in Psychiatry, 8*(269). https://doi.org/10.3389/fpsyt.2017.00269

* Laithwaite, H., & Gumley, A. (2007). Sense of self, adaptation and recovery in patients with psychosis in a forensic NHS setting. *Clinical Psychology & Psychotherapy*, *14*(4), 302-316. https://doi.org/http://dx.doi.org/10.1002/cpp.538

* Langley, E. (2020). *'In the Same Boat, Helping Each Other' : a Grounded Theory of Growth and Emancipation in Peer-Led Hearing Voices Groups* [DClinPsy, Middlesex University (United Kingdom)]. ProQuest Dissertations & Theses Global. https://www.proquest.com/dissertations-theses/same-boat-helping-each-other-grounded-theory/docview/2467511749/se-2?accountid=14511

Larsen, S. E., & Pacella, M. L. (2016). Comparing the effect of DSM-congruent traumas vs. DSM-incongruent stressors on PTSD symptoms: A meta-analytic review. *Journal of Anxiety Disorders, 38*, 37-46.

Leaune, E., Dealberto, M. J., Luck, D., Grot, S., Zeroug-Vial, H., Poulet, E., & Brunelin, J. (2019). Ethnic minority position and migrant status as risk factors for psychotic symptoms in the general population: a meta-analysis. *Psychological medicine*, *49*(4), 545-558

* Leavey, G., Guvenir, T., Haase-Casanovas, S., & Dein, S. (2007). Finding help: Turkish-speaking refugees and migrants with a history of psychosis. *Transcultural Psychiatry*, *44*(2), 258-274. https://doi.org/http://dx.doi.org/10.1177/1363461507077725

Leonhardt, B. L., Hamm, J. A., Fogley, R. L., Buck, K. D., Roe, D., & Lysaker, P. H. (2015). Allowing for Psychosis to be Approachable and Understandable as Human Experience: A Role for the Humanities in Psychotherapy Supervision. *The American Journal of Psychotherapy, 69*91), 35-51. https://doi.org/10.1176/appi.psychotherapy.2015.69.1.35

Leonhardt, B. L., Hamm, J. A., & Lysaker, P. H. (2020). The Recovery Model and Psychosis. In: J. C. Badcock, & G. Paulik. *A Clinical Introduction to Psychosis: Foundations for Clinical Psychologists and Neuropsychologists.* (pp. 113-132) Academic Press

Lewin, S., Glenton, C., Munthe-Kaas, H., Carlsen, B., Colvin, C. J., Gülmezoglu, M., Noyes, J., Booth, A., Garside, A., Garside, R., & Rashidian, A. (2015). Using Qualitative Evidence in Decision Making for Health and Social Interventions: An Approach to Assess Confidence in Findings from Qualitative Synthesis (GRADE-CERQual). *PLOS Medicine, 13*(6). https://doi.org/10.1371/journal.pmed.1001895

Lim, M. H., & Gleeson, J. F. (2014). Social connectedness across the psychosis spectrum: Current issues and future directions for interventions in loneliness. *Frontiers in Psychiatry, 5,* 154.

* Lyons, M., Evison, P., Berrios, R., Castro, S., & Brooks, H. (2020). The lived experience of psychosis in Nicaragua: a qualitative examination of the views of service users. *Journal of mental health (Abingdon, England),* 1-8. https://doi.org/https://dx.doi.org/10.1080/09638237.2020.1844871

Mazor, Y., Gelkopf, M., Mueser, K. T., & Roe, D. (2016). Posttraumatic Growth in Psychosis. *Frontiers in Psychiatry, 202*. https://doi.org/10.3389/fpsyt.2016.00202

Mauritz, M. W., van Gaa, B. G. I., Goossens, P. J. J., Jongedjik, R. A., & Vermeulen, H. (201). Treating patients with severe mental illness with narrative exposure therapy for co-morbid post-traumatic stress disorder. *BJPsych open, 7*(1). https://doi.org/10.119/bjo.2020.124

Menezes Jr, A., & Moreira-Almeida, A. (2010). Religion, Spirituality and Psychosis. *Current Psychiatry Reports, 12,* 174-179.

* Milligan, D., McCarthy-Jones, S., Winthrop, A., & Dudley, R. (2013). Time changes everything? A qualitative investigation of the experience of auditory verbal hallucinations over time. *Psychosis-Psychological Social and Integrative Approaches, 5*(2), 107-118. https://doi.org/10.1080/17522439.2012.667438

Mishara, A. L., Lysaker, P. H., & Schwartz, M. A. (2014). Self-disturbances in Schizophrenia: History, Phenomenology , and Relevant Findings From Research on Metacognition. *Schizophrenia Bulletin, 40*(1), 5-12. https://doi.org/10.1093/schbul/sbt169

Misra, S., Gelaye, B., Koenen, K. c., Williams, D. R., Borba, C. P. C., Quattrone, D., Di Forti, M., La Cascia, C., La Barbera, D., Tarricone, I., Berardi, D., Szöke, A., Arango, C., Tortelli, A., de Haan, L., Velthorst, E., Bobes, J., Bernardo, M., Sanjuán, J. (…) Morgan, C. (2019). Early

Parental Death and Risk of Psychosis in offspring A Siz-Country Case-Control Study. *Journal of Clinical Medicine, 8*(7). https://10.3390/jcm8071081

* Misra, S., Johnson, K. A., Parnarouskis, L. M., Koenen, K. C., Williams, D. R., Gelaye, B., & Borba, C. P. C. (2020). How Early Life Adversities Influence Later Life Family Interactions for Individuals with Schizophrenia in Outpatient Treatment: A Qualitative Analysis. *Community Mental Health Journal*, *56*(6), 1188-1200. https://doi.org/10.1007/s10597-020-00627-2

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

Morrison, A., Frame, L., & Larkin, W. (2003). Relationships between trauma and psychosis: A review and integration. *British Journal of Clinical Psychology, 42,* 331-353.

National Institute for Health and Care Excellence. (2014). *Psychosis and schizophrenia in adults prevention and management* (NIC clinical guidance CG178). Retrieved from https://www.nice.org.uk/guidance/cg178/chapter/recommendations#how-to-deliver-psychological-intervetions

National Institute for Health and Care Excellence. (2018). *Post-traumatic stress disorder* (NICE guideline NG166). Retrieved from https://www.nice.org.uk/guiance/ng166

Ng, F., Ibrahim, N., Ranklin, D., Jordan, G., Lewandowski, F., Fang, F., Roe, D., Rennick-Eglestone, S., Newby, C., Hare-Duke, L., llewellyn-Beardsley, J., Yeo, C., & Slade, M. (2021). Post-traumatic growth in psychosis: a systematic review and narrative synthesis. *BMC Psychiatry, 21,* 607. https://doi.org/10.186/s12888-021-03614-3

Noiriel, A., Verneuil, L., Osmond, I., Manolios, E., Revah-Levy, A., & Sibeoni, J. (2020). The Lived Experience of First Episode Psychosis: A Systematic Review and Metasynthesis of Qualitative Studies. *Psychopathology, 53,* 223-238. https://doi.org/10.1159/000510865

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

* O'Neill, N. (2010). *Women's experiences of childhood sexual abuse and psychosis in adulthood* [PhD, University of Hertfordshire (United Kingdom)]. ProQuest Dissertations & Theses Global. https://www.proquest.com/dissertations-theses/womens-experiences-childhood-sexual-abuse/docview/1780169135/se-2?accountid=14511

* Owiti, J. A., Palinski, A., Ajaz, A., Ascoli, M., De Jongh, B., & Bhui, K. S. (2015). Explanations of illness experiences among community mental health patients: An argument for the use of an ethnographic interview method in routine clinical care. *International Review of Psychiatry*, *27*(1), 23-38. https://doi.org/10.3109/09540261.2014.995602

* Pietkiewicz, I. J., Klosinska, U., & Tomalski, R. (2021). Delusions of Possession and Religious Coping in Schizophrenia: A Qualitative Study of Four Cases. *Frontiers in Psychology*, *12*. https://doi.org/10.3389/fpsyg.2021.628925

Poggenpoel, M., & Myburgh, S. (2003). The researcher as a research instrument in educational research: A possible threat to trustworthiness? *Education, 124*(2), 418-421.

Ponterotto, J. G. (2002). Qualitative Research Methods: The Fifth Force in Psychology. *The Counselling Psychologist, 30*(3), 394-406.

Powers, A., Fani, N., Cross, D., Ressler, K. J., & Bradley, B. (2016). Childhood trauma, PTSD and psychosis: findings from a highly traumatized minority sample. *Child Abuse and Neglect, 58*, 111-118. https://di.org/10.1016/j.chiabu.2016.06.015

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

Raby, K., L. Labella, M. H., Maritn, J., Carlson, E. A., & Roisman, G. I. (2017). Childhood abuse and neglect and insecure attachment states of mind in adulthood: Prospective, longitudinal evidence from a high-risk sample. *Development of Psychopathology, 29*, 347-363. https://doi.org/10.1017/S0954579417000037

Rafaeli, E., Bernstein, D. P., & Youn, J. E. (2011). *Schema therapy: Distinctive features.* Routledge. https://doi.og/10.4324/9780203841709

Raffard, S., D'Argembeau, A., Lardi, C., Bayard, S., Boulenger, J. P., & van der Linden, M. (2010). Narrative identity in schizophrenia. *Consciousness and Cognition, 19*(1), 328-340.

* Rhodes, J. E., O'Neill, N. D., & Nel, P. W. (2018). Psychosis and sexual abuse: An interpretative phenomenological analysis. *Clinical Psychology & Psychotherapy*, *25*(4), 540-549. https://doi.org/10.1002/cpp.2189

* Rhodes, J. E., Parrett, N. S., & Mason, O. J. (2016). A qualitative study of refugees with psychotic symptoms. *Psychosis-Psychological Social and Integrative Approaches, 8*(1), 1-11. https://doi.org/10.1080/17522439.2015.1045547

Read, J., Bentall, R. P., & Fosse, R. (2009). Time to abandon the bio-bio-bio model of psychosis: Exploring the epigenetic and psychological mechanisms by which adverse life events lead to psychotic symptoms. *Epidemiologia e psichiatria sociale, 18*(4), 299-310.

* Rice, E. (2006). Schizophrenia and violence: The perspective of women. *Issues in Mental Health Nursing*, *27*(9), 961-983. https://doi.org/http://dx.doi.org/10.1080/01612840600899840

Ritunnano, R., Kleinmann, J., Oshodi, D. W., Michail, M., Nelson, B., Humpston, C. S., & Broome, M. R. (2022). Subjective experience and meaning of delusions in psychosis: a systematic review and qualitative evidence synthesis. *The Lancet, 9*(6), 458-476. https://doi.org/10.1016/S2215-0366(22)00104-3

* Rosen, C., Jones, N., Longden, E., Chase, K. A., Shattell, M., Melbourne, J. K., Keedy, S. K., & Sharma, R. P. (2017). Exploring the Intersections of Trauma, Structural Adversity, and Psychosis among a Primarily African-American Sample: A Mixed-Methods Analysis. *Frontiers in Psychiatry*, *8*(57). https://doi.org/10.3389/fpsyt.2017.00057

Sarac, C., DeLuca, J. S., Bilgrai, Z. R., Herrera, S. N., Myers, J. J., Dobbs, M. F., Haas, S. S., Todd, T. L., Srivastva, A., Jespersen, R., Shaik, R. B., Landa, Y., Davidson, L., Pavlo, A., & Corcoran, C. M. (2022). A Qualitative Study on Identity in Individuals at Clinical High Risk for Psychosis: “…Why Does It Have To Be One Thing?” *Psychiatric Rehabilitation Journal, 45*(1), 44-53. https://doi.org/10.1037/PRJ0000492

Sass, L. A., & Parnas, J. (2003). Schizophrenia, consciousness and the self. *Schizophrenia Bulletin, 29*, 427-444.

Selten, J-P., van der Ven, E., & Termorshuizen, F. (2019). Migration and psychosis: a meta-analysis of incidence studies. *Psychological Medicine, 50*(2), 303-313. https://doi.org/10.1017/S0033291719000035

Shevlin, M., Dorahy, M., & Adamson, G. (2007). Trauma and psychosis: An analysis of the National Comorbidity Survey. *American Journal of Psychiatry, 164,* 166-169.

Sitko, K., Bentall, R. P., Shevlin, M., O’Sullivan, N., & Sellwood, W. (2014). Associations between specific psychotic symptoms and specific childhood adversities are mediated by attachment styles: an analysis of the national comorbidity study. *Psychiatry Research, 217*(3), 202-209. https://doi.org/10.1016/j.psychres.2014.03.019

Soilemezi, D., & Linceviciute, S. (2018). Synthesizing Qualitative Research: Reflections and Lessons Learnt by Two New Reviewers. *Interventional Journal of Qualitative Methods, 17,* 1-14. https://doi.org/10.1177/1609406918768014

* Schofield, P., Kordowicz, M., Pennycooke, E., & Armstrong, D. (2019). Ethnic differences in psychosis-Lay epidemiology explanations. *Health Expectations, 22*(5), 965-973. https://doi.org/10.1111/hex.12901

Staniszewska, S., Denegri, S., Matthews, R., & Minogue, V. (2018). Reviewing progress in public involvement in NIHR research: developing and implementing a new vision for the future. *BMJ Open, 8*(7), e017124.

Sterling, J., Barkus, E., & Lewis, S. (2007). Hallucination proneness, schizotypy and meta-cognition. *Behaviour Research and Therapy, 45*, 1401-1408.

Strachan, L.P., Paulik, G., & McEvoy, P. M. (2022). A narrative review of psychological theories of pot-traumatic stress disorder, vice-haring and other psychotic symptoms. *Clinical Psychology & Psychotherapy,* 1-21. https://doi.org/10.1002/cpp.2754

* Strand, J., Olin, E., & Tidefors, I. (2015). 'I divide life into different dimensions, one mental and one physical, to be able to handle life, you know?' Subjective accounts of the content of psychotic symptoms. *Clinical Psychology & Psychotherapy, 22*(2), 106-115. https://doi.org/https://dx.doi.org/10.1002/cpp.1872

* Taylor, E. P. (2005). *The interpersonal self in early-onset psychosis: a grounded theory analysis* [DClinPsy, The University of Edinburgh (United Kingdom)]. ProQuest Dissertations & Theses Global. https://www.proquest.com/dissertations-theses/interpersonal-self-early-onset-psychosis-grounded/docview/301650346/se-2?accountid=14511

Thomas, J. & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research methodology, 8*(45), 1471-2288. http://dx.doi.org/doi:10.11.86/1471-2288-8-45

* Thornhill, H. (2002). *Recovery from psychosis : Stories of escape, enlightenment and endurance : A qualitative study of 15 accounts of recovery after one or more psychotic episodes, using interpretative phenomenological analysis and narrative analysis* [DClinPsy, University of London, University College London (United Kingdom)]. ProQuest Dissertations & Theses Global. https://www.proquest.com/dissertations-theses/recovery-psychosis-stories-escape-enlightenment/docview/1732881760/se-2?accountid=14511

Trotta, A., Murray, R. M., & Fisher, H. L. (2015). The impact of childhood adversity on the persistence of psychotic symptoms: a systematic review and meta-analysis. *Psychological medicine, 45*(12), 2481-2498.

* Turton, W. (2015). *Living with psychosis as a longer-term health condition: an interpretative phenomenological analysis (IPA) study* [PhD, University of Southampton (United Kingdom)]. ProQuest Dissertations & Theses Global. https://www.proquest.com/dissertations-theses/living-with-psychosis-as-longer-term-health/docview/1780279023/se-2?accountid=14511

van Os, J., Rutten, B. P., & Poulton, R. (2008). Gene-environment interactions in schizophrenia: review of epidemiological findings and future directions. *Schizophrenia Bulletin, 34*(6), 1066-1082.

Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., Read, J., van Os, J., & Bentall, r. (2012). Childhood adversities increase the risk of psychosis: A meta-analysis of patient-control, prospective and cross-sectional cohort studies. *Schizophrenia Bulletin, 38*(4), 661-671/ https://doi.org/10.1093/schbul/sbs050

* Vallath, S., Luhrmann, T., Bunders, J., Ravikant, L., & Gopikumar, V. (2018). Reliving, Replaying Lived Experiences Through Auditory Verbal Hallucinations: Implications on Theories and Management. *Frontiers in Psychiatry, 9,* Article 528. https://doi.org/10.3389/fpsyt.2018.00528

* Vallath, S., Ravikanth, L., Regeer, B., Borba, P. C., Henderson, D. C., & Scholte, W. F. (2020). Traumatic loss and psychosis - reconceptualising the role of trauma in psychosis. *European Journal of Psychotraumatology, 11*(1), Article 1725322. https://doi.org/10.1080/20008198.2020.1725322

Walsh, D., & Downe, S. (2005). Meta-synthesis method for qualitative research: A literature review. *Journal of Advanced Nursing, 50,* 204-211. https://doi.org.uk/10.111/j.1365-2648.2005.03380.x.

Wickham, S., Sitko, K., & Bentall, R. P. (2015). Insecure attachment is associated with paranoia but not hallucinations in psychotic patients: the mediating role of negative self-esteem. *Psychological medicine, 45,* 1495-1507.

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

* Wheeler, C. (2019) *Snitches get Stitches: A Qualitative Exploration of Childhood Bullying Amongst Individuals with Early Psychosis Experiences* [DClinPsy, University of Essex (United Kingdom)]. ProQuest Dissertations & Theses Global. https://www.proquest.com/dissertations-theses/snitches-get-stitches-qualitative-exploration/docview/2411945958/se-2?accountid=14511

Wood, L., Price, J., Morrison, A., & Haddock, G. (2013). Exploring service users perceptions of recovery from psychosis: A Q-methodological approach. *Psychology and Psychotherapy: Theory, Research and Practice, 86*(3), 245-261.

Part II: Empirical paper

Narrative Exposure Therapy in Early Intervention in Psychosis services: Expert by Experience and clinician views

Abstract

Aim: This study aimed to explore the views of Experts by Experience (EbE) and clinicians on the use of Narrative Exposure Therapy (NET) in Early Intervention in Psychosis (EI) services.

Method: A semi-structured interview about the process and impact of NET was conducted with four EbE and eight clinicians. Data was analysed by thematic analysis.

Results: Five overarching themes were generated from the analysis. The first related to fear and avoidance of memories which reduced as the intervention progressed. The second related to the centrality of trust in trying NET. The third encompassed processes by which people organised and/or made meaning about past experiences, following which traumatic memories felt more distant and carried fewer distressing emotions. The fourth related to strong emotions generated through NET (usually temporary, sometimes overwhelming) for EbE and clinicians. The fifth related to considerations about the implementation of NET by EI clinicians.

Conclusion: This study presents rich insights into EbE and clinician experiences of NET in a naturalistic clinical setting. NET was valued by EbE and clinicians and had a meaningful impact on traumatic memories, but should be offered following careful consideration of the challenge of the intervention. Implications for clinical practice and future research are outlined.

Introduction

Links between traumatic events and psychosis

Recent years have seen an increased interest in links between trauma and psychosis, both in terms of theoretical understanding and therapeutic intervention (Larkin & Read, 2008). Psychosis is a term used to describe a broad range of experiences, including those considered anomalous such as voice-hearing and distressing beliefs (British Psychological Society; BPS, 2017).

The DSM-5 defines events as being traumatic where they involve exposure to actual or threatened death, serious injury or sexual violence (American Psychiatric Association; APA, 2013). Childhood traumatic events has been estimated to increase the risk of psychosis in prospective and cross-sectional research, and have been significantly associated with the severity of anomalous experiences (Bailey et al., 2018; Varese et al., 2012).

Psychosis may be particularly linked to multiple or repeated traumatic events (Croft et al., 2018; Mueser et al., 1998; Shevlin et al., 2007). Prospective studies suggest individuals are at a greater risk of psychosis following multiple traumatic events than single-case events (Croft et al, 2018; Galletly et al., 2011). Population data research has identified a dose-type relationship between incidences of traumatic events and risk of psychosis (Bentall et al., 2012; Shevlin et al., 2007).

Anomalous experiences (e.g. persecutory voices) and intervention for psychosis (e.g. hospital admission) may also constitute traumatic events in themselves- some suggest the first episode of psychosis (FEP) is particularly likely to be experienced as traumatic due to its novelty (Mueser & Rosenberg, 2003). Estimates of rates of psychosis-related post-traumatic stress disorder (PTSD) range from 11-51%, though methodological limitations in its assessment have prevented authors from calculating a revised estimate (Fornells-Ambrojo et al., 2016). One meta-analysis examining the traumatic experience of psychosis estimated a pooled prevalence of 30% for PTSD diagnosis following an episode of psychosis and 42% for PTSD symptoms, with results suggesting that people admitted to inpatient units may be at greater risk (Rodrigues & Anderson, 2017). Participants in one qualitative study described aspects of their experience of psychosis, strong emotions and hospitalised treatment as being traumatic (Lu et al., 2017).

Psychological models have considered pathways linking experiences of trauma and psychosis. Psychosis could be explained using similar psychological mechanisms thought to be involved in the development and maintenance of PTSD (Hardy, 2017; Morrison, Frame & Larkin, 2003). Key processes in PTSD-development are thought to involve obstructed encoding of traumatic memories by stress-induced neurobiological changes, resulting in memories high in emotional salience but lacking contextual information related to the ‘when’ and ‘where’ of the event. A similar mechanism may explain the development of psychosis, with parallels drawn between psychotic intrusions and post-traumatic flashbacks (Brewin & Burgess, 2014; Hardy, 2017).

Psychosis may also be maintained by similar processes to PTSD. A recent meta-analysis found emotional dysregulation, hyperarousal, avoidance and dissociation to mediate the relationship between traumatic events and the development of hallucinations, and negative schemata to mediate the relationship between traumatic events and delusions or paranoia (Bloomfield et al., 2021; Longden et al., 2012). These are processes often also implicated in PTSD, and may form distinct pathways from traumatic events to forms of anomalous experiences. Traumagenic neurodevelopmental models have also proposed neuroanatomical and biochemical mechanisms underpinning the development and maintenance of post-traumatic psychosis (Read et al., 2001; Read et al., 2014).

Trauma-focused interventions and psychosis

The National Institute for Health and Social Care Excellence (NICE) currently recommend following guidance for PTSD to inform trauma-focused work with people experiencing psychosis, with emerging literature exploring their effectiveness (NICE, 2014; 2018). A meta-analysis of 15 controlled and un-controlled studies examining trauma-focused interventions (cognitive behavioural therapy- CBT; eye movement desensitization and reprocessing- EMDR; prolonged exposure-PE) concluded that the interventions were safe, and effectively reduced PTSD symptoms in psychosis samples. EMDR and PE were also associated with improvements in mood and anxiety. Evidence regarding the interventions' impact on psychosis symptoms was inconsistent (Swan et al., 2017). Notably, one of the included randomised controlled trials (RCT) involving delivery of EMDR or PE with people experiencing psychosis found both interventions showed a greater reduction of PTSD symptoms than the waitlist condition, with people in the PE condition significantly more likely to achieve loss of diagnosis and full remission than the waitlist condition (van den Berg et al., 2015). Most benefits were sustained at 12 month follow up (van Minnen et al., 2018; van den Berg et al., 2018).

Another review focused on the impact of trauma-focused interventions on psychosis-related symptoms found the interventions had a small significant effect on positive symptoms post-treatment but not at follow-up, and a small significant effect on delusions and PTSD symptoms at follow-up. Hallucinations and negative symptoms did not reduce significantly (Brand et al., 2018).

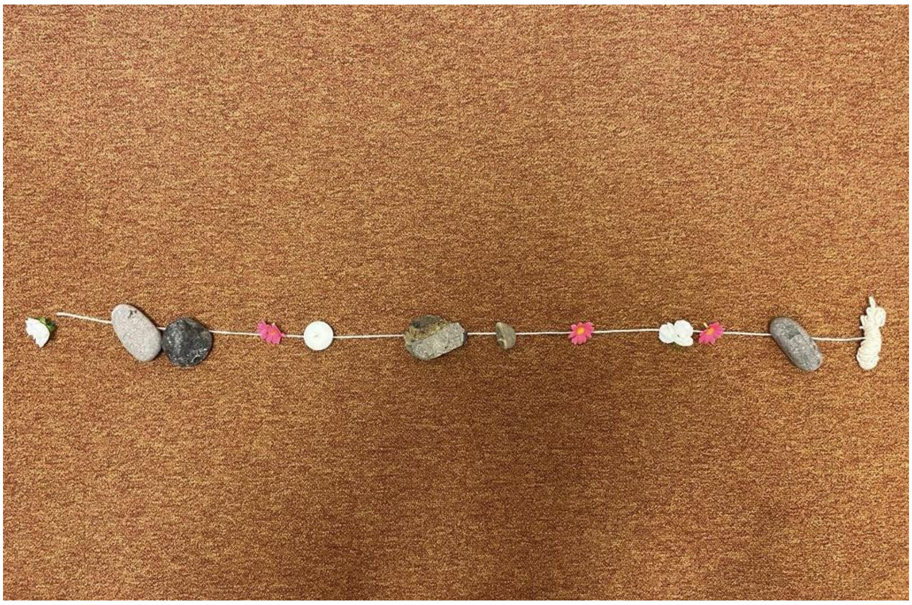
A review of six studies exploring the impact of EMDR on psychosis symptom scores found the intervention to be associated with reductions in delusions, negative symptoms, and use of medication and mental health services, with mixed findings related to auditory hallucinations and paranoia. No studies reported adverse events, though two noted initial increases in psychosis-related symptoms. The impact of EMDR and PTSD-related symptom scores was not assessed (Adams et al., 2020).

Despite emerging evidence supporting the acceptability and effectiveness of trauma-focused interventions, people accessing psychosis services are often not offered trauma-focused interventions, even when a diagnosis of PTSD is made (Álvarez et al., 2012). Whilst clinicians generally reported having a positive view on the use of trauma-focused interventions with this client group, barriers to implementation included concern about potential harm during the intervention, the dominance of the medical model in psychosis services, lack of structural support (e.g. training, communication between disciplines), workload pressures and difficulties with therapeutic engagement (Chadwick & Billings, 2022; Gairns et al., 2015). Research exploring how trauma-focused interventions are experienced by people with psychosis are vital in ensuring that interventions are acceptable and meet the needs of the individuals for whom they are designed. Speaking about traumatic events in therapy has been described as both relieving and distressing by people experiencing FEP, and was considered beneficial overall (Tong et al., 2017).

Narrative Exposure Therapy

Narrative Exposure Therapy (NET) is a NICE-recommended PTSD intervention for people who have experienced multiple traumatic events, and is therefore also recommended for psychosis (NICE, 2014; 2018). Based on psychological models of PTSD and memory (Brewin & Burgess, 2014), NET involves exposure to trauma memories in three stages; after a period of assessment and psychoeducation about PTSD or complex PTSD, a physical ‘lifeline’ is created by placing stones (traumatic events), flowers (positive events), candles (deaths) and sticks (involvement in violent acts) or other representational objects along a piece of rope (Figure 1); this further contextualises traumatic events within their personal timeline and highlights sources of strength amidst them (Elbert et al., 2012; Schauer et al., 2011) . The therapist and client then move through each of the objects of the lifeline; the client narrates each event, carefully integrating sensory-perceptual information with contextual information related to time, place and context, aimed at reducing the sense of current threat. The therapist produces a written testimonies after each narration which is shared and amended in the following session, and may be used in legal proceedings or to build documentation of human rights violations (Schauer et al., 2011).

Figure 1. Example of a NET lifeline using stones (traumatic events) and flowers (positive events; Schauer et al., 2011).



During the COVID-19 pandemic, guidelines around the online delivery of NET (e-NET) were produced. Similar challenges were encountered between e-NET and in-person NET, with the authors suggesting that it is the response to these challenges which may vary, including the assessment of and response to dissociation, and creative approaches to the formation of the lifeline (Kaltenbach et al., 2021).

Meta-analyses have reported significant and sustained reductions in PTSD symptoms and PTSD diagnosis eligibility following a course of NET (Siehl et al., 2021; Wei & Chen, 2021; Wright et al., 2020). NET has been observed to have small-to-medium between-group effect sizes on PTSD symptom scores in the short term (<6 months) and large long-term (≥ 6 months) effect sizes (Siehl et al., 2021). One review also supported the efficacy of NET for loss of PTSD diagnosis, though this was no longer significant when accounting for publication bias (Wei & Chen, 2021). One review identified a need for more specific reporting of cultural adaptation to NET to ensure cultural suitability of the intervention, though noted that the cultural adaptations that were described sounded 'promising' (Wright et al., 2020).

Emerging qualitative research into NET has explored the process and impact of NET from the perspective of asylum-seeking people (Cicconi, 2018) and unaccompanied minors (Said et al., 2021). Both studies spoke to the importance of a trusting therapeutic relationship in supporting participants to share traumatic memories, and generated themes related to improvements in general wellbeing, social relationships, and community participation (Cicconi, 2018), post-traumatic growth, self-expression and self-efficacy (Said et al., 2021) and a reduction in trauma symptoms (Cicconi, 2018; Said et al., 2021). The studies describe some challenges faced in the preparation and process of the intervention- some specific to the intervention (e.g. the retelling of traumatic events), some related to socio-cultural factors (e.g. differences between client and therapist, working with an interpreter).

Research has started to emerge related to therapists' experiences of using NET. In a study specifically exploring the use of the lifeline, therapists describe valuing the lifeline as a physical tool that helped develop a coherent life story. The lifeline process could be an 'emotional rollercoaster' for clients and therapists alike and presented some challenges around emotional containment, but was felt to strengthen the therapeutic relationship (Dix, 2021).

NICE recommends NET as a trauma-focused intervention to be offered to people accessing Early Intervention in Psychosis (EI) services due to the exposure component, proposed to be an active ingredient in supporting the integration of trauma memories and reducing intrusions (NICE, 2013). Research specifically evaluating the effectiveness and acceptability of NET for people accessing EI services is very limited. One available has found PTSD symptom scores associated with intrusions, avoidance, cognition and mood to reduce following a course of NET for people labelled as having 'serious mental illness' (SMI; a label given to people ascribed diagnoses of bipolar disorder, major depressive disorder, schizophrenia spectrum or personality disorder). Dissociation, medication-use and severity of SMI symptom scores were also found to decrease (Mauritz et al., 2021). One case study examining the use of NET with a woman diagnosed with PTSD with 'paranoid features' described the client noticing an increased ability to distance herself from emotionally engaging with traumatic memories, and a reduction in paranoia (Katsounari, 2015). One review exploring how NET is used in ‘complex circumstances’ found NET to be safely applicable following numerous unpublished pilot studies based in an inpatient psychosis setting in Germany (Breinlinger et al., 2020).

Research aims

Further research is required to examine the acceptability, feasibility, efficacy and effectiveness of NET for people experiencing psychosis. Qualitative methods have been deemed appropriate and important in informing newer areas of research and clinical practice (Barker et al., 2016). First-hand experiences of psychological interventions from the perspective of Experts by Experience (EbE) and clinicians is crucial in building understanding around the process of therapy, potential mechanisms of change and adaptations that may enhance the intervention for specific groups, as well as enhancing future quantitative evaluation (Skivington et al., 2021).

The current study aims to explore how NET is experienced by EbE and clinicians in EI services, including their perspectives on the impact of the intervention and what process factors may have contributed to this. Understanding this may inform possible adaptations to the intervention to best meet the needs of individuals with psychosis in clinical practice, and in possible future RCTs examining the use of NET with this population.

Method

Procedure

The study recruited EbE and clinicians from EI services, with first-hand experiences of NET. In order to capture a range of experiences from during and after the intervention, the inclusion criteria was inclusive of EbE mid-intervention, having finished the intervention and having dropped out. (Table 1).

Table 1. Inclusion and exclusion criteria for study participants

Experts by Experience	
Inclusion criteria	**Exclusion criteria**
- Aged 18+ years - Have a primary diagnosis of psychosis - Report a history of multiple traumas - Have had a minimum of one 'lifeline' and one 'narration of NET', *or* have had at least one session of NET before dropping out	- Unable to consent to the study under the Mental Capacity Act (MCA) - Have a primary diagnosis of intellectual disability or cognitive impairment
Clinicians	
Inclusion criteria	**Exclusion criteria**
- HCPC qualified clinicians - Undertaken training in NET - Delivered NET with minimum 1 individual with a primary diagnosis of psychosis	

Recruitment took place predominantly within four EI services across a London NHS Trust. Study information was shared with clinicians by email and in team meetings, and clinicians were invited to self-refer, and/or identify clients they thought may be eligible for the study. Former EI clinicians were also invited to interview via generic email. Study documents can be found in Appendices A – F.

Clinicians introduced potential EbE to the study and sought consent for them to be contacted by the researcher. Nine EbE were contacted about taking part in the study and given a minimum of 24 hours to read the study information before consent to participate was sought; five declined to take part in the study due to time commitments or not wanting to take part. A further two were tentatively identified by their clinicians, but later experienced an increase in risk and distress and were referred to inpatient wards, thus approaching them about the study was no longer deemed appropriate. 10 clinicians were approached, with two declining to take part due to time commitments and not being eligible. Interviews were arranged on Microsoft Teams where possible and face-to-face at local EI services where more appropriate. The final sample comprised four EbE and eight clinicians, who were interviewed between December 2021 and May 2022. Eight were interviewed remotely (clinicians n = 8; EbE n = 2), and the remainder face-to-face (EbE n = 2).

Before commencing the interview, the study information was reviewed, questions answered, and participants reminded of their right to withdraw from the study at any time. Participants then took part in semi-structured interviews (described below) lasting around 1 hour, recorded on an encrypted electronic recording device. Participants were debriefed at the end of the interview using a debrief form and informal discussion, to ensure they felt supported if any difficult emotions had arisen. Participants were compensated £10 in vouchers or bank transfer for their time and expertise, and were given contact details for the researcher for any follow-up questions. Audio files were transcribed using Scrintal (a GDPR-compliant online transcription software), pseudonymising the data and removing identifying information. Recordings were then destroyed.

Routine outcome measures

Routine outcome measure data was retrieved from the EbE participants' clinical files for descriptive purposes with participant consent. The Trauma and Life Events checklist (TALE; Carr et al., 2018) is a 21-item checklist which asks whether participants have experienced common traumatic or stressful life events (including psychosis-related trauma), and which of them have had the most impact. The PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013) is a 20-item self-report measure which assesses PTSD symptoms based on the DSM-5 diagnostic principles.

Semi-structured interview

Two semi-structured interview schedules- for EbE and clinicians- were developed iteratively. *Phase I:* Initial areas of interest regarding EbE and clinician experiences of NET were developed following a review of the NET literature, with a particular focus on studies focusing on NET and psychosis, and any qualitative NET research (e.g.Cicconi, 2018; Mauritz et al., 2021; Said et al., 2021). Initial areas of interest were noted; for example, Cicconi's research highlights challenges faced by EbEs during NET, which led to the inclusion of questions in both interview schedules around ending NET early. *Phase II:* An initial interview schedule was drawn up and developed iteratively, through a process of refining and reviewing with the research supervisor (MFA), professional experts and an EbE. *Phase III:* The final interview schedules were piloted with a trainee clinical psychologist with experience of delivering NET, and some minor amendments were made.

The final interview schedules (Appendices G & H) aimed to explore three areas- the process of delivering/receiving NET, the impact of the intervention and ideas about factors involved in bringing about change. The interview schedules followed these topic areas, starting with broad questions about each, followed by more specific follow-up questions if needed. The interview schedule was used flexibly to ensure the participants' sharing of their experiences was guided- rather than limited- by the questions and allowed space for unexpected aspects of experience to be shared (Smith et al., 2009).

Ethical considerations

This study received NHS HRA ethical approval from the Dulwich Research and Ethics Committee (reference 21/LO/0525; Appendix K). Participants provided written informed consent before taking part in interviews and were given the opportunity to take breaks to minimise the risk of distress or fatigue, though both risks were considered unlikely. Due to the sensitive nature of trauma-focused therapies, EbE were advised of the topic areas at the start of the interview, and informed that they would not be asked about the sensitive topics they discussed during their NET sessions.

Analysis

Interview transcripts were analysed using thematic analysis, in line with literature identifying thematic analysis as an appropriate method for change process research (Braun et al., 2014; Elliott et al., 2001; Levitt, 2015). Thematic analysis aims to identify patterns of themes within data, allowing for the consideration of similarities and differences within how participants describe their experiences of NET, and their perspectives on mechanisms of change.

Braun & Clarke's (2006; 2013) six step methodology was followed in an iterative manner; 1) Familiarisation- reading and re-reading transcripts and making notes of initial analytic observations. 2) Coding- systematically identifying and labelling relevant features of the data relevant to the research question- the first step in identifying patterns in the data, as it groups together segments of data. 3) 'Searching' for themes- clustering codes to create a map of key patterns in the data. 4)

Reviewing themes- checking whether the candidate themes ‘fit’ the coded data and the total dataset, and that each theme has a distinct central organising concept. 5) Defining and naming themes- writing a brief summary or definition for each theme and selecting a name- this should ensure conceptual clarity. 6) Writing the report- weaving together the analytic narrative and vivid data extracts.

Transcripts were coded promptly after each interview, and the integration of EbE and clinician accounts in the analysis was guided by a similar approach adopted by Galloway and Pistrang (2019). Due to the recruitment schedule, the clinician interviews were analysed first, followed by the service user interviews. In order to prioritise the voice of service users and to examine similarities and differences between service user and clinician accounts, the themes and codes generated from the clinician analysis were then revisited using the thematic framework generated from the service user analysis, to identify whether and how each of the service user themes occurred in clinician accounts. A final theme structure was then developed incorporating the themes shared across the service user and clinician accounts, and one additional theme generated only from the clinician analysis. The final set of themes was informed by their centrality and emphasis within individual transcripts, as well their frequency across interviews.

Validity checks

In line with available guidance, validity checks were used to ensure the research was rigorous and transparent (Elliot et al., 1999).

The researcher engaged in a bracketing interview at the start of the research process to consider her own position and assumptions, and how this might influence the ongoing research. This reflection continued throughout with a research journal used to aid this; some pertinent reflections are shared below.

Demographic data was related to the personal background of participants- plus professional backgrounds of clinician participants- to enable the sample to be situated, and this was referred to throughout data analysis.

The coding and themes were discussed between the author and research supervisor throughout the analysis process, highlighting inconsistencies, overlaps or biases, in reaching agreement on the final construction of themes.

Member-checking (Cresswell & Miller, 2000) was then used to check the final analysis fit with what participants had tried to convey in interviews. The final analysis was then shared with eight study participants, who were invited to respond with feedback in exchange for a £10 voucher. Two EbE and one clinician fed back that they felt their experiences had been represented in the analysis.

Reflexivity statement

The author (RS) is a white British female in her 20's. She is a trainee clinical psychologist, with experience working therapeutically with people experiencing psychosis in community and inpatient settings; this involved incorporating traumatic events into formulations, but not undertaking trauma-focussed work. Later in the research process, she worked in a child sexual abuse service; this involved doing trauma-focussed work with young people, but not NET. This lack of experience using NET clinically allowed her to approach the interviews from a position of naivety and curiosity, allowing her to focus on the experiences shared by participants. Half-way through the research process, she undertook training in NET, thus increasing her theoretical understanding of the intervention; following this, the researcher reflected on her learning from the training to make her new understandings of NET observable, attempting to reduce the implicit influence this may have on the analysis and make biases visible.

By nature of her professional training, the researcher holds assumptions about talking therapies, for example that talking therapies are generally helpful. This view evolved throughout her training after building experience of indirect ways-of-working, and following her own positive and negative experiences of personal therapy. She reflected on the impact of these experiences throughout- particularly when designing the interview schedule, data collection and analysis- to ensure she was attending to the full spectrum of experiences shared in interviews.

The researcher, as a white British able-bodied female, was also acutely aware that her social identities align with white Western ideals which are privileged within research more broadly. Aware of the history of health research in both silencing and exploiting people with minoritised social identities, in addition to the racial disparities in the diagnosis and treatment on people experiencing psychosis (Schwartz & Blankenship, 2014), the researcher aimed to pay particular attention to these issues.

The researcher approached the research from a critical realist epistemological standpoint; as such, while the researcher acknowledged that structures and processes relevant to NET may exist ontologically, these cannot be independently accessed or examined outside of the context of the experiences and perceptions of participants. As such, experiences shared may reflect a truth about the external world, but not give direct access to this reality (Willig, 2012; 2013). Given the importance of personal meaning-making within therapy itself, critical realism felt appropriate in relation to the study’s aims. One challenge faced by the secondary aim relating to change-factors within NET is that some of these may operate subconsciously or outside of the awareness of EbE, however the self-made meaning about the impact of the intervention is considered as relevant as theories about subconscious factors within the intervention.

Results

Descriptive information

Descriptive demographic information for EbE and clinicians is shown below (Table 2). EbE and clinicians were aged between 29 and 40 years. All but one of the clinicians were female, with three quarters of the clinician sample white British/European females.

Table 2. Demographic information about EbE and clinician participants

	Age range (mean)	**Ethnicity: *n* (%)**	**Gender: *n* (%)**
Experts by Experience n=4	29 – 40 (34.75)	British Asian- Pakistani: 1 (25%) Mixed-ethnicity- Caribbean/Irish/Dutch: 1 (25%) Asian- Other: 1 (25%) Black- African: 1 (25%)	Female: 2 (50%) Male: 2 (50%)
Clinicians n=8	29 – 38 (34)	White- British: 4 (50%) Black- British: 1 (12.5%) Black- British, African: 1 (12.5%) White- Spanish: 1 (12.5%) Pakistani: 1 (12.5%)	Female: 7 (87%) Male: 1 (13%)

Clinical information for EbE is presented below in group format, to preserve confidentiality. Based on available TALE data (unavailable for one participant), all participants reported having experienced events related to loss/separation; intentional interpersonal abuse; a sudden change in life circumstances; victimisation/discrimination; and psychosis-related events (including frightening contact with services). Two participants also reported having experienced accidents and neglect. Events took place between the ages 3 – 37 years (Table 3).

Table 3. Descriptive clinical information for EbE

			Mean (SD) / n(%)
Length to time with EI service (months)			23.3 (5.3)
Number of NET session attended at the time of interview			11.7 (3.5)
Routine outcome measures	TALE*	Loss/separation events	3 (75%)
		Intentional interpersonal abuse	3 (75%)
		Sudden change of circumstances	3 (75%)
		Victimisation/abuse	3 (75%)
		Neglect	2 (50%)
		Accident	2 (50%)
		Psychosis-related trauma	3 (75%)
	PCL-5 (PTSD Checklist for DSM 5)		55.8 (19.4)

*Data available for n=3/4

Information about the professional backgrounds of clinicians was collected using demographic forms. Most clinicians had ≤2 years of experience delivering NET both generally and with EI clients. Everyone had used NET with 1-5 EI clients. Most clinicians were accessing monthly specialist NET supervision while using NET.

Table 4. Clinical experience data for clinician participants (n (%))

	NET experience
Professional background	Clinical psychologist: 8 (100%)
Total years of experience using NET *n* (%)	≤ 2 years: 6 (75%) 3 – 5 years: 1 (12.5%) 5 – 8 years: 1 (12.5%)
Years of experience using NET with clients experiencing psychosis *n* (%)	≤ 2years: 8 (100%)
Approximate number of total clients seen for NET *n* (%)	1 – 5: 6 (75%) 6 – 10: 2 (25%)
Approximate number of clients experiencing psychosis seen for NET *n* (%)	1 – 5: 8 (100%)
Confidence with NET (0 = Novice, 10 = Confident) range (mean)	3 – 7 (4.57)
	Frequency of NET supervision
Monthly	6 (75%)
Less than monthly	1 (12.5%)
None	1* (12.5%) (*stopped delivering NET when no longer had access to supervision)
	Formal training in other trauma-focussed interventions
EMDR	2 (25%)
tfCBT	1 (12.5%)
tfCBT (top-up/CPD)	2 (25%)
tfCT as part of DClinPsy training	5 (62.5%)

Thematic analysis

The analysis generated five superordinate themes, comprising a total of 17 themes. Broadly, these related to apprehension before starting NET; the role of trust when starting NET; organising and making meaning around memories; the process of reconnecting with emotions; and psychosis-specific considerations when using NET (Table 5). Illustrative quotes supporting each theme are displayed in Table 6.

Table 5. Structure of superordinate themes and themes for all participants (EbE and clinicians)

Superordinate theme	Themes
1. Apprehension related to revisiting the past	**1.1.** Fear and avoidance of revisiting the past **1.2.** Sharing traumatic events as different to cultural norms **1.3.** NET feeling like a last resort *(EbE only)*
2. Trust was key in trying NET	**2.1.** Care and thoughtfulness helped build trust in the therapeutic relationship **2.2.** Choice and control helped build trust in the process **2.3.** Sharing a story in a trusted relationship can feel reparative *(clinicians only)*
3. Organising memories and relating to them differently	**3.1.** Mapping out events in context and realising “how much I’ve been through” **3.2.** Organising memories and locating them in the past **3.3.** Reflecting on events and making new meaning **3.4.** Challenging self-blame and building self-compassion **3.5.** Memories not going away, but feeling less held back by them
4. Reconnecting to emotions can be painful, and helpful	**4.1.** Emotions resurfacing can be a painful process for all **4.2.** A whole-system approach is important **4.3.** Connecting to emotions as an alternative to ‘carrying them’
5. Psychosis-specific considerations when using NET *(clinicians only)*	**5.1.** Embedding NET in EI services *(clinicians only)* **5.2.** The demands of NET *(clinicians only)* **5.3.** The nature of ‘stones’ selected *(clinicians only)*

Superordinate theme 1: Apprehension related to revisiting the past

The first superordinate theme relates to apprehension experienced prior to starting NET, mentioned primarily by EbE but also by clinicians. Fear about what it might be like to revisit the past was negotiated by considering the potential benefit, and apprehension was linked to the ‘newness’ of facing up to the past, and this feeling at odds with cultural norms (Table 6).

Theme 1.1. Fear and avoidance of revisiting the past

Both participant groups noted that EbE tended not to voluntarily think about difficult past events- or for some, about the past at all- before NET started; intrusive memories of the past were experienced as unwanted. People tended to push traumatic memories to the back of their mind (Table 6); as such, there was a fear about what revisiting the past would be like. This was emphasised by one EbE as a particularly relevant theme during member checking. Similarly, some clinicians shared a concern that speaking about past traumatic events may de-stabilise, or come to feature in, EbE anomalous experiences.

Clinicians noted that revisiting the past differed significantly from their clients’ usual approach to memories. As such, sharing ideas about a) why past events may be relevant to present experiences, and b) why revisiting these in therapy could be helpful, was an important part of exploring whether NET could fit a clients’ needs (Table 6).

The fear continued throughout the NET process, including instances of wanting to avoid upcoming sessions focused on particularly difficult ‘stones’ (traumatic events to be narrated). Through the process of NET, some EbE noticed patterns of avoidance in their lives more broadly and had started to face feared situations rather than avoiding them- a skill they hoped to carry into the future.

Table 6. Illustrative quotes for themes

Superordinate theme	Theme	Illustrative quotes	Number of participants (*k*)
1.Apprehension related to revisiting the past	1.1. Fear and avoidance of revisiting the past	EbE 2: I think I was scared to revisit certain things that I'd probably pushed aside and not dealt with in the past, and having to talk about them, um… that scared me. It was just feeling like I was going to have to bring up those things again that I sort of pushed back. Clinician 4: Like he was saying… another thing, he was talking about avoiding those memories, like pushing them back when he noticed them. And now he recognises that when they were coming back, because obviously he was saying that the day after doing the narration he started having more memories of the event that had happened, and of his childhood in general. And he was saying how doing that and not avoiding it was helping him realise that it was not actually as bad.	EbE: 4 Clinician: 5
	1.2. Sharing traumatic events as different to cultural norms	Clinician 8: Maybe there is something about this storytelling that had fit in quite well with her own past experiences. So kind she'll talk about her FAMILY MEMBER, spending time with her FAMILY MEMBER, and I think that also had, like, a storytelling type relationship to it as well EbE 1: And the thing is, being an African, you just keep your problems to yourself. It's like... telling people about your problems shows a sign of weakness. That is how we were brought up. So you just keep your problem. And a lot of things are like your family secret- you want to protect your family name who might know that as well. So that was the fear that came with it.	EbE: 2 Clinician: 6
	1.3. NET feeling like a last resort *(EbE only)*	EbE 3: You know, when you're all out of options, you'll try anything. I said, "I'll give you a go". You never know. Nothing has worked so far. So I was apprehensive. I wanted to see if I'll give it a good go. EbE 1: I think at a point I was really vulnerable, when you have kind of like... I had a very close contact with death. Kind of like, what is there to lose anymore? I wasn't really interested in anything anymore, so what difference is that gonna make? (…) If it was my normal self, I wasn't ill, I wouldn't have gone through with it. Because like I said, not all Africa- I'm not going to generalise, the way we have been brought up is usually a sign of like, weakness. But I was already a coward. Because if you've attempted to take your life, that is, you don't have any pride left in you. So which is why I say that I lost my identity already. And um... So I didn't really see anything... but if I was my normal African self, I would not be sitting in with THERAPIST to discuss my family, it's never gonna happen.	EbE: 2

Superordinate theme	Theme	Illustrative quotes	Number of participants (*k*)
2. Trust was key in trying NET	2.1. Care and thoughtfulness helped build trust in the therapeutic relationship	Clinician 3: Therapeutic relationship is so important. And again, I've said this before, but I think you can't overstate that in a psychosis client group, where trust… trust is always important, and trust can be something that takes time to build, but I think even more so for people who have been or are experiencing psychosis. EbE 2: Um, I think I felt quite comfortable with all my NET sessions. Um, again, it was I think a big part of it was because I had a good relationship with THERAPIST which we built up before I just started the NET therapy. So that made a difference, the trust was there. (…) I think that made a big difference to me doing it in the first place.	EbE: 4 Clinician: 7
	2.2. Choice and control helped build trust in the process	Clinician 8. I think there is something about NET that feels more empowering because it's… they're in control of what they choose to share, what they feel has impacted them, even the physical part of practically picking out the objects, putting it down. EbE 1: The fact that I got the choice to do or not do. Because... sorry (pause) I wasn't given a lot of choices. I... it's like, it's this way or (unclear) for me, it's always been like that. If I come into the session and I don't want to talk about a stone, I don't want to talk about anything, I just want to have like a general chat- it's fine. She's not gonna force me to do what I don't want to do because if I say anything that they are like forcing me to do something, I'm just going to like... that is going to be the barrier (unclear) for me. Because that's what I've done all my life	EbE: 4 Clinician: 6
	2.3. Sharing a story in a trusted relationship can feel reparative *(clinician only)*	Clinician 3: I think there's something really important about, you know, the more shame-based trauma memories can bring up feelings of anger and disgust, and having a corrective experience of a therapist just being validating and just being there and not having that rejecting or shaming experience. Clinician 5: Almost like a kind of gratefulness that somebody was willing to sit through this with them like, and be there, and give a response back to something that was horrific that shouldn't have happened in those cases.	Clinician: 7

Superordinate theme	Theme	Illustrative quotes	Number of participants (*k*)
3. Organising memories and relating to them differently	3.1. Mapping out life events in context and “realising how much I have been through”	Clinician 7: I think for one, the idea of using the lifeline, it just gives you a really nice overview of their whole story, because I think often people with psychosis are not routinely asked about their whole life’s journey. And it’s very much focused on the episode, and what was leading up to the episode, and just very illness-related information is gathered as opposed to thinking about their life context. EbE 2: I think that I like the fact that you can step back and just look at it. And then you can see you can see the... yeah, I think that was the thing when I stepped back and I saw it. And I saw all my stones, the bigger stones. And it was just like, "Wow, I've been carrying quite a bit with me," which I didn't realise, I think, because I've always been someone that kind of pushed things away and just carried on, so, yeah, to see it like that does make you realise "Well, that's quite a bit I need to go through".	EbE: 3 Clinician: 8
	3.2. Organising memories and locating them in the past	Clinician 2: I think what NET really allows you to do is really break things down into “so this is the emotion, these are the thoughts, okay and then we’re going to go back and focus on the past”. Then I’ll make sure to anchor it to the present, and go back. So like that constant weaving, I think, is really helpful. EbE 4: I felt like I was standing outside of a memory, if that makes sense. So I was... I was literally just... imagine, like a film theatre where you're watching something on the screen. That's what it felt like. And just to reiterate what had happened from a not so different perspective, but a perspective familiar enough to me. (…) I think my understanding and memory of what the events were, how they came to be, what they ended like, or what they projected like later, that got better. It was good to understand, with someone else, um, what was going on in those events.	EbE: 4 Clinician: 8
	3.3. Reflecting on events and making new meaning	Clinician 4: I think he did link putting things in a chronology to try and understand things. And he was very good at making connections for himself. Sometimes he would make connections, for example, he might link how [people] spoke to him and he might make a link to how his voice talks to him, and the relationship he has to his voice. So he was kind of doing that on his own, even just through the process of doing the lifeline. (…) That (voice content) was thematically coming from what his parents said to him, and how much do you want to let what they say dictate what you do now? He was able to take a bit more independence against the voice. EbE 3: She focused on the positive and the trauma at the same time. So while you are you looking at the trauma, there's positive stuff happening every day. Well you just don't see it. You just see the negative. So she's bringing all the positive from all of them circumstances as well as the negative. And I think he made a massive difference because I just I was looking at mostly negatives. And just never seen none of the positive. And it showed me that in between all the period of positive and negative, I was growing. And I was affecting changes.	EbE: 4 Clinician: 7

Superordinate theme	Theme	Illustrative quotes	Number of participants (*k*)
3. Organising memories and relating to them differently (cont.)	3.4. Challenging self-blame and building self-compassion	Clinician 2: So the first client, as we were doing NET, stopped dating people that were super chaotic and not good for her. I think that was linked to the self-confidence growing, and I think that was linked to going through a lot of these memories from the past that still had their hooks in her. It was almost as if when she was able to process the memories a bit more, she was able to be a bit more like “Yeah I definitely want to date. I do want to be with somebody. But just because someone is showing me attention, it doesn’t mean I have to follow through with anything.” (…) And I don’t think she would have done that before, because a lot of the beliefs about herself were still being driven by the experiences of the past. EbE 1: I said that to you, you know, like some of the things the... each time I think about it, or each time I have a nightmare or flashback about it, I feel myself... the self-blame, the self-worthlessness, the guilt... I just kept thinking, I am the cause of everything. The difference is that most of those things were not really my fault- it was because the adults didn't handle things the way they should have handled things. (…) I t would take weeks of sometimes for me to be like "Hang on, THERAPIST said this- it's true, I wouldn't do that to my own children right now". So I'll... it takes time for me to process whatever has happened in the stone that we spoke about.	EbE: 3 Clinician: 6
	3.5. Memories not going away, but feeling less held back by them	Clinician 3: She described that it just felt like every time she talked about a stone and it was really difficult and painful, even straight after the session (obviously having had spent some time just grounding and regulating that down), even then would just feel a sense of… she described it as like letting go of a hot coal, or something like that. EbE 2: They don’t just come out of nowhere now, whereas I used to have that. I can speak about most things now without feeling like, um, the emotional… surges with it.	EbE: 4 Clinician: 6

Superordinate theme	Theme	Illustrative quotes	Number of participants (*k*)
4. Reconnecting with emotions can be painful, and helpful	4.1. Emotions resurfacing can be a painful process for all	Clinician 4: He would actually get on the bus to come to therapy and the voice would say “There’s no point going. This isn’t helpful. You’re not gonna get anything from this.” And I think that happened more around the NET sessions than in any other sessions. And he managed to work against that and generally come, but I think there was this kind of… the voice got more intense, and that was harder for him to manage. Clinician 1: I’ve had a couple of experiences where I felt like we weren’t doing enough, we were kind of doing the processing, then the next week the person would say they found it completely overwhelming and found it a bit too much. (…) and if it’s something about the kind of numbing effect, you know, even something about how people present, maybe when there is a lot of medication, there’s something masking a little bit that reaction, and it feels like that’s a really important part to get right EbE 3: It’s been like three weeks now, and I'm still trying to like... It's a lot better because through that three weeks I couldn't even go into my shower to have a wash or anything. The day I was able to, that was the day it came on me that I... I'm in London now, I've got my own house. I'm able to go into my bathroom. It's not going to hurt as it was before. Putting water on myself, it's not gonna be that painful anymore. So that was when I was able to, like, detach myself from the session had, put myself in the bathroom, I had a good wash, and I even had to send a text to CLINICIAN- 'I had a wash today, it was so nice'	EbE: 4 Clinician: 8
	4.2. A whole-system approach is important	Clinician 1: I think kind of like, ideally, people's families, being aware as well and being kind of clear about what their loved one has signed up to him and what that might be like. Um, I think that's quite important, I think, um, yeah, just making sure the team are aware as well. EbE 1: I said to THERAPIST, if I don't have a strong support network... I don't think the session might do me a lot of good. Because when I get home, everybody around me knows, "every Wednesday she goes to her session. And sometimes when she comes back, she's not.... she's always worse off." So they'll keep coming. If I get home now, there must be someone at home. Someone dropped me. They'll be someone at home to like, you know, baby-sit, more like. Til I decide to like come out of my shell again.	EbE: 2 Clinician: 7
	4.3. Connecting to emotions as an alternative to ‘carrying them’	Clinician 5: People have talked about feeling lighter and not as heavy across their chest. One woman talked about this pain she used to get down the side of her face, and that being lifted. So yeah, being sensory-led, that can be really lifting. EbE 2: Now I feel like I've done... I've done the hard work with it, and the difficult part of it, I've spoken about it and went through all the emotions and everything, um, in a safe environment where I needed to, and it feels like I've let it all out and then just kind of... I've released it and I'm not, I keep saying it, but I feel like I'm not carrying it with me anymore.	EbE: 4 Clinician: 2

Superordinate theme	**Theme**	**Illustrative quotes**	**Number of participants (*k*)**
5. Psychosis- specific considerations when using NET *(clinician only)*	5.1. Embedding NET in EI services *(clinician only)*	Clinician 4: He was quite reluctant to do it for a long time (…) he didn't understand the rationale for it, basically. And there were two sticking points, one of which was "Why would I talk about the terrible things that have happened to me? So how is that going to help me?", and two, "How is what happened to me in the past related in any way to the current experiences I have?" Clinician 7: Um, so I think having that boundary sometimes can get a little bit tricky and and it sort of goes back to that setup of like, this isn't something you can launch into. You do have to have someone on board and committed to work on trauma. That's way working, whereas generally, when you're doing other psychosis work, it's not quite the same feel, isn't it? You're not necessarily contracting people to that way of working. It is very much let's see how this goes. It might work. It might not work for you. We can review at the time how you're finding it. We can change the scope we need to, and there's much more flexibility. Whereas there isn't so much I thought in this model. And... but having said that, like, most people did take to it quite well.	Clinician: 8
	5.2. The demands of NET *(clinician only)*	Clinician 5: Sometimes people's experience of psychosis and whether it's the trauma or whatever in the brain, is just shut down a little bit. And it is really difficult to think and reflect and remember, and so the detail they give is a little bit too sparse, and you're trying to enrich the picture more and more. But it just feels… it really feels like it's in there, but they can't get it out. Clinician 2: You have to be able to talk… a lot. You have to be quite descriptive.	Clinician: 7
	5.3. The nature of 'stones' selected *(clinician only)*	Clinician 7: With psychosis, it's a range of traumatic experiences. It's the accumulation often of the smaller T's that has the biggest impact. (…) obviously, you have some traumatic incidences that there are obvious, but the vast majority it felt like repeated experiences of being, you know, feeling shitty in lots of different ways. Um, and I think that it just didn't allow that kind of level of processing. So I suppose if I was thinking of a way to adapt, it would be like, how are you going to be inclusive of people that have had these and smaller T's and accumulation of those that don't necessarily impact them in obvious ways. But they have a huge impact on maintaining factors. (…) I've always found that people give really positive feedback about working on those stones. Clinician 4: The main thing is that we figure out what I was saying before about traumas that don't seem to link to the anomalous experiences.	Clinician: 6

Theme 1.2. Sharing traumatic events as different to cultural norms

Sharing difficult experiences with others was felt to clash with cultural norms by many, with one EbE commenting that it would be experienced as a sign of weakness in their African culture (Table 6). In particular, sharing family stories outside of one's family which would otherwise be kept private brought about a level of guilt. Clinicians noted that if people were willing to speak about the past despite the apprehension, NET felt relatively cross-culturally applicable (or at least neutral); this was attributed to the lack of jargon, the de-pathologising stance of the intervention, and in particular the emphasis on storytelling. Their clients had compared the storytelling nature of NET with members of their family who they identified as being storytellers (Table 6). The limits of using individualised interventions where a) people identify with collectivist cultures, and b) abuse has been perpetrated, leaving the onus on the person themselves to access support, were noted. Some clinicians felt NET made space for consideration of socio-political contexts such as racism, whilst others felt the intervention unhelpfully placed most emphasis on the events at an individualised level. One clinician felt assumptions were often made about the suitability of NET based on their cultural identity, suggesting instead individual choice and preference should be considered.

Theme 1.3. NET feeling like a last resort (EbE only)

Two EbE felt that trying NET was a last resort, given how difficult their circumstances had become and sometimes having tried other avenues of support beforehand (Table 6). This theme was not brought up by clinicians. One person had considered suicide as a means of preventing the traumatic events they had endured from becoming known. They also shared that a disconnection from their cultural identity- related to the shame attached to traumatic past events- led to a willingness to try NET that they may not have had otherwise, due to how different the NET approach is to their cultural norms (Table 6).

People spoke about having a determination to ‘get better’, and a willingness to endure the fear associated with revisiting the past. The encouragement of family members and clinicians was helpful for some in this decision-making process.

Superordinate theme 2: Trust was key in trying NET

The second superordinate theme encompasses ideas shared about the role of trust in the therapeutic relationship, and the importance of this in supporting people to try NET. EbE placed a greater emphasis on trust in their interviews, though this was also mentioned by most clinicians. Clinicians also shared ideas about the potential reparative impact of sharing one’s story in a trusted therapeutic relationship.

Theme 2.1. Care and thoughtfulness helped build trust in the therapeutic relationship

Care and thoughtfulness supported the development of trust in the therapeutic relationship, and the NET process strengthened these relationships further. Being seen as a whole-person was important in this process, especially through clinicians caring about and giving space to EbE’s lives beyond NET and helping with practical tasks; clinicians felt was particularly important for EI clients, who often had a lot going on in their life more generally (e.g. housing circumstances) alongside distress linked to anomalous experiences. Being asked how they were and checking in outside of sessions where distress was high also supported EbE in trust-building. Most EbE had worked therapeutically with clinicians before starting NET (e.g. completing a CBTp intervention), and both participant groups emphasised the value of this existing relationship in building trust and understanding (Table 6). Some EbE doubted whether they would have tried NET were it not for the existing trusting relationship they shared with their therapists.

Warmth, empathy and validation were considered important ingredients in trust-building by clinicians. NET was described and ‘respectful’, ‘human’ and ‘less formal’ than other trauma-focused interventions, which was felt to aid trust-building and engagement. Clinicians acknowledged that trust is important in all therapeutic work, but arguably more so when working with a client group (such as people affected by psychosis and multiple trauma) who have often experienced ongoing breeches of trust (Table 6).

Theme 2.2. Choice and control helped build trust in the process

EbE emphasised the role of choice, control and collaboration in building trust in the NET process. Knowing they could stop at any time enabled EbE to try the therapy; for some this meant pausing in sessions, and for others it meant coming to a session and not doing the NET-related tasks. Being told what to expect and given adequate time in sessions helped EbE feel in control of the process. Kind encouragement to continue and a reminder of the rationale of the work helped EbE choose themselves to continue with NET, without forcing them. Had this not been possible, EbE commented that they would have felt ‘pressured’ or ‘forced’, which would have been a barrier to ongoing engagement (Table 6). This was linked by EbE to the lack of choice and autonomy they had experienced at other times of their lives.

Clinicians found NET a collaborative intervention, linked particularly to the process of constructing the lifeline on the floor alongside clients. Similarly, giving people control over the construction of their own lifeline (i.e. choosing which events to include, and which items used to symbolise these) and clinicians not touching the lifeline themselves unless invited was experienced as respectful and empowering by participants in both groups (Table 6).

Theme 2.3. Sharing a story in a trusted relationship can feel reparative (clinician only)

Clinicians suggested that the process of sharing one's story in a trusted therapeutic relationship could be reparative in itself. In their experience, EI clients often had not been given an opportunity to 'share their story' meaningfully in other encounters with services, or in important relationships. As such, NET gave people a chance to share their story- with control over which events are focused on- and receive a warm and empathetic response (Table 6). Witnessing people's stories, 'being with' them throughout and still being there (i.e. not rejecting) them afterwards was felt to reduce shame (Table 6).

Superordinate theme 3: Organising memories and relating to them differently

Aspects of the NET process contributing to a sense of people's timelines feeling more organised, and to the creation of new meaning and relationships with past events.

Theme 3.1. Mapping out life events in context and realising "how much I have been through"

The lifeline helped map out a coherent chronology of life events where the narrative of events previously felt jumbled or unclear; EbE compared this to a roadmap, or the index of a book. This also acted as a clear 'map' through the intervention.

The tactile, interactive experience of constructing the lifeline combined with the chronological approach taken was felt to be an accessible way of opening rich, detailed conversations about significant events that may otherwise have been missed. The physicality of the lifeline allowed people to step back and see (and therefore realise) how much they had been through (Table 6), which contextualised and, to a degree, normalised their current experiences of distress. Clinicians spoke to the relevance of this when working with people affected by psychosis, many of whom had not considered their current experiences in the context of past life events before; this realisation gave rise to both self-compassion and sadness.

The incorporation of both positive and negative life events on the same lifeline- by design and choice of the EbE- situated traumatic events within a whole life context, and connected to valued moments, activities and relationships amidst traumatic life events. Clinicians noted the difference between this process, and other types of assessments that EbE were likely to have encountered in health services (Table 6).

Theme 3.2. Organising memories and locating them in the past

NET helped people to organise their memories, with all EbE referring to the 'cupboard metaphor'[1] often used in NET and other trauma-focused interventions. Detailed narration helped fill in the gaps of individual events, building a clearer picture of what happened and when (Table 6). Hearing narrations read back provided an opportunity to consolidate and further clarify events. Clarity about 'what happened' helped intrusive memories feel less distressing.

---

[1] The 'cupboard metaphor' refers to a metaphor commonly used in trauma-focused interventions. The mind is compared to a cupboard, into which clothes have been thrown quickly in a disorganised fashion. Processing traumatic memories is compared to the removal of items of clothing (memories) one-by-one, folding them, and putting them back into place- after which, the clothing (memories) will be organised and easier to access when needed (Ehlers & Clark, 2000).

Clinicians placed greater emphasis on the process of connecting to past and present sensory-emotional experiences as a means of differentiating the past from the present (though most EbE also commented on this; Table 6). A clarification of ‘what happened, and when’, built a newfound sense of safety in the present. This ‘sensory-weaving’ process was helpful in grounding distress outside of NET, with some EbE appreciating that this was a skill they could take into their future lives.

Theme 3.3. Reflecting on events and making new meaning

NET allowed EbE to reflect on life events and generate new perspectives on what happened, and the meaning they drew from them. This often linked to self-blame (e.g. Table 6). For some, meaning-making was linked to the process of connecting to strengths and ‘positives’ throughout their life-course alongside traumatic events, which led to a re-appraisal of themselves as someone who has survived a great deal, and still been able to create valued memories and relationships (Table 6). For some, new meaning was made around the role of themselves and others in a traumatic event. This was valued and helped people understand their current distress.

According to EbE, reflection and consolidation took place after narration sessions- for some, intentionally; for others, this seemed less within their control and was difficult. EbE valued developing the skill of slow, thorough reflection through NET; this was linked to being ‘less rash’, more likely to think things through slowly before acting, and more likely to consider other people’s circumstances or histories before making judgements.

Clinicians noticed that chronological nature of the lifeline allowed people to notice patterns between significant events earlier in life, and later experiences related to psychosis (e.g. thematic links between childhood abuse and the content of voices; Table 6). Given that psychosis-related events tended to fall further along the lifeline, people could notice and build links themselves; this was felt to build understanding around the development and content of anomalous experiences, and enable people to relate to them differently (e.g. feeling more in control of how to respond). Past-present links also helped the EI team's understanding of distress, and was felt to contribute to a 'paradigm shift' towards a trauma-informed understanding of psychosis.

Theme 3.4. Challenging self-blame and building self-compassion

Reflections about meaning-making often referred to self-blame (Table 6); for one EbE, this was the most important shift in helping them to 'move forwards'. Clinicians valued the human rights stance of NET- stating clearly that what happened was not their fault; some EbE explicitly mentioned finding this helpful, others seemed to appreciate it but did not feel a shift in self-blame for themselves until after further reflection and consolidation outside of the session.

Shifting self-blame helped build self-compassion in relation to past events, and in life more broadly. One EbE used spontaneous, compassionate self-talk throughout the interview- affirming their strengths and congratulating themselves on their achievements. Connecting to strengths throughout the NET process bolstered a positive sense-of-self and hope for the future. One clinician commented that allowing people to self-define flowers open up unconventional stories about strengths and values, which may otherwise have been missed. Some EbE noticed an increase in self-confidence, and one EbE (interviewed mid-intervention) felt they had noticed improvement in self-blame, but not self-confidence.

Building self-compassion and self-worth was linked to a general prioritisation of one's own needs. For some this linked specifically to relationships- e.g. setting boundaries in relationships, expressing oneself more and noticing less worry about other people's opinions of them (Table 6). This, in turn, strengthened relationships. For others, a more strengths-based sense-of-self was built greater sense of hope and control over the future; people commented on making other life changes in relation to their wellbeing, e.g. having a more balanced diet, more stable medication adherence, and engaging in activities such as yoga and meditation. These life changes contributed to improved wellbeing, in addition to NET itself.

Theme 3.5. Memories not going away, but feeling less held back by them

Regarding the impact of NET, most participants commented on the fact that although memories had not 'gone away', people held a different relationship to them, characterised by feeling a greater distance (Table 6). The power that memories held over EbE's lives was less- this was noted, even, by an EbE interviewed mid-intervention (Table 6). The 'problems' people associated with traumatic memories varied- examples including flashbacks, self-blame, difficult emotions and suicidal thoughts. EbE and clinicians spoke about memories 'popping up' less frequently, less out-of-the-blue and with less intensity; moreover, people spoke about a greater degree of control over how they responded to such events; one clinician described this as being less 'hooked' by the memory, which was linked by some with no longer avoiding places or situations linked to the memory. People spoke generally about a reduction in difficult emotions (e.g. anger, fear, shame) that had been linked to memories, and more connection with more 'positive' states-of-being, such as happiness, calmness, balance and stability. EbE all spoke about there still feeling a 'way to go' in their recovery, but that this felt like a significant step forward.

One EbE was interviewed mid-intervention, and spoke about balancing the benefit of NET (for them, self-blame) with the cost of the distress linked with the intervention (discussed more below). Similarly, clinicians shared stories of some EI clients who had not seen a significant benefit from NET, linked for some to a hope that the memories would completely go away, and for others to a significant increase in distress during the NET process. Clinicians noted the complexity often encountered in the life circumstances of people accessing EI services (e.g. instability in housing and employment circumstances, stigma), suggesting that this might limit the impact possible from an individualised therapeutic intervention such as NET.

Superordinate theme 4: Reconnecting to emotions can be painful, and helpful

Most participants spoke about NET (or at least elements of NET) and being difficult, albeit to varying degrees. Based on EbE and clinician accounts, the intensity of emotion aroused by NET varied but had the potential to be strong, and painful. Participants spoke about factors that supported them through this distress, and emotion-related skills they had since been able to implement in life outside of NET.

Theme 4.1 Emotions resurfacing can be a painful process for all

All clinicians described NET as being a difficult process for many EI clients, with EbE emphasising this to varying degrees in their accounts. Both groups spoke described re-connecting with emotions and bodily sensations linked to the past as being painful. For one EbE (interviewed mid-intervention) the degree and duration of distress was a significant drawback of the intervention; they described a sense of having been transported back to the time and location in which the events took place, which was incredibly distressing (Table 6). Some experienced physical, embodied responses to NET (e.g. two participants spoke about bleeding, and some also spoke about physical pain). This distress was most often described as temporary, and though sometimes extreme, did not compare to the pain of the event itself.

Repeated exposure to the narration reduced the intensity of the emotion it aroused. Grounding techniques, therapists checking in, doing NET face-to-face and starting to notice some benefit from NET also helped people withstand their distress. One EbE suggested that doing NET in a private outdoor space could help further.

Clinicians described experiences with EI clients who encountered significant levels of distress, and with whom the intervention was stopped early. Clinicians felt there was an additional layer of vulnerability with EI clients that warranted careful consideration around the timing and appropriateness of the intervention, including preparing people and their support networks for potential distress experienced in the intervention. In such cases NET could be dysregulating, and anomalous experiences grew in intensity around NET sessions which was an additional burden to manage (Table 6). Clinicians shared concerns about NET interacting with anomalous experiences, for example one clinician spoke about the content of a 'stone' incorporating into fixed belief and contributing to a relapse. There was a general sense that people had to be in a 'better place' with some stability around them before offering NET; it was felt that a stabilisation phase could be beneficial for some, acknowledging conflicting views in the literature about the necessity and utility of this.

Conversely, one EbE did not speak about finding the sessions particularly distressing or painful. Clinicians noticed that it was sometimes difficult to judge the emotional impact of the processing aspect of NET (e.g. people appearing calm throughout, even if they later reported feeling overwhelmed). Some clinicians linked this to their own relative inexperience in using NET, but also wondered whether psychosis-specific factors may impact this- e.g.

‘negative symptoms’ (such as flatness and emotional disconnection) and antipsychotics having a numbing effect (Table 6).

Most clinicians reflected on the emotional impact of NET on themselves, which, due to the level of detail in the narration, was experienced as more visceral and intense than other trauma-focused therapies. No clinicians shared this as a barrier to them using NET (in fact, most mentioned valuing the intervention), but doubts were raised about the number of clients they could use NET with at one time, given the emotional intensity of the work and the time required to complete it (e.g. writing up the narrative, reading the narrative at the start of the next session).

Theme 4.2. A whole-system approach is important

EbE valued family members providing sensitive and attuned support through the distress of NET (Table 6); one EbE stressed that without this, this distress could have outweighed the benefit of the intervention and had a significant impact on their wellbeing. Post-session routine was important to some EbE in mitigating this distress. Clinicians felt that including family in the set-up of the intervention would be helpful (Table 6), where possible and appropriate.

Clinicians also considered impact of service infrastructure in the implementation of NET. An understanding of the rationale and potential impact (i.e. distress and benefit) of NET within the wider multi-disciplinary team was felt to be important in enabling other members of the care team to provide appropriate support and encouragement. It was noted that because EI services are not ‘trauma service’, this understanding is not embedded in the team. NET was described as resource-heavy, and clinicians considered service-level provision needs to enable NET to be used safely and effectively, including provision of equipment and adequately sized rooms, and time for longer sessions and breaks accounted for in job plans.

The complexity of adapting NET for this client group was also noted; as such, the provision of regular, specialist supervision was felt to be necessary in enabling NET to be used in this setting. One clinician commented that since joining a service where this is no longer available, they have stopped using NET with this group.

Theme 4.3. Connecting to emotions as an alternative to 'carrying them'

The process of connecting to emotions during NET allowed EbE to put them to one side, as opposed to 'carrying them' as they had been before (Table 6). This was often described as a visceral experience, such as a feeling of a weight being lifted, feeling lighter, and unburdened (Table 6). This was also linked to a sense of moving forwards, rather than being held back. This was also mentioned by clinicians, though to a lesser degree.

Many also commented that connecting to emotions was a skill they developed during NET, and hoped to use in the future. This was linked to normalising of experiencing and sharing emotions, and experiences of the therapist noticing, naming and co-regulating difficult emotions in sessions. The benefits of 'opening up' in relationships was discussed, as well as using creative outlets as a way of processing difficult experiences and emotions.

Superordinate theme 5: psychosis-specific considerations when using NET (clinician only)

The final superordinate theme consists of reflections by clinicians about dilemmas encountered when using NET specifically with people affected by psychosis. Due to its focus on delivery of the intervention, EbE accounts did not contribute directly to this theme.

Theme 5.1. Embedding NET in EI services (clinician only)

Consideration was given to the implementation of a 'trauma-intervention' in EI- a service which is not a specialist 'trauma service'. The impact of this on understanding the process of NET and the provision of appropriate MDT support is mentioned above. On an individual level, clinicians noted that many EbE had not considered their current distress in the context of past experiences (Table 6). Whilst for many this was a helpful realisation, some people expected and wanted their therapy space to be one for focusing on current experiences and worries. Moreover, even where people did see relevance in speaking about past experiences, many simply did not want to- this was linked to people having 'managed' without speaking about it for all their lives, and to the professional discourse as 'talking about trauma as enabling healing' being particularly Westernised. Clinicians noted that most people who decided they were willing to attempt to revisit the past, then went on to find NET an understandable and acceptable model.

Similarly, clinicians wondered about how flexibly NET can be used (Table 6). Some EbE emphasised the impact of 'unusual experiences' (particularly voices) on sessions and described grounding strategies (such as visualisations) used in sessions to mitigate this; even so, they described the voices as pulling people out of the narrative and wondered about the impact of this on the effectiveness of the intervention. They also described having additional sessions around the NET sessions to formulate the temporary increase in voices, and practice grounding techniques. Some clinicians also noted that irregular session attendance can be common in EI settings, which was seen as a barrier to offering NET to some.

A dilemma between strictly adhering to the protocol versus working in a flexible client-led was identified, especially in the context of flexibility and person-centred care being felt to be central to the ethos of EI services. Examples included allowing space to speak about non-NET-related matters (which EbE shared helped in trust-building and engagement) and allowing more time for the lifeline session where it did not feel possible to complete it in one session (due to the number of stones; interpersonal factors; or where clients had specifically requested this). Clinicians questioned the extent to which this flexibility- which was felt to be important- could be accommodated without compromising the intervention's effectiveness.

Theme 5.2. The demands of NET (clinician only)

Clinicians considered difficulties with cognition (e.g. memory, focus and concentration) often seen in an EI setting, and shared dilemmas they had encountered in the NET process related to this. In particular, this included the reliance on language and speaking in NET feeling difficult for some (Table 6); memories feeling jumbled (particularly related to psychosis-related 'crises', or where linked to psychosis-related 'fixed beliefs'); 'thought disorder' obstructing the flow of narration; in-depth narration and longer sessions requiring a greater level of concentration than felt possible for some people. As such, some clinicians found it difficult to generate the level of detail they felt was necessary for the narration to be helpful (Table 6). Revisiting the narration at the start of each session was found to aid memory, as well as giving people a chance to reflect and amend their story as needed. Adaptations such as slowing down the process could feel counter-productive for those who already found concentration difficult in the longer sessions. Conversely, clinicians valued the physicality of the lifeline in making the process of developing a timeline less verbal and more accessible.

Theme 5.3. The nature of ‘stones’ selected (clinician only)

Dilemmas related to the selection and narration of ‘stones’ were identified by almost all clinicians; many tentatively linked this to their relative inexperience in using NET, though some also hypothesised about psychosis-specific factors affecting this.

Lifelines often included a large number of stones, which presented challenges in a) completing the lifeline in one session (as above), and b) selecting which ‘stones’ to narrate, in relation to how many sessions clinicians and EbE felt was appropriate to contract for the piece of work. The dilemma in selecting ‘stones’ was linked to the less-obvious links between past events and psychosis-related experiences (Table 6), and to stones being held in equal importance by EbE.

Clinicians noted that EI clients often emphasised the importance of an accumulation of a broad range of adverse life events, in addition to discrete traumatic events. Where ‘stones’ did not link clearly to current experiences, clinicians wondered a) how decisions should be made about which stones to narrate (generally an inclusive approach was taken to give people the opportunity to make meaning, but concerns were shared about how long a course of treatment might then be), and b) whether ‘stones’ that do not seem to have the fragmentation of sensory-emotional and contextual information (but may still be phenomenologically linked to current anomalous experiences) should be narrated in the same way, or approached differently.

Discussion

This study aimed to explore the EbE and clinician experiences of NET in EI services. The thematic analysis resulted in five domains linked to the emotional experience of NET (before and during), ideas about mechanisms of change, and facilitators and barriers to the intervention; these encompassed 17 themes.

Pain and challenge of trauma work

All participants spoke to the challenge of engaging with NET. While clinicians put forward similar accounts of NET as a potentially distressing and dysregulating process, EbE accounts fell across a spectrum of ‘challenging but not too distressing’ to ‘extremely frightening and overwhelming’. This variance could be linked to clinician queries about whether emotional disconnection and/or numbing of antipsychotics (Moncrieff et al., 2009) may limit the emotional impact of narration for some. Breinlinger and colleagues observed that antipsychotics could ‘dampen’ the ‘subjective experience and presentations’ during NET, though suggested that there had not been a need to modify medication during therapy, in their experience (Breinlinger et al., 2020).

On the other end of the spectrum, one EbE emphasised the degree of distress that was encountered during NET, and noticed an increase in fear, shame and exhaustion throughout the intervention. Clinicians might not be aware of what the consequences will be for someone speaking about traumatic events until they started. Similarly, while clinicians acknowledged the (sometimes great) distress encountered by people during NET, they perhaps did not describe it to the same extremity as EbE; as such, clinicians may not be aware of the true extent of distress that can develop through the NET process.

The distress described was comparable to findings of other qualitative research into experiences of trauma-focused interventions with people accessing EI services (Tong et al., 2017) and people diagnosed with PTSD (Shearing et al., 2011), which described reliving as ‘painful but achievable'. Participants described feeling like past events were happening in the present, which 'took over people's lives'. There was a sense of relief when this had stopped. Similarly, existing qualitative NET research noted the narration sessions could generate high levels of distress, but to a lesser degree than the pain of the original event (Cicconi, 2018; Said et al., 2021). Distress was typically described as temporary and, in line with previous findings, reduced as the intervention progressed and people started to notice benefit (Cicconi, 2018).

Clinicians' concern about the potential distress of trauma-focused interventions has also been noted elsewhere as a barrier to offering such interventions in psychosis services (Walters et al., 2016; Gairns et al., 2015; Chadwick & Billings, 2022). Increases in distress during trauma-focused interventions for have been reported by quantitative research; this tended to be for a minority of participants, which led to authors concluding the interventions were safe and tolerable. Moreover, twice as many waitlist-controls reported symptom exacerbation compared to the experimental group, and participants who experienced distress and symptom exacerbation still showed improvement from the intervention (Foa et al., 2002; Jayawickreme et al., 2014; Larsen et al., 2016). Nonetheless, the payoff between distress and potential-benefit must be considered beforehand and monitored throughout; one clinician in the present study spoke about an EI client for whom the potential benefit of NET did not feel worth the risk of increase in distress, as they had been 'managing' for many years. For others, a sense of relief and being 'unhooked' from the memories justified the challenge.

A common concern is that the increased distress could increase the risk of drop-out; one systematic review estimated rates of drop-out for trauma-focused interventions with people experiencing psychosis ranged from 14-41%, with higher rated reported by studies evaluating tf-CBT (Swan et al., 2014). One meta-analysis estimated the average drop-out rate for trauma-focused interventions (outside of psychosis settings) as 18% (Imel et al., 2013). Interestingly, one study found no association between symptom exacerbation and risk of drop-out (van den Berg et al., 2016). Although this study aimed to be inclusive of people who had dropped out from NET, a limitation is that none were recruited or interviewed. Understanding the experience of people who drop out from NET is an important avenue for future research to ensure possible instances of harm within the intervention can be understood, and the intervention adapted accordingly (Patel et al., 2016; Tong et al., 2017).

The findings of the current study suggest that NET can be delivered safely, and that people retrospectively found the benefit of NET to outweigh the distress or challenge it presented. Clinicians described a process of carefully assessing for whom NET might be suitable and appropriate, considering the degree of stability around a person. Participants in both groups mentioned the importance of a supportive network (family; friends; EI clinicians) when distress was high; this had also been raised in qualitative trauma-focused therapy literature (Shearing et al., 2011) but not in NET literature (Cicconi, 2018; Said et al., 2021).

Trust and therapeutic alliance at the core of NET

Trust was mentioned by most participants, particularly emphasised by EbE. Trust enabled EbE to try NET despite apprehension about revisiting the past and the sensitivity of the stories being shared. Care, kindness and consideration were factors that EbE associated with trust-building. There was a sense that clinicians 'went the extra mile' and that EbE were 'more than just a number' to them, which meant they 'really cared'; this has been linked to trust-building in other qualitative psychosis research (Laugharne et al., 2011). EbE also emphasised the benefit of having some control over the therapeutic in building trust, which was linked by some to repeated historical experiences of disempowerment. This is in keeping with existing research suggesting the people experiencing psychosis particularly value empathy, trustworthiness and collaboration in therapeutic relationships (Lawlor et al., 2017; Pipkin et al., 2021; Wood et al., 2015).

Therapeutic alliance broadly encompasses goal agreement, task agreement and therapeutic bond (Bordin, 1979), and is hypothesised to be a 'non-specific' factor responsible for a proportion of therapeutic effect across all interventions (Rosenzweig, 1936; DeRubeis et al., 2005). Therapeutic alliance has been found to predict therapy outcomes and has been linked with a reduction in global- and psychosis-symptom scores for people experiencing psychosis, with poor therapeutic alliance linked to a detrimental therapeutic outcome (Bourke et al., 2021; Goldsmith et al., 2015; Horvath et al., 2011). As such, understanding facilitators to the development of therapeutic alliance (and, within this, trust) with people experiencing psychosis is central to ensuring therapeutic interventions help, rather than harm.

Difficulties in trust may be linked to insecure attachment styles (Fonagy et al., 2017). Rates of insecure attachment have been estimated at 76% in individuals experiencing psychosis compared to 38% non-clinical samples, with insecure attachment (particularly fearful attachment) significantly associated with negative symptom scores and, to a lesser degree, positive symptom scores (Carr et al., 2017). This could be understood in the context of associations between adverse, attachment-disrupting events (e.g. abuse) and psychosis (Bentall et al., 2014). Fearful attachment styles have been linked to unhelpful views of self and other for people and emotional dysregulation for people experiencing psychosis, which may have implications for trust-building (Mason et al., 2005; Quijada et al., 2015).

Therapeutic alliance may be particularly important in trauma-focused interventions, especially where events (e.g. abuse) have shattered assumptions about the world and other people as being safe, benevolent and trustworthy (Cloitre et al., 2002; Ormhaug et al., 2014). One study found no association between child sexual abuse history and strength of therapeutic alliance, suggesting that a strong relationship can still be built despite previous violations of trust (Keller et al., 2010). Therapeutic alliance has been found to predict therapeutic outcome in tf-CBT, but not a non-specific treatment control condition, suggesting alliance may have a specific change-facilitating role in trauma-focused interventions (Ormhaug et al., 2014).

Mechanisms of change: exposure and meaning-making

EbE and clinicians referenced the exposure component of NET (though EbE tended to refer to this as ‘going through the memory in detail’). Clinicians described feeling particularly active in this part of the intervention and commented that it seemed particularly challenging for clients, which for some linked to an idea that the process was important in enabling change. EbE described a sense of memories feeling jumbled and confusing prior to NET starting, and valued the role of the lifeline, narration sessions and re-reading of narratives in organising memories. This helped clarify ‘what happened’ and ‘when’, which was linked to a reduction in distress linked to the memories.

These observations are in line with NET theory, and literature about the mechanisms of other trauma-focused interventions. Theoretically, NET is informed by models of autobiographical memory which propose that sensory-perceptual information is linked to a traumatic event is processed and stored differently as a result of high levels of arousal (Conway, 2001; Schauer et al., 2011). The NET model draws from dual representation theory (Brewin et al., 2010) in its distinction between sensory-perceptual information (‘hot memory’ in NET; S-reps in dual representation theory), and contextual information as (‘cold memory in NET; C-reps in dual representation theory). NET proposes that when ‘hot memory’ is not embedded within contextual, autobiographic memory, its detachment from time and place can result in the ‘hot memory’ being experienced intrusively and out-of-context as a flashback. As such, NET aims to reintegrate the memory through a process of detailed narration, weaving between sensory-perceptual information linked to the memory and in the present moment, to re-integrate the ‘hot’ and ‘cold memory’ and contextualise it in time and place (Schauer et al., 2011).

With most quantitative NET research focusing on PTSD symptom scores and loss of diagnosis, this research contributes to understanding people’s subjective experience of the impact of NET. Following NET (and even during, for the EbE interviewed mid-intervention), EbE noticed that although intrusive traumatic memories did not stop (similar to Cicconi, 2018), they felt less intrusive, more distant, emerged less frequently, and had fewer ‘problems’ attached to them (e.g. fear, anger, shame, suicidal thoughts). This was often described as an embodied experience- a sense of a ‘weight being lifted’, or emotions no longer being ‘carried’. With some quantitative NET literature suggesting that improvement is seen predominantly at the 6 month follow-up (e.g. Patel, 2016), it is interesting that participants in the present study noticed improvement as the therapy is progressing; this may help ‘mobilise hope’ and build expectation of success, which has been linked to better engagement and therapeutic outcomes (Tsai et al., 2012).

Dual representation theory would suggest that such improvements can be attributed to the processing of 'hot' and 'cold memory' led to the reintegration of sensory-perceptual information with information related to time and place, thus contextualising memories and reducing instances of memories being re-experienced unexpectedly (Brewin et al., 2010). As noted in Cicconi's findings, it is not clear theoretically why flashbacks do not subside entirely; this may be linked to a need for more sessions, a greater activation of the sensory-perceptual network during processing; or a limit to which dual representation theory can be applied to prolonged, multiple and/or repeated trauma (Cicconi, 2018).

All EbE seemed to have 'assimilated' the 'cupboard metaphor' used in trauma-focused interventions, an observation also made in research of asylum seekers' experiences of NET (Cicconi, 2018). Given that being given clear information about NET and prepared for what to expect were identified as important facilitators for trying NET, psychoeducation may have an important role in both engagement and providing a framework for people to understand their experiences. Clinicians felt the model was easy to understand and believed including families in psychoeducation could help build understanding and inform appropriate support- a view echoed in other psychosis-related psychoeducation research (Lincoln et al., 2007).

As well as the sensory-perceptual integration of memories, most participants mentioned a sense of memories feeling contextualised within one's personal history. This has also been observed in qualitative research into therapists' experiences of using the lifeline, which suggested this was a distinct process to the 'contextualisation' referenced in relation to the integration of 'hot' and 'cold memory' in NET as it seems specifically linked to the lifeline, which aims to collect details related to the 'cold memory' only (Dix, 2021). This may hold particular relevance when using NET with people accessing EI services. One review considered the characteristics of narrative identity in participants experiencing psychosis; narrative structure was described as temporally incoherent and lacking in detail and context- through a trauma-lens, this is theoretically in keeping with a dual representation model of memory (Brewin et al., 2010). The authors also characterised the autobiographical reasoning of participants as 'marked by disconnection between events and the present-self', which was attributed to difficulties in drawing connections and meaning about past events in relation to the present self (Cowan et al., 2021). As such, the NET lifeline may have a role in supporting the development of a coherent and connected narrative identity, which could be considered a therapeutic outcome in itself (France & Uhlin, 2006). Further research is required to explicitly examining these processes in NET and build on this hypothesis.

Meaning-making also emerged as an important mechanism of change in the current study. Participants described a process of making new meaning about past events, related to the extent to which events defined them; the role of self and other in events; relationship to self-blame; and a new view of self in light of past events (e.g. characterised by strength and resilience). Survivor-led movements are advocating for the prioritisation and amplification of ‘collectively produced knowledge’ in moving away from singular, medical conceptualisations of anomalous experiences (Bergström et al., 2019; Rose, 2017). Meaning-making has also been found to have a potential mediatory role in post-traumatic growth (Mazor et al., 2016).

Clinicians emphasised the role of people making links between past traumatic experiences and present distress in understanding anomalous experiences, which they observed allowed people to have a greater degree of control over how their responses to the experiences. EbE did not comment on the role of NET in aiding understanding of psychosis-associated experiences. Interestingly, when referencing current experiences of distress they also did not often differentiate between experiences labelled as ‘psychosis’ (e.g. voice-hearing) or experiences commonly linked to PTSD (e.g. flashbacks). It is not clear whether this is because participants did not feel able to speak about their anomalous experiences, or whether they did not differentiate between their experiences so definitively. Phenomenological links between life events and anomalous experiences have been described (Alsawy et al., 2015; Brand et al., 2017; Corstens & Longden, 2013), but research is lacking into the impact of meaning-making processes on recovery.

EbE also mentioned skills developed through the process of NET which they had taken with them beyond the intervention; forming secondary outcomes, of sorts. These related to experiencing and expressing emotions; building relationships; noticing avoidance and facing fears; and grounding by connecting to the senses. Given that emotion regulation and social relationships can present challenges to people accessing EI services- especially those who have experienced interpersonal child trauma- NET may also act as an effective skill-developing intervention in domains beyond the processing of traumatic memories (Eisenstadt et al., 2012; Khoury & Lecomte, 2012; Satin et al., 2014). Moreover, three EbE spoke about valuing the slow, detailed process of narration, and noticed that it this helped them to think more thoroughly before acting or making a judgement; respond to situations ‘less rashly’; and consider other people’s histories and perspectives. Future research could explore the impact of this on ‘hasty decision-making’ and paranoia, given the association between these and psychosis (Dudley et al., 2016)

NET in EI service: empowerment and the whole person

NET’s emphasis on strengths- initially through the flowers, and then through the weaving of strengths and values throughout the NET process- was appreciated by most participants. The building of a more strengths-based and compassionate sense-of-self was linked by EbE and clinicians to other life changes that contributed to well-being- a point emphasised by one EbE during the member checking process. Coping self-efficacy has been linked to post-traumatic growth in psychosis (Mazor et al., 2016).

NET was felt to encompass ‘the whole person’ by way of the lifeline, which made space for stories from across the lifespan- positive and negative; this is consistent with research into clinician views of the lifeline (Dix, 2021). This was felt by clinicians to fit the ethos of EI and ‘psychosis work’ more broadly, which was characterised as person-centred. Moreover, EbE spoke about valued when clinicians took an interest in their lives beyond what was relevant to the NET process, and appreciated clinicians helping with practical tasks associated with daily living (e.g. housing). Similarly, clinicians described a conflict between making space for concerns arriving in peoples’ present lives versus sticking to the protocol and keeping sessions focused on NET-related tasks. This dilemma has been described by NET clinicians working in non-psychosis settings (Coope, 2019), but there was a sense that this felt particularly relevant in an EI setting in which support would typically be flexible in its focus. CBTp, routinely used in EI services, also holds flexibility as a central tenet, and clinicians are encouraged to assist people with non-therapy-related tasks related to larger goals that may improve quality of life (Landa, 2017).

Clinicians spoke about the importance of a whole-system approach to the implementation of NET in EI. A cohesive MDT understanding of the relevance of trauma-focused interventions was thought to facilitate the process of service users receiving appropriate support and encouragement throughout the NET process, especially in light of distress. This is in line with research into barriers and hesitations around offering trauma-focused interventions to people experiencing psychosis, with one study noting that the tension of implementing a biopsychosocial model has been observed when implementing trauma-focused interventions in psychosis services, in a way that has not been observed in PTSD services (Chadwick & Billings, 2022). In supplementary comments shared during the member-checking process, one clinician shared their interest in the sense of trauma work as 'additional' in psychosis services with such high rates of trauma in the service.

Limitations

There are several limitations to the present study. The EbE analysis was based on a small sample of participants; although many of the experiences shared by EbE were paralleled by stories shared by clinicians about other clients they had worked with, the views shared may not be generalisable to that of other people accessing EI services. Moreover, though themes were generated across the EbE accounts, people experienced aspects of the intervention very differently (e.g. the emotional experience of the intervention); recruiting a larger sample would allow for a deeper and more nuanced analysis of such experiences. Similarly, given the variety in cultural backgrounds and trauma histories of the sample, generalisability may be further limited, and aspects of experience relevant to specific cultural backgrounds or traumatic experiences may have been missed.

Although it was stressed that the researcher was not part of the EI service and people's care would not be affected by their engagement with the study, the researcher's affiliation with the service due to recruitment taking place through clinicians may have made it difficult for EbE to share difficult or negative experiences of NET. Effort was made to foster a warm, collaborative relationship in which EbE would hopefully feel able to share such experiences, however in my position as a white British trainee psychologist, the power hierarchy would have undoubtedly shaped the nature of our conversations and the experiences shared.

Most clinicians mentioned their own confidence and competence in NET when reflecting on barriers they had encountered, with most clinicians having been trained in NET in the last 2 years; as such, it is difficult to conclude whether difficulties encountered represent psychosis-specific complications to the NET process, or therapist-factors. That said, a strength of the study is the ecological validity of focusing on clinical practice in an NHS setting, highlighting barriers and challenges that have clear implications for the implementation of NET in similar settings.

The clinician sample also predominantly comprised white European women, as were the researchers. As such, it is inevitable that the experiences of the intervention, perspectives shared and themes generated were done so through a white Western lens. A strength of the analysis, however, is the prioritisation of the EbE analysis- three of whom were not white. Moreover, member checking process was used to mitigate the risk of researcher bias in the analysis and ensure participants' felt their views were reflected, and the feedback from this suggested the analysis represented the views of those who responded. However a degree of bias is still inevitable- for example, the researcher's identity as a white British woman may have made it difficult for some to share particular reflections about culture, though these were shared by some. As an individualised intervention its cross-cultural applicability cannot be assumed, especially when working in areas with a high proportion of collectivist cultures; for example, the intervention may have been considered cross-culturally applicable by clinicians because the comparative baseline was other individualised treatments available in NHS services. Careful consideration should be given not only to the cultural applicability of available therapeutic interventions, but also to intervention-specific decisions made within the NET process (such as prioritisation of which events to place on the lifeline; Dix, 2021; Patel et al., 2016).

Clinical implications

This study is an exploration EbE and clinician accounts of NET in EI services. While there are limitations to the study, it provides detailed insights into the process and impact of NET for people accessing EI services, as well as ideas about mechanisms of change. As a naturalistic study, these insights reflect the day-to-day reality of working clinically in an NHS setting, and can be considered more generalisable than RCTs (Philips & Falkenström, 2021);

The findings suggest that while the process of NET can generate distress and intense emotional experiences, this is most often temporary and experienced as worthwhile in light of the benefit of NET- which included an organised and coherent sense of one's lifespan; fewer intrusive memories with a reduced emotional impact; reduced self-blame; increased self-compassion and sense of strengths; and meaning-made about experiences. That said, the degree of distress and dysregulation that can occur means that starting NET warrants thorough and ongoing assessment, consent-seeking, monitoring and preparation (ideally involving family members and other EI support staff), as well as acknowledgement of distress when it does emerge.

Insights from EbE and clinicians suggested that a flexible approach to the NET protocol can help engagement and feels in line with the EI ethos; future research may consider the effectiveness of this. Moreover, emphasis on the role of trust in engaging with NET (supported in particular by kindness, care and collaboration) may indicate the utility of starting NET after a period of engagement or prior therapeutic support. Future research may consider how NET can be adapted to meet the needs of people accessing EI services in such a way that maximises the safety, effectiveness and acceptability of the intervention.

References

Adams, R., Ohlsen, S., & Wood, E. (2020). Eye Movement Desensitization and Reprocessing (EMDR) for the treatment of psychosis: a systematic review. *European Journal of Psychotraumatology, 11.* https://doi.org/10.1080/20008198.2019.1711349

Alsawy, S., Wood, L., Taylor, P. & Morrison, A. (2015). Psychotic experiences and PTSD: exploring associations in a population survey. *Psychological Medicine, 45,* 2849-2859.

Álvarez, M-J., Roura, P., Foguet, Q., Osés, A., Solà, J., & Arrufat, F-X. (2012). Posttraumatic stress disorder comorbidity and clinical implications in patients with severe mental illness. *The Journal of Nervous and Mental Disease, 200*(6), 549-552.

American Psychiatric Association. (2013). Trauma- and Stressor-Related Disorders. *Diagnostic and statistical manual of mental disorders* (5th ed). Arlington, VA.

Barker, C., Pistrang, N., & Elliott, R. (2016). *Research Methods in Clinical Psychology: An Introduction for Students and Practitioners (3rd ed.).* Chichester, UK: John Wiley & Sons.

Bentall, R. P., Wickham, S., Shevlin, M., & Varese, F. (2012). Do Specific Early-Life Adversities Lead to Specific Symptoms of Psychosis? A Study From The 2007 The Adult Psychiatric Morbidity Survey. *Schizophrenia Bulletin, 38*(4), 734-740. https://doi.org/10.1093/schbul/sbs049

Bentall, R. P., de Sousa, P., Varese, F., Wickham, S., Sitko, K., Haarmans, M., & Read, J. (2014). From adversity to psychosis: Pathways and mechanisms from specific adversities to specific symptoms. *Social Psychiatry and Psychiatry Epidemiology, 49*(7), 1011-1022.

Bergström, T., Seikkula, J., Holma, J., Mäki, P., Köngäs-Saviaro, P., & Alakare, B. (2019). How do people talk decades later about their crisis that we call psychosis? A qualitative study of the personal meaning-making process. *Psychosis: Psychological, Social and Integrative Approaches, 11*(2). https://doi.org/10.1080/17522439.2019.1603320

Bloomfield, M. A., Chang, T., Wood, M. J., Lyons, L. M., Cheng, Z., Bauer-Staeb, C., Hobbs, C., Bracke, S., Kennerley, H., Isham, L., Brewin, C., Billings, J., Greene, T., & Lewis, G. (2021). Psychological processes mediating the association between developmental trauma and specific psychotic symptoms in adults: a systematic review and meta-analysis. *World Psychiatry, 20*(1), 107-123. https://doi.org/10.1002/wps.20841

Bourke, E., Barker, C., & Fornells-Ambrojo, M. (2021). Systematic review and meta-analysis of therapeutic alliance, engagement and outcome in psychological therapies for psychosis. *Psychology and Psychotherapy: theory, Research and Practice, 94*(3), 822-853. https://doi.org/10.1111/papt.12330

Bordin, E. S. (1979). The generalisability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice, 16*(3), 252.

Brand, R., Rossell, S., Bendall, S., & Thomas, N. (2017). Can we use an interventionist-causal paradigm to untangle the relationship between trauma, PTSD and psychosis? *Frontiers in Psychiatry, 8*, 306.

Brand, R., McEnery, C., Rossell, S., Bendall, S., & Thomas, N. (2018). Do trauma-focussed psychological interventions have an effect on psychotic symptoms? A systematic review and meta-analysis. *Schizophrenia Research, 195*, 13-22.

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

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*: SAGE Publications LTD.

Braun, V., Clarke, V., & Rance, N. (2014). How to use thematic analysis with interview data (process research). In: A. Vossler, & N. Moller (Eds.). The counselling & psychotherapy research handbook. Open University.

Breinlinger, S., Pütz, A-K., Stevens, N. R., Mier, D., Schalinski, I., & Odenwald, M. (2020). Narrative Exposure Therapy in challenging cases and conditions. *Maltrattamento e abuso all'infanzia, 22*(3), 37-50. https://doi.org/10.3280/MAL2020-003004

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

Brewin, C. R. & Burgess, N. (2014). Contextualisation in the revised dual representation theory of PTSD: A response to Pearson and colleagues. *Journal of Behavior Therapy and Experimental Psychiatry, 45*(1), 217-219. https://doi.org/10.1016/j.jbtep.2013.07.011

Carr, S. C., Hardy, A., & Fornells-Ambrojo, M. (2017). Relationship between attachment style and symptom severity across the psychosis spectrum: A meta-analysis. *Clinical Psychology Review, 59*, 145-158.

Carr, S., Hardy, A., & Fornells-Ambrojo, M. (2018). The Trauma and Life Events (TALE) checklist: development of a tool for improving routine screening in people with psychosis. *European Journal of Psychotraumatology, 9.* https://doi.org/10.1080/20008198.2018.1512265

Chadwick, E., & Billings, J. (2022). Barriers to delivering trauma-focused interventions for people with psychosis and post-traumatic stress disorder: A qualitative study of health care professionals' views. *Psychology and Psychotherapy: Theory, Research and Practice, 95*, 541-560. https://doi.org/10.1111/papt.12387

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

Cloitre, M., Cohen, L. R., & Scarvalone, P. (2002). Understanding revictimization among child sexual abuse survivors: An interpersonal schema approach. *Journal of Cognitive Psychotherapy, 16*, 91-112. https://doi.org/10.1891/jcop.16.1.91.63698

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

Coope, N. (2019). *Therapist dilemmas in narrative exposure therapy with clients who have experienced multiple or prolonged trauma: A tape-assisted recall study.* (Doctoral dissertation, UCL (University College London).

Corstens, D., & Longden, E. (2013). The origins of voices: links between life history and voice hearing in a survey of 100 cases. *Psychosis, 5,* 270-285.

Cowan, H. R., Mittal, V. A., & McAdams, D. P. (2021). Narrative identity in the psychosis spectrum: A systematic review and developmental model. *Clinical Psychology Review, 88.* https://doi.org/10.1016/j.cpr.2021.102067

Croft, J., Heron, J., Teufel, C., Wolke, D., Thomspon, A., Houtepen, L. & Zammit, S. (2018). Association of trauma type, age of exposure and frequency in child and adolescence with psychotic experiences in early adulthood. *JAMA Psychiatry, 34,* 193-199. https://doi.org/10.1093/schbul/sbm069

DeRubeis, R. J., Brotman, M. A., & Gibbons, C. J. (2005). A conceptual and methodological analysis of the nonspecifics argument. *Clinical Psychology: Science and Practice, 12*(2), 174-183. https://doi.org/10.1093/clipsy.bpi022

Dix, J. (2021). *The lifeline in narrative exposure therapy: the experience of therapists.* [Doctoral thesis, University College London]. UCL Discovery. https://discovery.ucl.ac.uk/id/eprint/10134564/

Dudley, R., Taylor, P., Wickham, S., & Hutton, P. (2016). Psychosis, Delusions and the “Jumping to Conclusions” Reasoning Bias: A Systematic Review and Meta-Analysis. *Schizophrenia Bulletin, 42*(3), 652-665. https://doi.org/10.1093/schbul.sbv150

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behavioural Research and Therapy, 38*94), 319-345. https://10.1016/s0005-7967(99)00123-0

Eisenstadt, P., Monteiro, V. B., Diniz, M. J. A., & Chaves, A. C. (2012). Experience of recovery from a first-episode psychosis. *Early Intervention in Psychiatry, 6*(4), 476-480. https://doi.org/10.1111/j.1751-7893.2012.00353.x

Elbert, T., Hermenau, K., Hecker, T., Weierstall, R., & Schauer, M. (2012). FORNET: Behandlung von traumatisierten und nicht-traumaisierten Gewalttätern mittels Narrativer Expositionstherapie. In J. Endrass, A. Rossegger & B. Borchard (Hrsg.), *Interventionen bei Gewalt- und Sexualstraftätern. Risk-Management, Methoden und Konzepte der forensischen Therapie* (S. 255–276). Berlin: MWV Medizinisch-Wissenschaftliche Verlagsgesellschaft.

Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative Change Process Research on Psychotherapy: Alternative Strategies. *Psychological Test and Assessment Modelling, 42,* 69.

Foa, E. B., Zoellner, L. A., Feeny, N. C., Hembree, E. A., & Alvarez-Conrad, J. (2002). Does imaginal exposure exacerbate PTSD symptoms? *Journal of Consulting and Clinical Psychology, 70,* 1022-1028. https://doi.org/10.1037//0022-006x.70.4.1022

Fonagy, P., Gergely, G., & Target, M. (2007). The parent-infant dyad and the construction of the subjective self. *Journal of Child Psychology and Psychiatry, 48,* 288-328.

Fornells-Ambrojo, M., Gracie, A., Brewin, C. R., & Hardy, A. (2016). Narrowing the focus on the assessment of psychosis-related PTSD: a methodologically oriented systematic review. *European Journal of Psychotraumatology, 7*(1). https://doi.org/10.3402/ejpt.v7.32095

France, C. M., & Uhlin, B. D. (2006). Narrative as an outcome domain in psychosis. *Psychology and Psychotherapy, 79,* 53-67.

Gairns, S., Alvarez-Jiminez, M., Hulbert, C., McGorry, P., & Bendall, S. (2015). Perceptions of clinicians treating young people with first-episode psychosis for post-traumatic stress disorder. *Early Intervention in Psychiatry, 9*, 12-20. https://doi.org/10.1111/eip.12065

Galletly, C., Van Hooff, M., & McFarlane, A. (2011). Psychotic symptoms in young adults exposed to childhood trauma- A 20 year follow-up study. *Schizophrenia Research, 127,* 76-82. https://doi.org/10.1016/j.schres.2010.12.010

Galloway, A., & Pistrang, N. (2019). “We’re stronger if we work together”: experiences of naturally occurring peer support in an inpatient setting. *Journal of Mental Health, 28*(4), 419-426. https://doi.org/10.1080/09638237.2018.1521925

Horvath, A. O., De Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*(1), 9.

Imel, Z. E., Laska, K., Jakcupcak, M., & Simpson, T. L. (2013). Meta-analysis of dropout in treatments for post-traumatic stress disorder. *Journal of Consulting and Clinical Psychology, 81,* 393-404. Htpps://doi.org/10.1037/aoo31474

Jayawickreme, N., Cahill, S. P., Riggs, D. S., Rauch, S. A., Resick, P. A., Rothbaum, B. O., & Foa, E. B. (2014). Primum non nocere (first do no harm): symptom worsening and improvement in female assault victims after prolonged exposure for PTSD. *Depression and Anxiety, 31,* 412-419. https://doi.org/10.1002/da.22225

Kaltenbach, E., McGrath, P. J., Schauer, M., Kaiser, E., Crombach, A., & Robjant, K. (2021). Practical guidelines for online Narrative Exposure Therapy (e-NET)- a short-term treatment for posttraumatic stress disorder adapted for remote delivery. *European Journal of Psychotraumatology, 12*(1). https://doi.ord/10.1080/20008198.2021.1881728

Katsounari, I. (2015). Narrative Exposure Therapy for treating PTSD with Psychotic Features: A Case Study. *Clinical Case Studies, 14*(5), 342-356. https://doi.org/10.1177/1534650114559831

Keller, S. M., Zoellner, L. A., & Feeny, N. C. (2010). Understanding Factors Associated With Early Therapeutic Alliance in PTSD Treatment: Adherence, Childhood Sexual Abuse History, and Social Support. *Journal of Consulting and Clinical Psychology, 78*(6), 974-979. https://doi.org/10.1037/a0020758

Khoury, B., & Lecomte, T. (2012). Emotional regulation and schizophrenia. *International Journal of Cognitive Therapy, 5,* 67-76.

Landa, Y. (2017). Cognitive behavioural therapy for psychosis (CBTp): An introductory manual for clinicians. *Mental Health Research, Education & Clinical Center.* https://www.mirecc.va.gov/visn2/docs/CBTp_Manual_VA_Yulia_Landa_2017.pdf

Larkin, W., & Read, J. (2008). Childhood trauma and psychosis; Evidence, pathways, and implications. *Journal of postgraduate medicine, 54*(4), 287-293.

Larsen, S. E., Wiltsey Stirman, S., Smith, B. N., & Resick, P. A. (2016). Symptom exacerbations in trauma-focused treatments: associations with treatment outcome and non-completion. *Behaviour Research and Therapy, 77,* 68-77. Htpps://doi.org/10.1016/j.brat.2015.12.009

Laugharne, R., Priebe, S., McCabe, R., Garland, N., & Clifford, D. (2011). Trust, choice and power in mental health care: Experiences of patients with psychosis. *International Journal of Social Psychiatry, 58*(5), 496-504.

Lawlor, C., Sharma, B., Khondoker, M., Peters, E., Kuipers, E., & Johns, L. (2017). Service user satisfaction with cognitive behavioural therapy for psychosis: Associations with therapy outcomes and perceptions of the therapist. *British Journal of Clinical Psychology, 56*(1), 84-102. https://doi.org/10.1111/bjc.12122

Levitt, H. (2015). Qualitative psychotherapy research: The journey so far and future directions. *Psychotherapy, 52,* 31-37.

Longden, E., Madill, A., & Waterman, M. G. (2012). Dissociation, trauma and the role of lived experience: Toward a new conceptualisation of voice-hearing. *Psychological Bulletin, 138*(1), 28-76. https://doi.org/10.1037/a0025995

Lu, W., Mueser, K. T., Rosenberg, S. D., Yanos, P. T., & Mahmoud, N. (2017). Posttraumatic reactions to psychosis: A qualitative analysis. *Frontiers in Psychiatry, 8.* https://doi.org/10.3389/fpsyt.2017.00129

Mason, O., Platts, H., & tyson, M. (2005). Early maladaptive schemas and adult attachment in a UK clinical population. *Psychology and Psychotherapy: Theory, Research and Practice, 78*(4), 549-564.

Mauritz, M. W., van Gaal, B. G. I., Goossens, P. J. J., Jongedijk, R. A., & Vermeulen, H. (2021). Treating patients with severe mental illness with narrative exposure therapy for comorbid post-traumatic stress disorder. *BJPsych Open*, *7*(1). https://doi.org/10.1192/bjo.2020.124

Mazor, Y., Gelkopf, M., Mueser, K. T., & Roe, D. (2016). Posttraumatic Growth in Psychosis. *Frontiers in Psychiatry, 202.*

Morrison, A., Frame, L., & Larkin, W. (2003). Relationships between trauma and psychosis: A review and integration. *British Journal of Clinical Psychology, 42,* 331-353.

Moncrieff, J., Cohen, D., & Mason, J. P. (2009). The subjective experience of taking antipsychotic medication: a content analysis of Internet data. *Acta Psychiatrica Scandinavica, 120*(2), 102-111. https://doi.org/10.1111/j.1600-0447.2009.01356.x

Mueser, K., Goodman, L., Trumbetta, S., Rosenberg, S., Osher, F., Vidaver, R., Auciello, P., & Foy, D. (1998). Trauma and Posttraumatic Stress Disorder in Severe Mental Illness. *Journal of Consulting and Clinical Psychology*, *66*, 493-499.

Mueser, K. T., & Rosenberg, S. D. (2003). Treating the trauma of first episode psychosis: a PTSD perspective. *Journal of Mental Health, 12*(2), 103-108.

National Institute for Health and Care Excellence. (2014). *Psychosis and schizophrenia in adults: prevention and management* (NICE clinical guideline CG178). Retrieved from https://www.nice.org.uk/guidance/cg178/chapter/recommendations#how-to-deliver-psychological-interventions.

National Institute for Health and Care Excellence. (2018). *Post-traumatic stress disorder* (NICE guideline (NICE guideline NG166). Retrieved from https://www.nice.org.uk/guidance/ng116" https://www.nice.org.uk/guidance/ng116

Ormhaug, S. M., Jensen, T. K., Wentzel-Larsen, T., & Shirk, S. R. (2014). The Therapeutic Alliance in Treatment of Traumatised Youths: Relation to Outcome in a Randomised Clinical Trial. *Journal of Consulting and Clinical Psychology, 82*(1), 52-64. https://doi.org/10.1037/a0033884

Patel, N., Williams, A. C. D. C., & Kellezi, B. (2016). Reviewing outcomes of psychological interventions with torture survivors: conceptual, methodological and ethical issues. *Torture Journal, 26*(1), 2-16.

Philips, B., & Falkenström, F. (2021). What Research Evidence Is Valid for Psychotherapy Research. *Frontiers in Psychiatry,* 1549.

Pipkin, A., Hogg, L., & Armitage, S. (2021). ‚Someone on my level‘: A Meta-Ethnographic Review of Therapeutic Relationships in Cognitive Behavioural Therapy for Psychosis. *Clinical Psychology & Psychotherapy, 28*(5), 1297-1313. https://doi.org/10.1002/cpp.2578

Quijada, Y., Kwapil, T. R., Tizón, J., Sheinbaum, T., & Barrantes-Vidal, N. (2015). Impact of attachment style on the 1 year outcome of persons with an at-risk mental state for psychosis. *Psychiatry Research, 228*(3), 849-856.

Read, J., Perry, B., Moskowitz, A., & Connolly, J. (2001). The contribution of early traumatic events to schizophrenia in some patients: A traumagenic neurodevelopmental model. *Psychiatry, 64,* 319-345.

Read, J., Fosse, R., Moskowitz, A., & Perry, B. (2014). The traumagenic neurodevelopmental model of psychosis revisited. *Neuropsychiatry, 4,* 65-79.

Rodrigues, R., & Anderson, K. K. (2017). The traumatic experience of first-episode psychosis: A systematic review and meta-analysis. *Schizophrenia Research, 189,* 27-36. https://doi.org/10.1016/j.schres.2017.01.045

Rose, D. (2017). Service-user/survivor-led research in mental health: Epistemological possibilities. *Disability & Society, 32*(6), 773-789.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy: “At last the Dodo said, ‘Everybody has won and all much have prizes’.” *American Journal of Orthopsychiatry, 6,* 412-415. https://doi.og/10.1111/j.1939-0025.1936.tb05248.x

Said, G., Alqadri, Y., & King, D. (2021). Unaccompanied minors’ experiences of narrative exposure therapy. *The Cognitive Behaviour Therapist, 14*(11). https://doi.org/10.1017/S1754470X21000088

Schauer, M., Neuner, F., & Elbert, T. (2011). *Narrative Exposure Therapy: A short term intervention for traumatic stress disorders after war, terror or torture.* Germany: Hogrefe & Huber.

Schwartz, R. C., & Blankenship, D. M. (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. *World Journal of Psychiatry, 4*(4), 133-140. https://10.5498/wjp.v4.i4.133

Shearing, V., Lee, D., & Clohessy, S. (2011). How do clients experience reliving as part of trauma-focused cognitive behavioural therapy for posttraumatic stress disorder? *Psychology and Psychotherapy: Theory, Research and Practice, 84,* 458-472. https://doi.org/10.1111/j.2044-8341-2010.02012.x

Shevlin, M., Dorahy, M., & Adamson, G. (2007). Trauma and psychosis: An analysis of the National Comorbidity Survey. *American Journal of Psychiatry, 164,* 166-169.

Siehl, S., Robjant, K., & Crombach, A. (2021). Systematic review and meta-analyses of the long-term efficacy of narrative exposure therapy for adults, children and perpetrators. *Psychotherapy Research, 31*(6), 695-710. https://doi.org/10.1080/10503307.2020.1847345

Skivington, K., Matthews, L., Simpson, S. A., Craig, P., Baird, J., Blazeby, J. M., Boyd, K. A., Craig, N., French, D. P., McIntosh, E., Petticrew, M., Rycroft-Malone, J., White, M., & Moore, L. (2021). A new framework for developing and evaluating complex interventions: update of Medical Research Council guidance. *BMJ,* 374. https://doi.org/10.1136/bmj.n2061

Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: Sage.

Swan, S., Keen, N., Reynolds, N., & Onwumere, J. (2017). Psychological interventions for post-traumatic stress symptoms in psychosis: A systematic review of outcomes. *Frontiers in Psychology, 8,* 341.

Tong, J., Simpson, K., Alvarez-Jiminez, M., & Bendall, S. (2017). Distress, Psychotic Symptom Exacerbation, and Relief in Reaction to Talking about Trauma in the Context of Beneficial Trauma Therapy: Perspectives from Young People with Post-Traumatic Stress Disorder and First Episode Psychosis. *Behavioural and Cognitive Psychotherapy, 45,* 561-576. https://doi.org/10.1017/S1352465817000236

Tsai, M., Ogrodniczuk, J. S., Sochting, I., & Mirmiran, J. (2012). Forecasting Success: Patients' Expectations for Improvement and Their Relations to Baseline, Process and Outcome Variables in group Cognitive Behavioural Therapy for Depression. *Clinical Psychology & Psychotherapy, 21*(2), 97-107. https://doi.org/10.1002/cpp.1831

van den Berg, D., de Bont, P., van der Vleugel, B., de Roos, C., de Jongh, A., Van Minnen, A., & van der Gaag, M. (2015). Prolonged exposure vs eye movement desensitisation and reprocessing vs waiting list for posttraumatic stress disorder in patients with a psychotic disorder: a randomised clinical trial. *JAMA psychiatry, 72,* 259-267.

van den Berg, D. P. G., de Bont, P. A. J. M., van der Vleugel, B. M., de Roos, C., de Jongh, A., van Minnen, A., & van der Gaag, M. (2016). Trauma-Focused Treatment in PTSD Patients With Psychosis: Symptom Exacerbation, Adverse Events, and Revictimization. *Schizophrenia Bulletin, 42*(3), 693-702. https://doi.org/10.1093/schbul/sbv172

van den Berg, D., de Bont, P. A. J. M., van der Vleugel, B. M., de Roos, C., de Jongh, A., van Minnen, A., & van der Gaag, M. (2018). Long-term outcomes of trauma-focused treatment in psychosis. *The British Journal of Psychiatry, 212*(3), 180-182. https://doi.org/10.1192/bjp.2017.30

van Minnen, A., van der Vleugel, B. M., van den Berg, D. P. G., de Mont, P. A. J. M., de Roos, C., van der Gaag, M., & de Jongh, A. (2018). Effectiveness of trauma-focussed treatment for patients with psychosis with and without the dissociative subtype of post-traumatic stress disorder. *The British Journal of Psychiatry, 209*(4), 347-348. https://doi.org/10.1192/bjp.bp.116.185579

Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., Read, J., van Os, J. & Bentall, R. (2012). Childhood adversities increase the risk of psychosis: A meta-analysis of patient-control, prospective- and cross-sectional cohort studies. *Schizophrenia Bulletin, 38*(4), 661-671. https://doi.org/10.1093/schbul/sbs050

Walters, S., Hogg, L., & Gillmore, C. (2016). Evaluation of a tailored training programme to improve the assessment and treatment of trauma in an Early Intervention in Psychosis (EIP) service, *Psychosis, 8*(3), 226-237. https://doi.org/10.1080/17522439.2015.11313

Weathers, F., Litz, B., Keane, T., Palmieri, T., Marx, B., & Schnurr, P. (2013). The PTSD Checklist for DSM-5 (PCL-5). Scale available from the National Centre for PTSD at www.ptsd.va.gov

Wei, Y., & Chen, S. (2021). Narrative Exposure Therapy for Posttraumatic Stress Disorder: A Meta-Analysis of Randomized Controlled Trials. *Psychological Trauma: Theory, Research, Practice and Policy, 13*(8), 877-884. https://doi.org/10.1037/tra0000922

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

Willig, C. (2013). Introducing qualitative research in psychology. (2nd ed.) Berkshire: Open University Press.

Wood, L., Burke, E., & Morrison, A. (2015). Individual cognitive behavioural therapy for psychosis (CBTp): A systematic review of qualitative literature. *American Journal of Psychiatry, 168*, 472-485. https://doi.org/10.1176/appi.ajp.2010.1006085

Wright, A., Reisig, A., & Cullan, B. (2020). Efficacy and cultural adaptations of narrative exposure therapy for trauma-related outcomes in refugees/asylum-seekers: A systematic review and meta-analysis. *Journal of Behavioral and Cognitive Therapy, 30*(4), 301-314. https://doi.org/10.1016/j.hbct.2020.10.003

Part III. Critical Appraisal

Introduction

This critical appraisal will document some of my personal reflections from throughout the research process, intending to parallel and expand upon the ideas written in my reflective log. After contextualising the start of my journey with the project, I will outline one dilemma encountered in the process of completing the systematic review and one from the empirical research, as well as the new insights, ideas and questions I am taking away as a result. I will also consider how the research project has contributed to my development as a clinical psychologist- in my roles both as researcher and clinician.

Starting the project

As we started to consider research topics for our thesis in early 2020, I remember feeling clear that I wanted to do a qualitative project; my undergraduate dissertation had been quantitative, in fact most of my early exposure to research methods in psychology (i.e. my undergraduate teaching and placement) had a strong quantitative focus with very little time paid to qualitative methods. As I grew more familiar with qualitative approaches, I found that its relativistic epistemological underpinning and interest in people's subjective experiences aligned with my own epistemological world-view and research interests. As such, the thesis process presented an opportunity- and a challenge- not only to develop skills in qualitative methodology but also to develop my identity as a researcher.

I was quickly drawn to this specific research topic because of its focus on intersecting areas I had pre-existing interest in- psychosis and trauma. I had very little pre-knowledge about psychosis until my first-year teaching and placement; we had little-to-no teaching at undergraduate level, so any preconceptions I had were based either on brief teaching on 'schizophrenia' heavily influenced by the medical model, or references made in films and culture more broadly. I was struck by the persistence of deterministic, medical models of psychosis in narratives about psychosis, and felt shame about my own ignorance to the stigma and misinformation around psychosis. As such, I was grateful for the chance to do person-centred work in the recovery-oriented psychosis service I was placed in during my first year. It was here that I was first introduced to the recovery model (e.g. Wallcraft et al., 2003) and principles of trauma-informed care (SAMHSA, 2014), including the phrase "It's about 'what happened to you' not 'what's wrong with you''.

Systematic Review: Conceptualising 'traumatic events'

One of the stumbling blocks I encountered in the planning stages of the systematic review related to the definition and conceptualisation of traumatic events. The nature of the problem I had encountered was not initially clear- more a sense of 'stuck-ness' when during the iterative process of scoping possible searches related to 'trauma' and 'psychosis' and developing my inclusion/exclusion criteria. Initially attributing this to my relative inexperience in research, the 'stuck-ness' eventually started to untangle when I considered the meaning of the word 'trauma'- which both in some of the studies I was reading and in my own anecdotal experience was often used as if it connoted transparency, but without being clearly defined.

For some, the word 'trauma' is used synonymously with the psychiatric diagnosis post-traumatic stress disorder (PTSD), characterised by the 'symptoms' shown in Appendix M, as defined in the DSM-5 (American Psychiatric Association; APA, 2013; Appendix M). The ICD-11, on the other hand, specifies that a person may develop symptoms following an 'extremely threatening or horrific event, or series of events', without providing a specific definition (World Health Organisation; WHO, 2019). The variance in breadth versus narrowness of criteria represent attempts both to ensure people can access support associated with a diagnosis where it is needed, and to avoid 'over-use' of the label (Stein et al., 2014). The ICD-11 (but not DSM-5) also lists complex-PTSD as a diagnosis that is related-but-separate to PTSD, and is associated with chronic and repeated traumatic events and emotional and relational difficulties on-top of those listed under the PTSD diagnosis (Cloitre et al., 2014; WHO, 2019).

Other definitions of 'trauma'- also focused on the impact on the person- take a more general approach. Bessel van der Kolk, psychiatrist and author of 'The Body Keeps The Score', describes trauma as ‘not the story of something that happened back then, but the current imprint of that pain, horror and fear living inside [the individual’ (van der Kolk, 2014). The APA defines trauma as ‘an emotional response to a terrible event’ (APA, n.d.)

As well as referring to the subjective experience of an event on an individual (e.g. ‘post-traumatic symptomology’), ‘trauma’ can also be used to refer to the adverse event itself, or the harm perpetrated within the adverse event (Bath, 2017; Kaminer & Eagle, 2010). In Eye Movement Desensitization and Reprocessing (EMDR) literature- now adopted more broadly- Shapiro differentiates between ‘big T’ traumatic events (typically life-threatening events, serious harm or sexual violence, comparable to Criterion A of the DSM-V PTSD diagnosis) and ‘small t’ traumatic events (more ubiquitous adverse events which can cause significant distress, such as loss, bullying, victimisation). While the literature emphasises that this is not with the intention of diminishing the severity or impact of ‘small t’ events, I cannot help but feel this language inadvertently does so. Interestingly, traumatic events as characterised by diagnostic manuals have been linked with only slightly higher levels of ‘PTSD symptomology’ than adverse events that fall outside of this categorisation (Hyland et al., 2021; Larsen & Pacella, 2016), prompting some to suggest a more inclusive approach to the definition of ‘traumatic event’ should be taken to improve access to trauma-specific and trauma-focused interventions and services (Campodonico et al., 2021). In fact, there is debate in the field as to whether PTSD diagnoses should require exposure to a specific event at all, with some suggesting that developing an event-specific criterion which is inclusive but not overgeneralised is unattainable (Brewin et al., 2009) and others suggesting that PTSD, by nature, should presume exposure to specific events as part of its aetiology (Kilpatrick et al., 2009).

How trauma and/or traumatic events are defined has important implications for the support people can access. A study of assessments in a child welfare system illustrates the impact of varying conceptualisations and thresholds for trauma; an analysis of assessments found 95% had been exposed to potentially traumatic events, 28% reported some clinical symptoms associated with ‘trauma’, and 3% met the threshold for PTSD (Griffin et al., 2011).

‘Traumatic events’ were defined to varying degrees in the studies included in the literature review. Eleven of the included references explicitly stated that they were exploring experiences of psychosis in the context of ‘trauma’- of these, three (O’Neill, 2010; Rhodes et al., 2017; Wheeler, 2019) focused on specific adverse life events, one used diagnostic PTSD criteria (Anketell et al., 2010), two used the term ‘negative life experiences’ which they operationalised for the purpose of the study (Vallath et al., 2018; 2020), four used constructs such as adversity but did not define these, and one stated that they allowed participants to self-define whether they had experienced ‘trauma’; Campodonico et al., 2021). The remaining 21 studies which did not explicitly explore the role of ‘trauma’ were included if events mentioned were referred to as ‘traumatic’, or were events commonly associated with ‘trauma’ (such as abuse, accidents, sudden loss, bullying). I decided from the outset to take an inclusive approach to the studies that would be eligible for the review (for example, the search criteria included broad terms such as ‘past experiences’ to account for variation in language used, and the data extracted from papers could pertain to a broad range of events). I believe this is a strength of the study; a finding of the literature review I found particularly interesting was the relevance of loss events the connections Experts by Experience (EbE) made between traumatic events and subsequent experiences of psychosis, and I question whether this theme would have emerged had we adopted a stricter definition of traumatic events.

Reflecting on my own epistemological stance- both as a researcher and a clinician- led me to consider similarities and differences in how researchers and clinicians work with constructs such as trauma. As clinicians, especially working individually, we are afforded the opportunity to work within a person’s own systems of meaning and language. Being on placement in a child sexual abuse service strongly influenced by principles of Narrative Therapy (White & Epston, 1989), much of my thinking in my clinical work was underpinned by post-structuralist principles; for example, that our understanding of ‘reality’ is based on language as a means of creating and sharing meaning, and thus is inherently subjective (Besley, 2002). Whilst this translates well into clinical work, research requires a degree of classification and definition- for example, when developing inclusion criteria, having comparative groups in quantitative research, and to facilitate the wider dissemination of research findings usefully and applicably. Within this, taking an operationalised-but-inclusive approach to the definition of traumatic events made space for inclusion of events that participants themselves felt were traumatic, whilst ensuring the research methods were systematic and phenomena were clearly defined.

Empirical research: From clinician to qualitative researcher

As a novice qualitative researcher, all aspects of the research process were new to me; one tension that was particularly prominent in the reflections in my reflexive log was that of my role as a 'qualitative interviewer', and the more familiar position of a warm and validating clinician.

Even prior to conducting the interviews, I had concerns about how I would 'be' in the position of interviewer- particularly with regard to my manner of interacting with participants and responses to their comments. Validation felt like such a natural feature of my way-of-being as a psychologist. This, however, was at odds with ideas about how I understood researcher 'should' respond in a semi-structured interview so as not to unintentionally influences the responses of participants. Based on the assumption that most of the clinicians were familiar with the process of research and were unlikely to find the interview distressing, this was a particular consideration when conducting interviews with EbE.

I was acutely aware of this conflict given my experience working therapeutically in a psychosis service. A warm, trusting, therapeutic relationships is important arguably when working with anyone, but my experience has been that this has been particularly emphasised in psychosis settings (Chadwick. 2006). In my experience, I had valued adopting an authentic way-of-being and using appropriate self-disclosure to build trust in the therapeutic relationship, and was concerned about what losing these 'tools' would mean for engagement with the interview. The nature of the research topic added to my concern; though I had emphasised that I would not be asking about any of the traumatic events EbE had spoken about in therapy, there was a chance that people may find the interview distressing if they were revisiting memories about the intervention being distressing (though this had not been noted in existing research). As such, EbE feeling ‘safe-enough’ throughout the process was a priority of mine.

Flexibility is also something I was used to bringing to my therapeutic work in psychosis settings, and something which I understood to support engagement in Cognitive Behavioural Therapy for psychosis, for example (CBTp; Kilbride et al., 2013). I chose to use a semi-structured schedule to guide the interview through topics of interest, whilst also enabling participants to expand on and explore areas that felt particularly relevant or important to them (Rabionet, 2011). In writing the schedule, I included fairly broad questions pertaining to a topic, followed by a number of prompts and follow-ups which were narrower and more specific by nature. My hope was that this would afford some degree of flexibility based on the extent to which EbE felt able to share (be it extensively, or minimally).

It struck me that perhaps I would neither be bringing the same degree of flexibility as I usually would to by clinical work, nor would my approach be as systematic as a purist researcher- a tension that has been acknowledged elsewhere by qualitative researchers in the psychosis field (e.g. Billings, 2005). This tension spoke to a conflict between my willingness to ‘do research properly’, and my values of compassion and care meaning that I wanted EbE to feel comfortable. Ongoing reflection and supervision was central to this balance being struck in such a way that satisfied the ethical and methodological demands of the study.

Smith and Osborne propose that careful and transparent preparation in the setting up of a research study can help put participants at ease and support a rich engagement with the interview questions (Smith & Osborn, 2003). This reminds me of the phrase ‘well begun is half done’, often associated with systemic therapy (Lang & McAdam, 1990). As such, I spent time both during the initial phone calls setting up the interview and at the start of the interview building rapport with EbE. It also occurred to me that whilst the difference between the role of a researcher and a clinician (and what that then means for what questions are asked, and how) was clear in my mind, the nature of that difference may not have been obvious to the EbE I was interviewing. As such, I gave an overview of my role as researcher, and what that would mean for the research process- that I was primarily interested in hearing their experiences in their words, and would ask occasional questions to guide us and to ask for some more information, and check I understood.

This dilemma manifested differently in different interviews. Interestingly, I noticed that the transition to researcher-role felt more natural to me during the interviews I conducted on Zoom; whilst I still spent time chatting informally, to build rapport, this was less at the forefront of my mind that in the face-to-face interviews and it felt appropriate to start the interviews fairly quickly. Given that I only interviewed four EbE, this cannot be causally attributed to the platform, though I was intrigued by this reflection. It led to me wondering why this might be, and how else the format of the interview may have shaped the process. My therapeutic work in the psychosis service had taken place in both virtual and face-to-face formats, so I was familiar with both. I wondered whether the regularity of video-call meetings throughout the COVID-19 pandemic had fostered an association with Zoom-based calls as ones which have a more formal, meeting-like format- for me, and perhaps participants too? Equally, being in a room with someone, by nature, gives you more access to visible aspects of participants' experiences- whether subtleties in body language or facial expression, or interaction with the environment- which may have enabled me to be more attuned to the experiences and emotional needs of face-to-face participants. In all interviews, I switched off the recording device after the final question and allowed time to check out, debrief, reflect on the interview process and 'wind down'. This felt important as a means of re-engaging with participants in what felt to me in a more 'human' way, without the constraints of the semi-structured interview schedule and research methodology.

I was aware of the positions of power I held in relation to EbE throughout the process; for example, my position as a middle-class white British woman- which varied from the social identities of all EbE, albeit in different ways. This will have undoubtedly shaped their experience of the interview, and what answers they felt able to give. For example, would my identity as middle-class- and therefore potentially very different experiences of and access to housing, finances and education- influence what EbE shared in relation to these areas? As a white woman, would this influence (or silence) reflections related to culture- for example, in relation to the cultural applicability and acceptability of NET? Whilst this was a theme explored in detail in one interview, it is undoubtable that my social identity will have influenced this process.

I was also in a position of power in terms of profession; although I technically was not affiliated with the EI teams that EbE were accessing (this, and the fact the interview would have no bearing on their care, was emphasised), it is likely that I was experienced as an EI 'professional' given that EbE were recruited through their EI services. In the empirical paper I mention taking these factors into consideration during analysis, and they were also on my mind during the interview process. As a professional in a position of power- especially one affiliated with (and therefore likely experienced as being part of) the mental health system, my consideration of the wellbeing of EbE during interviews was heightened. I was acutely aware of this given a) the likelihood (both statistically, and by nature of the participants having been offered NET) that participants had experienced breaches of trust in their lives, possibly repeated; and b) that they may have had difficult experiences with health and/or police services in the past, and therefore may have had difficult experiences with people in positions of authority. This further highlighted the need for a 'well begun is half done' approach to rapport building before the interview, in an attempt to rebalance the power hierarchy (acknowledging that it will still exist) in an attempt to build safety and trust. Memories of getting to know EbE and building rapport are some of my most valued and cherished of the research process- I was struck by the openness and candidness of some of the participants, who shared personal stories and creative endeavours.

Reflections on the dilemmas encountered during this process- in addition to the challenge- generated a curiosity about how this is approached by experienced qualitative researchers in the psychosis field. What skills and abilities do researchers draw on to address this balance between ethics and methodological rigor? It also generated a curiosity about other creative approaches to qualitative research that span beyond the traditional interview context, which may open doors to new ways of eliciting ideas and expertise from people accessing psychosis services, and in research broadly.

Conclusion

To conclude, this critical appraisal has considered two dilemmas encountered during the research process. During the literature review, reflections about how terms such as ‘trauma’ and ‘traumatic events’ are defined (or in some cases, are not defined) helped me make sense of a ‘stuck-ness’ I encountered when designing the study. Taking an inclusive approach to the resolution of this dilemma- I believe- made space for an interesting theme to develop about the role of loss events in self-made links between traumatic events and psychosis. In the empirical paper, I was challenged by the differences in the role of clinician and researcher- particularly in relation to the interview process, and linked to the expectations of the researcher role and aspects of my social identity. Tending to the wellbeing and comfort of participants was a priority throughout the research, which required careful reflection about the remit of the researcher role.

References

American Psychiatric Association. (2013). Trauma- and Stressor- Related Disorders. *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA

American Psychiatric Association (n.d.). *Trauma*. https://www.apa.org/topics/trauma

Anketell, C., Dorahy, M. J., & Curran, D. (2011). A preliminary qualitative investigation of voice hearing and its association with dissociation in chronic PTSD. *Journal of Trauma & Dissociation*, *12*(1), 88-101. https://doi.org/http://dx.doi.org/10.1080/15299732.2010.514844

Bath, H. (2017). The Trouble with Trauma. *Scottish Journal of Residential Child Care, 16*(1), 1-12.

Besley, A. C. (2002). Foucault and the turn to narrative therapy. *British Journal of Guidance and Counselling*, *30*(2), 125-143. https://doi.org/10.1080/03069880220128010

Billings, J., (2005). *Making Sense of First Episode Psychosis.* [Doctoral thesis, University College London]. UCL Discovery. *https://discovery.ucl.ac.uk/id/eprint/1446413/1/U594383%20REDACTED.PDF*

Brewin, C. R., Lanius, R., Novac, A., Schnyder, U., & Galea, S. (2009). Reformulating PTSD for DSM-V: Life After Criterion A. *A Journal of Traumatic Stress*, *22*, 366-373.

Campodonico, C., Varese, F., & Berry, K. (2021). Trauma and Psychosis: A Qualitative Study Exploring the Perspectives of People with Psychosis. Preprint. https://doi.org/10.21203/rs.3.rs-568000/v1

Chadwick, P. (2006). *Person-based cognitive therapy for distressing psychosis.* New Jersey: John Wiley & Sons

Cloitre, M., Garvert, D. W., Weiss, B., Carlson, E. B., & Bryant, R. A. (2014). Distinguishing PTSD, Complex PTSD and Borderline Personality Disorder : A latent class analysis. *European Journal of Psychotraumatology*, *5*(1). https://doi.org/10.3402/ejpt.v5.25097

Griffin, G., McClelland, G., Holzberg, M., Stolback, B., Maj, N., & Kiesiel, C. (2011). Addressing the impact of trauma before diagnosing mental illness in child welfare. *Child Welfare, 90¸* 69-89. Retrieved from https://www.cwla.org/child-welfare-journal/journal-archives/

Hyland, P., Karatzias, T., Shevlin, M., McElroy, E., Ben-Ezra, M., Cloitre, M., & Brewin, C. (2021). Does requiring trauma exposure affect rates of ICD-1.

Kaminer, D., & Eagle, G. (2010). *Traumatic Stress in South Africa.* Johannesburg: Wits University Press

Kilbride, M., Byrne, R., Price, J., Wood, L., & Barratt, S. (2013). Exploring Service Users' Perceptions of Cognitive Behavioural Therapy for Psychosis: A User Led Study. *Behavioural and Cognitive Psychotherapy*, *41*, 89-102. https://doi.org/10.1017/S1352465812000495

Kilpatrick, D., Resnick, H., & Acierno, R. (2009). Should PTSD Criterion A be retained? *A Journal of Traumatic Stress*, *22*, 374-383.

Lang, P., & McAdam, E. (1990). Referrals, referrers and systems of concern. A chapter about good beginnings designed to lead to quicker endings! Available from: https://www.taosinstitute.net/files/Content/5694552/McAdam-lang-_Referrals,_Referrers_and_the_System.pdf.

Larsen, S. E., & Pacella, M. L. (2016). Comparing the effects of DSM-congruent traumas vs. DSM-incongruent stressors on PTSD symptoms: A meta-analytic review. *Journal of Anxiety Disorders, 38*, 37-46.

O'Neill, N. (2010). *Women's experiences of childhood sexual abuse and psychosis in adulthood* [PhD, University of Hertfordshire (United Kingdom)]. ProQuest Dissertations & Theses Global. https://www.proquest.com/dissertations-theses/womens-experiences-childhood-sexual-abuse/docview/1780169135/se-2?accountid=14511

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

Rhodes, J. E., O'Neill, N. D., & Nel, P. W. (2017). Psychosis and sexual abuse: An interpretative phenomenological analysis. *Clinical Psychology & Psychotherapy, 25*(4), 540-549. https://doi.org/10.1002/cpp.2189

Smith, J. A., & Osborn, M. (2003). Interpretative Phenomenological Analysis. In J. A. Smith (Ed). *Qualitative Health Psychology.* London: Sage. 219-240.

Stein, D. J., McLaughlin, K. A., Koenen, K. C., Atwoli, L., Friedman, M., Hill, E., Maercker, A., Petukhova, M., Shahly, V., van Ommeren, M., Alonso, J., Borges, G., de Girolamo, G., de Jonge, P., Demyttenaere, K., Florescu, S., Karam, E. G., (…) Kessler, R. C. (2014). DSM-5 and ICD-11 definitions of posttraumatic stress disorder: Investigating "narrow" and "broad" approaches. *Depression and Anxiety, 31*(6), 494-505. https://doi.org/10.1002/da.22279

Vallath, S., Luhrmann, T., Bunders, J., Ravikant, L., & Gopikumar, V. (2018). Reliving, Replaying Lived Experiences Through Auditory Verbal Hallucinations: Implications on Theories and Management. *Frontiers in Psychiatry, 9,* Article 528. https://doi.org/10.3389/fpsyt.2018.00528

Vallath, S., Ravikanth, L., Regeer, B., Borba, P. C., Henderson, D. C., & Scholte, W. F. (2020). Traumatic loss and psychosis - reconceptualising the role of trauma in psychosis. *European Journal of Psychotraumatology*, *11*(1), Article 1725322. https://doi.org/10.1080/20008198.2020.1725322

van der Kolk, B. (2014). *The Body Keeps The Score: Brain, mind and body in the transformation of trauma.* UK: Penguin

Wheeler, C. (2019) *Snitches get Stitches: A Qualitative Exploration of Childhood Bullying Amongst Individuals with Early Psychosis Experiences* [DClinPsy, University of Essex (United Kingdom)]. ProQuest Dissertations & Theses Global. https://www.proquest.com/dissertations-theses/snitches-get-stitches-qualitative-exploration/docview/2411945958/se-2?accountid=14511

White, M., & Epston, D. (1989). *Literature Means to Therapeutic Ends.* Adelaide: Dulwich Centre.

World Health Organization. (2019). *The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research.* Geneva: World Health Organization

Appendices

Appendix A. Research flyer (EbE)

UCL

NELFT NHS
NHS Foundation Trust

Have you done a talking therapy called Narrative Exposure Therapy (NET) with a therapist?

We would like to speak to people who use Early Intervention services about their experiences of doing Narrative Exposure Therapy (NET) with a therapist. This is for a piece of doctoral research at University College London.

NET is a type of talking therapy for people who have experienced a number of upsetting or traumatic events in life. If you have done the therapy, you might have made a lifeline with your therapist. You might have used stones to represent traumatic memories and flowers to represent positive memories, or you might have used different objects.

Participants will be paid £10 for taking part

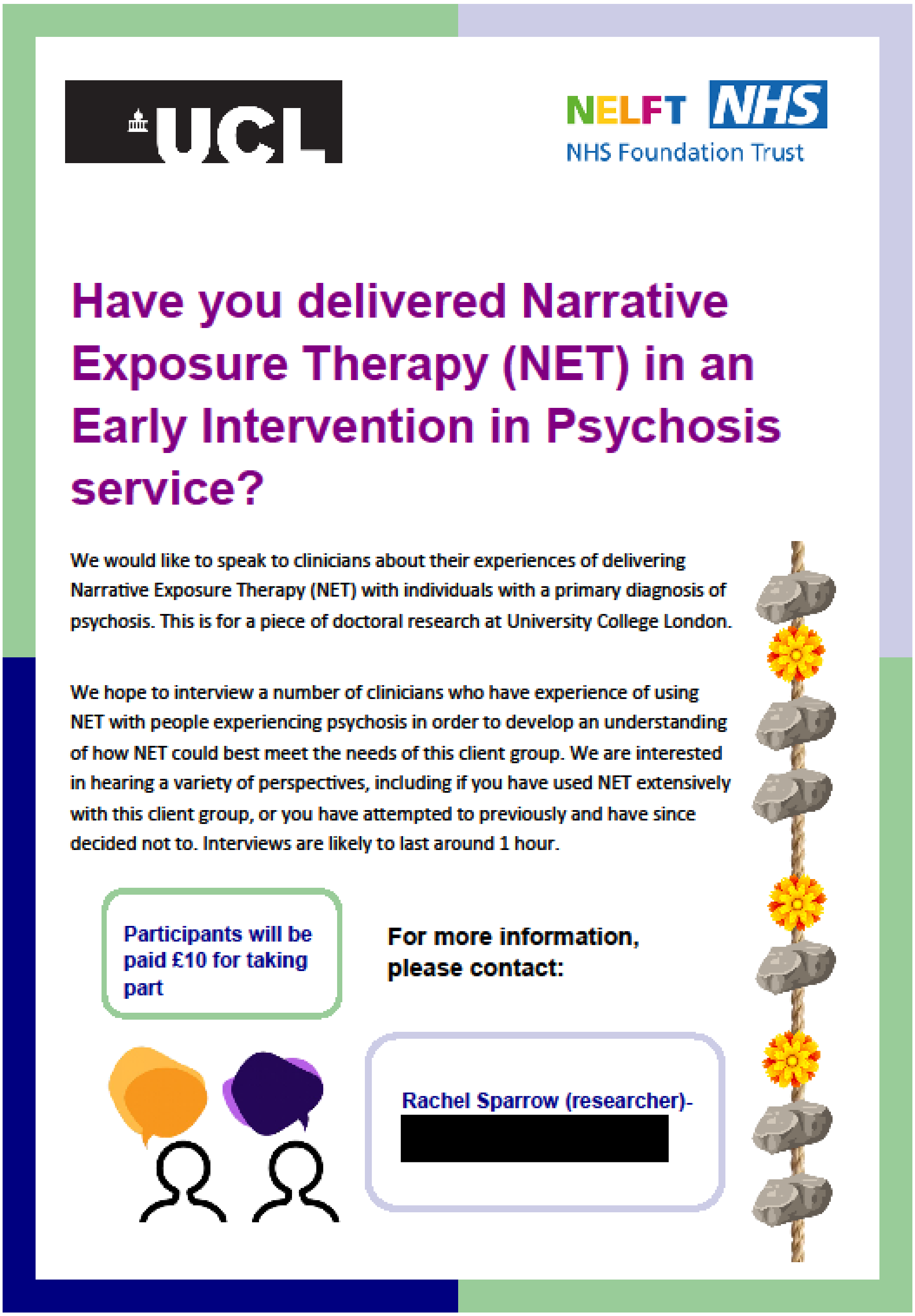
For more information, please contact:

Rachel Sparrow (researcher)-
[redacted]

Or speak to the psychologist you did NET with in EIP

Experiences of the process and impact of Narrative Exposure Therapy in Early Intervention in Psychosis services. Participant flyer (client). IRAS:291094, Version 4.1 (30/07/2021)

Appendix B. Research flyer (clinicians)



UCL

NELFT NHS
NHS Foundation Trust

Have you delivered Narrative Exposure Therapy (NET) in an Early Intervention in Psychosis service?

We would like to speak to clinicians about their experiences of delivering Narrative Exposure Therapy (NET) with individuals with a primary diagnosis of psychosis. This is for a piece of doctoral research at University College London.

We hope to interview a number of clinicians who have experience of using NET with people experiencing psychosis in order to develop an understanding of how NET could best meet the needs of this client group. We are interested in hearing a variety of perspectives, including if you have used NET extensively with this client group, or you have attempted to previously and have since decided not to. Interviews are likely to last around 1 hour.

Participants will be paid £10 for taking part

For more information, please contact:

Rachel Sparrow (researcher)-
[redacted]

Experiences of the process and impact of Narrative Exposure Therapy in Early Intervention in Psychosis services. Participant flyer (client). IRAS:291094, Version 4.1 (02/08/2021)

Appendix C. Participant information sheet (EbE)

The process and impact of Narrative Exposure Therapy for people experiencing psychosis.

We invite you to take part in a Doctorate of Clinical Psychology research study.

- Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve.
- Please take time to read the following information carefully. Discuss it with family and friends if you wish.
- You are free to decide whether or not to take part in this research. If you choose not to take part, this will not affect the care you receive from the Early Intervention in Psychosis service, or other healthcare professionals.
- If there is anything that is not clear or if you would like more information, please let me know. Take time to decide whether or not to take part.

Summary of research study.

- We want to hear about the experiences of people in Early Intervention in Psychosis services who have had Narrative Exposure Therapy (NET).
- We want to ask people questions about how they found the therapy- these questions will probably take 1 hour, but may take longer.
- We will not ask about the personal things you shared in therapy.
- You can stop taking part in the study at any time.

Contents

1. What is the project's purpose?

The purpose of the project is to hear about the experiences of Early Intervention in Psychosis service users who have had Narrative Exposure Therapy (NET). NET is a talking therapy for people who have experienced a number of distressing or traumatic events in their lives. We want to understand what the therapy is like for people in Early Intervention in Psychosis services, and the impact it has on their lives. We hope that by understanding this better, we can consider how to adapt the therapy to best meet the needs people who use Early Intervention in Psychosis services..

2. Am I suitable for this study?

You are being approached because you are currently using an Early Intervention in Psychosis service, and have tried NET. We are interested in hearing from people who have completed a course of NET, and also from people who have decided to stop NET early, to get a variety of perspectives. In order to be eligible to take part in this study, we ask that you read this inclusion and exclusion criteria carefully. If you have any questions about whether or not you are suitable for the study, please contact Rachel Sparrow using the email address at the bottom of this form.

Inclusion Criteria

- *Individuals aged 18 years and over*
- *Individuals who have experienced psychosis and are currently using an Early Intervention in Psychosis service*
- *Individuals who have either finished a course of NET, or who had some sessions and decided to stop the therapy early*
- *Individuals who have access to a private space to engage in the interview over video-call (if the interview is taking place remotely)*

Exclusion Criteria

- *Individuals aged 17 years and under*
- *Individuals currently detained under the Mental Health Act, and/or who are unable to consent to the study*
- *Individuals with a primary diagnosis of intellectual disability or cognitive impairment*

3. Do I have to take part?

No- it is up to you if you to decide whether or not to take part. You can withdraw from the research at any time without giving a reason and without it affecting your care in NELFT and your Early Intervention in Psychosis service in any way. If you decide to withdraw from the study before the interview, we will delete all data relating to you, in accordance with GDPR (guidelines with ensure the protection of your personal data). If you withdraw from the study after the interview, the interview data will be retained for use in the study, but all identifiable data will be destroyed, and you will not be asked to do anything else associated with the study.

4. What will happen to me if I take part?

The psychologist who has been doing NET with you might have mentioned this study, and asked if you would agree to being contacted about the study. The researcher- Rachel Sparrow- will have contacted you to introduce herself and the study, and take your contact details to send you this Participant Information Sheet and the Informed Consent Form (either by post or email). Alternatively, you may have seen a flyer for this study at your local Early Intervention in Psychosis service and may have contacted the researcher yourself.

You will be invited to read this Participant Information Sheet and Informed Consent Form, and you will have the opportunity to ask the researcher- Rachel Sparrow- any questions about the study. The researcher will contact you at least 24 hours after you receiving the documents- or at a time agreed during the first telephone call- to answer any questions about the form. She will also ask if you would like to consent to taking part in the study. If you do wish to take part, you will then return the completed Informed Consent Form with your name back to the researcher, and we will arrange a data and time for the one-to-one interview. This is likely to take place using Microsoft Teams- the researcher will ask whether you have access to a compatible computer/tablet/smartphone, WiFi connection, and a private space to have the interview. If you do not, we will talk about arrangements we could make to enable you to take part, such as providing a device to use for the interview. Depending on COVID-19 Government and NELFT guidelines at the time of you being approached to take part in the study, we might be able to meet face-to-face to conduct the interview. The researcher will let you know if this is a possibility when they share the Participant Information Sheet with you. It would then be up to you to decide if you would prefer meeting face-to-face or online. If your interview is held in person, your travel costs will be paid back to you.

On the Informed Consent Form, we will ask if you consent to us accessing some personal information from your NHS clinical file. This will include some information about you (your date of birth, gender and ethnicity), your NET sessions (how many you had, when they started and finished), and some scores from questionnaires you have already completed in the Early Intervention Service.

The interview is estimated to last 1 hour, but might last longer if, for example, you want to take a break. The interview will start with us speaking about the project, checking you understand the purpose of the research and answering any questions. We will then start the main interview; you will be asked questions about what it was like having NET, what impact it had, and what you found helpful and unhelpful. We will not ask you about the personal things you spoke about in therapy, and the answers you give will be kept confidential. We do not expect the interview to be distressing, however if you find the discussion challenging or tiring, you can ask to take breaks or end the interview early. If the interview process is too challenging for you at the time, we may decide to end the interview early.

Once the interview has ended, you will be given the opportunity to ask any questions you might have about the study and to give feedback, if you would like to. You will be paid £10 in the form of cash or a voucher (depending on your preference) for your participation in the study- we will discuss arrangements for this at the end of the interview. You will also be asked if you would like to be informed of the findings of the study at the end of the research- this will be one of the check boxes on the Informed Consent Form, and if you choose to be contacted, we will email you a document summarising the main findings of the research.

Additionally, we would also like to speak to a few participants when we have finished all the interviews (March 2022), to ask for their feedback on the themes and ideas we have gathered- you will also have the chance to opt in to this on the Informed Consent Form. We will contact some people who have opted in to arrange a telephone or videocall to discuss the themes and ideas developed from the research. Alternatively, feedback can be given over email. People who take part in this part of the study will be paid an additional £10 in the form of cash or a voucher (depending on your preference) as a thank you for their time.

5. Will I be recorded and how will the recorded media be used?

If you agree to be interviewed, the interview will be audio-recorded by the researcher, Rachel Sparrow. The audio-recording will be stored on a secure computer drive until we have typed up the notes from the interview, and then it will be destroyed. If your interview took place on Microsoft Teams, the researcher will use the ‘transcription’ function on Microsoft Teams to help type up the notes. Quotes from the interview might be used in reports and publications written up from the research, but not in a way that could identify you. No other use will be made of them without your written permission, and no one outside the project will be allowed to access the recordings or interview notes.

6. How will information about me be used?

How will you use information about me?

We will need to use information from you for this research project.

This information will include your [initials/ NHS number/ name/ contact details/ provide a bullet list of identifiers held by site and/or sponsor for the research]. People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are my choices about how my information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can I find out more about how my information is used?

You can find out more about how we use your information in the following places:

- *www.hra.nhs.uk/information-about-patients/*
- *https://www.ucl.ac.uk/legal-services/privacy*
- *By asking one of the research team using the contact details below*
- *By emailing the Sponsor Data Protection Officer on data-protection@ucl.ac.uk*

7. What are the possible disadvantages and risks of taking part?

We do not anticipate any disadvantages or risks of participating in this study. We appreciate that you are taking time out of your busy schedule to participate in this research.

Due to the nature of these personal conversations regarding talking therapy, some people may experience some strong emotions during the interview. We do not expect that this process will be too distressing, and will ensure you are not feeling upset prior to leaving the interview for example, by doing some joint breathing/relaxation exercises. If the interview is upsetting for you, we might ask if we can inform someone involved in your care so that they can ensure you are supported.

For some, answering questions for 1 hour or longer might feel tiring. If this is the case, you will be able to ask for breaks or end the interview early. You can also choose not to answer any of the questions in the interview, if you would prefer not to.

8. What are the possible benefits of taking part?

Taking part in this research will allow you to reflect on the therapy you have had, which some people might find interesting. Your views might help inform future adaptations for the therapy to best support other people who use Early Intervention in Psychosis services- we believe it is very important for the views of service users to be included in this process.

9. What if something goes wrong?

If you want to complain, or have concerns about any aspect of how you have been approached or treated by members of staff you have encountered in the study, complaints processes through both the NHS and University College London (UCL) are available to you. Please ask the researcher or principal investigator, using the contact details below, if you would like more information on this. In the unlikely event that you are harmed by taking part in this study, compensation may be available.

If you suspect that the harm is the result of the sponsor (UCL) or the hospital's negligence then you may be able to claim compensation. Please make the claim in writing to Miriam Fornells-Ambrojo (using the email address at the end of this document) who is the Principal Investigator for the research and is based at 1-19 Torrington Place, UCL. The Principal Investigator will then pass the claim to the Sponsor's insurers, via the Sponsor's office. You may have to bear the costs of the legal actions initially, and you should consult a lawyer about this.

If you have a concern about any aspect of this study, you should ask to speak to the researcher using the contact details at the end of this document- contact details are at the end of the document. If you remain unhappy and wish to complain formally, you can do this via the Patient Advice Liaison Service (PALS).

Site: North East London NHS Foundation Trust (NELFT) PALS

Address: NELFT PALS, Goodmayes Hospital, Barley Lane, Ilford, IG3 8XJ

Telephone: 0844 600 1225

Email: r-pct.palscomplaints@nhs.net

10. Will my taking part in this project be kept confidential?

In this research study we ask you for the the following information about you: your name, email address, phone number, date of birth, gender, ethnicity, the number of NET sessions you had, , and which NELFT Early Intervention in Psychosis service you access treatment from. We will also have access to the scores from questionnaires you have done already with the Early Intervention in Psychosis service, and your primary diagnosis The researcher and Principal Investigator will use this information to do the research and to check the research is being done properly.

We will also have the information you discuss in your interview as an audio recording as and in the form of an anonymised written transcript. Only the researcher and Principal Investigator will have access to your name and contact details. Your data will use a participant number instead of your name. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no one can work out that you took part in the study.

11. Limits to confidentiality

We will keep your participation in the study confidential unless there is a significant reason for it to be breached- for example, if something you shared gave us concern about the safety of yourself or someone else. If we felt that we had to break confidentiality, we would inform you of this.

12. What will happen to the results of the research project?

The project results will be written up in a report for the researcher Rachel Sparrow's thesis, which is part of her assessment process for her Doctoral course in Clinical Psychology. The results may also be published in scientific journals following the completion of Rachel Sparrow's doctorate. The results of the study will also be shared with Early Intervention in Psychosis teams in NELFT in the form of presentations and written documents. At all times, the data will be fully anonymised, and it will not be possible to identify individual participants based on the study results. The data collected for this study will be deleted following the completion of the project, and will not be used in any subsequent research.

13. Local Data Protection Privacy Notice

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This ‘local’ privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our ‘general’ privacy notice:

For participants in health and care research studies, click here

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the ‘local’ and ‘general’ privacy notices.

The lawful basis that will be used to process your personal data are: ‘Public task’ for personal data and’ Research purposes’ for special category data.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

14. Who is organising and funding this study?

This study has been organised and funded by UCL.

15. Who has reviewed this study?

The Dulwich Research Ethics Committee has examined the research proposal and has raised no objections from the point of view of research ethics. It is a requirement that our records in this research be made available for review by UCL and NELFT, whose role is to check that research is properly conducted and the interests of those taking part are adequately protected.

16. How have patients and the public been involved in this study?

Members of the UCL Patient and Public Involvement (PPI) team has been involved in the design of the participant documents (Participant Information Sheet, Informed Consent Form, poster) and interview schedule.

17. Contact for further information.

For further information about this study, please contact:

Researcher: Rachel Sparrow [redacted]

Principal Investigator: Miriam Fornells-Ambrojo [redacted]

Thank you for reading this information sheet and considering participating in this study.

Appendix D. Participant information sheet (clinicians)

Experiences of process and impact of Narrative Exposure Therapy in Early Intervention in Psychosis services.

Clinician version

We invite you to take part in a Doctorate of Clinical Psychology research study.

- Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve.
- Please take time to read the following information carefully. Discuss it with family and friends if you wish.
- You are free to decide whether or not to take part in this research.
- If there is anything that is not clear or if you would like more information, please let me know. Take time to decide whether or not to take part.

Summary of research study.

- We want to hear about the experiences of clinicians delivering Narrative Exposure Therapy (NET) to people with a primary diagnosis of psychosis.
- We want to ask people questions about how they found the therapy- these questions will probably take around 1 hour, but may take longer.
- You can stop taking part in the study at any time.

Contents

1. What is the project's purpose?

The purpose of the project is to hear about the experiences clinicians who have delivered Narrative Exposure Therapy (NET) to individuals experiencing psychosis. NET is a talking therapy for people who have experienced a number of distressing or traumatic events in their lives. We want to build understanding of the process and impact of NET for individuals with psychosis. We hope that by hearing about the experiences of clinicians using NET with this population, we can consider how to adapt the therapy to best meet the needs of people with psychosis. We will also be interviewing service users who have engaged with NET during their time with Early Intervention in Psychosis services, in order to incorporate their perspectives.

2. Am I suitable for this study?

You are being approached because you have delivered, or attempted to deliver, NET with at least one individual(s) with psychosis. We are interested in hearing from people with a variety of experiences delivering the intervention in order to get a variety of perspectives. In order to be eligible to take part in this study, we ask that you read this inclusion and exclusion criteria carefully. If you have any questions about whether or not you are suitable for the study, please contact Rachel Sparrow using the email address at the bottom of this form.

Inclusion Criteria

- *Qualified clinicians who have undertaken training in NET*
- *Qualified clinicians who have delivered, or attempted to deliver, NET with at least 1 service user with a primary diagnosis of psychosis*
- *Access to a private space to engage in a video call (not necessary if interviews take place face-to-face, dependent on COVID-19 restrictions)*

Exclusion Criteria

- *Clinicians who use NET but have not completed NET training*

3. Do I have to take part?

No- it is up to you if you to decide whether or not to take part. You can withdraw from the research at any time without giving a reason. If you decide to withdraw from the study before the interview, we will delete all data relating to you, in accordance with GDPR. If you withdraw from the study after the interview, the interview data will be retained for use in the study, but all identifiable data will be destroyed, and you will not be asked to do anything else associated with the study.

4. What will happen to me if I take part?

You may have seen a poster advertising the study, and made contact with the researcher- Rachel Sparrow- yourself. Alternatively, you may have indicated to a member of the research team- Dr Miriam Fornells-Ambrojo or Rachel Sparrow- that you were happy to be contacted and given further information about the study. The researcher- Rachel Sparrow- will have taken your contact details to send you this Participant Information Form and the Informed Consent Form.

You will be asked to read this Participant Sheet and Informed Consent Form, and you can contact the researcher- Rachel Sparrow- with any questions you may have or for more information. The researcher will contact you at least 24 hours after you receiving the documents- or at a time agreed during the first telephone call- to answer any questions about the form. She will also ask if you would like to consent to taking part in the study. If you wish to take part, you will then email the signed Informed Consent Form back to the researcher, and we will arrange a date and time for the one-to-one interview. This is likely to take place on Microsoft Teams; the researcher will check that you have access to a private space to have the interview. If COVID-19 guidelines change in the future, there may be the option to have interviews in-person at your local NELFT Early Intervention in Psychosis service, if this is your preference..

The interview is estimated to last 1 hour, but might last longer if you wish to take breaks or have more information that you would like to share. The interview will start with us speaking about the project, checking you understand the purpose of the research and answering any questions. We will then start the main interview; you will be asked questions about what it was like delivering NET with individuals with psychosis, what impact you think it had, and any particular aspects of components that you think were important in bringing about change. The answers you give will be kept confidential. We do not expect the interview to be distressing, however if you find the discussion challenging or tiring, you can ask to take breaks or end the interview early. If the interview process is too challenging for you at the time, we may decide to end the interview early.

Once the interview has ended, you will be given the opportunity to ask any questions you might have about the study and to give feedback, if you would like to. You will be paid £10 in the form of cash or a voucher (depending on your preference) for your participation in the study- we will discuss arrangements for this at the end of the interview. You will also be asked if you would like to be informed of the findings of the study at the end of the research- this will be one of the check boxes on the Informed Consent Form, and if you choose to be contacted, we will email you a document summarising the main findings of the research.

We would also like to speak to a few participants when we have finished all the interviews (March 2022), to ask some questions about the themes and ideas we have gathered- you will also have the chance to opt in to this on the Informed Consent Form. We will contact some people who have opted in to arrange a telephone or videocall to discuss the themes and ideas developed from the research. Alternatively, feedback can be given over email. People who take part in this part of the study will be paid an additional £10 in the form of cash or a voucher (depending on your preference) as a thank you for their time.

5. Will I be recorded and how will the recorded media be used?

If you agree to be interviewed, the interview will be audio-recorded by the researcher, Rachel Sparrow. The audio-recording will be used only for transcription and analysis. Where Microsoft Teams is used for interviews, the researcher will use the inbuilt 'transcription' function to aid the transcription process. Quotes from the interview might be used in reports and publications written up from the research, but not in a way that could identify you. No other use will be made of them without your written permission, and no one outside the project will be allowed to access the recordings. The audio recordings will be stored on a secure UCL electronic drive until we have written them up, and will be destroyed when we have finished transcription.

6. How will information about me be used?

How will you use information about me?

We will need to use information from you for this research project.

This information will include your [initials/ NHS number/ name/ contact details/ provide a bullet list of identifiers held by site and/or sponsor for the research]. People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are my choices about how my information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can I find out more about how my information is used?

You can find out more about how we use your information in the following places:

- *www.hra.nhs.uk/information-about-patients/*

- *https://www.ucl.ac.uk/legal-services/privacy*
- *By asking one of the research team using the contact details below*
- *By emailing the Sponsor Data Protection Officer on data-protection@ucl.ac.uk*

7. What are the possible disadvantages and risks of taking part?

We do not anticipate any disadvantages or risks of participating in this study. We appreciate that you are taking time out of your busy schedule to participate in this research.

We appreciate that speaking about one's own clinical work can feel challenging for some. Whilst we do not anticipate the process will feel distressing, you will be able to request breaks at any point, and can decline to answer questions if you prefer.

For some, answering questions for 1 hour or longer might feel tiring. If this is the case, you will be able to ask for breaks or to end the interview early.

8. What are the possible benefits of taking part?

Taking part in this research will allow you to reflect on your clinical work, which some people might find interesting. Your views might help inform future adaptations for the therapy to best support people with psychosis- we believe it is very important for the views of clinicians involved in delivering the intervention to be included in this process.

9. What if something goes wrong?

If you want to complain, or have concerns about any aspect of how you have been approached or treated by members of staff you have encountered in the study, complaints processes through both the NHS and University College London (UCL) are available to you. Please ask the researcher or principal investigator, using the contact details below, if you would like more information on this. In the unlikely event that you are harmed by taking part in this study, compensation may be available.

If you suspect that the harm is the result of the sponsor (UCL) or the hospital's negligence then you may be able to claim compensation. Please make the claim in writing to Miriam Fornells-Ambrojo who is the Principal Investigator for the research and is based at 1-19 Torrington Place, UCL. The Principal Investigator will then pass the claim to the Sponsor's insurers, via the Sponsor's office. You may have to bear the costs of the legal actions initially, and you should consult a lawyer about this.

If you have a concern about any aspect of this study, you should ask to speak to the researcher using the contact details at the end of this document- contact details are at the end of the document. If you remain unhappy and wish to complain formally, you can do this via the Patient Advice Liaison Service (PALS).

Site: North East London NHS Foundation Trust (NELFT) PALS

Address: NELFT PALS, Goodmayes Hospital, Barley Lane, Ilford, IG3 8XJ

Telephone: 0844 600 1225

Email: r-pct.palscomplaints@nhs.net

10. Will my taking part in this project be kept confidential?

In this research study we will have access to the following information about you: your name, email address, phone number, date of birth, gender and ethnicity. The researcher and Principal Investigator will use this information to do the research and to check the research is being done properly.

We will also have the information you discuss in your interview as an audio recording as and in the form of an pseudonymised written transcript. Only the researcher and Principal Investigator will have access to your name and contact details. Your data will use a participant number instead of your name. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no one can work out that you took part in the study.

11. Limits to confidentiality

We will keep your participation in the study confidential unless there is a significant reason for it to be breached- for example, if something you shared gave us concern about the safety of yourself or someone else. If we felt that we had to break confidentiality, we would inform you of this.

12. What will happen to the results of the research project?

The project results will be written up in a report for the researcher Rachel Sparrow's thesis, which is part of her assessment process for her Doctoral course in Clinical Psychology. The results may also be published in peer-reviewed scientific journals following the completion of Rachel Sparrow's doctorate. The results of the study will also be shared with Early Intervention in Psychosis teams in NELFT in the form of presentations and written documents. In all of these instances, the data will be fully anonymised, and it will not be possible to identify individual participants based on the study results. The data collected for this study will be deleted following the completion of the project, and will not be used in any subsequent research.

13. Local Data Protection Privacy Notice

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice:

For participants in health and care research studies, click here

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

The lawful basis that will be used to process your personal data are: 'Public task' for personal data and' Research purposes' for special category data.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk

14. Who is organising and funding this study?

This study has been organised and funded by UCL.

15. Who has reviewed this study?

The Dulwich Research Ethics Committee has examined the research proposal and has raised no objections from the point of view of research ethics. It is a requirement that our records in this research be made available for review by UCL and NELFT, whose role is to check that research is properly conducted and the interests of those taking part are adequately protected.

16. How have patients and the public been involved in this study?

Member of the UCL Patient and Public Involvement (PPI) team has been involved in the design of the participant documents (Participant Information Sheet, Informed Consent Form, flyer) and interview schedule.

17. Contact for further information.

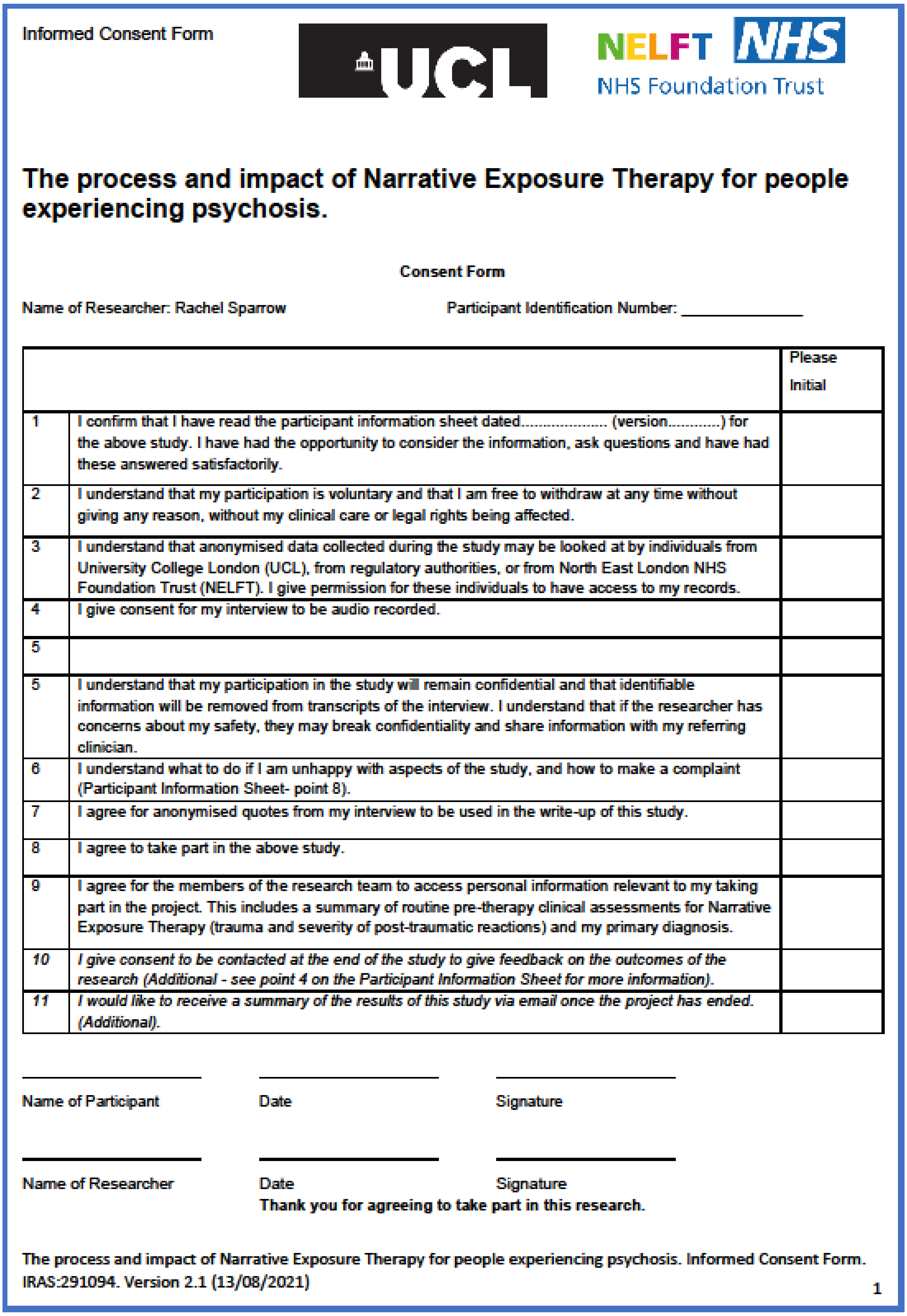
For further information about this study, please contact:

Researcher: Rachel Sparrow [redacted]

Principal Investigator: Miriam Fornells-Ambrojo [redacted]

Thank you for reading this information sheet and considering participating in this study.

Appendix E. Informed consent form (EbE)



Informed Consent Form

The process and impact of Narrative Exposure Therapy for people experiencing psychosis.

Consent Form

Name of Researcher: Rachel Sparrow

Participant Identification Number: ______________

		Please Initial
1	I confirm that I have read the participant information sheet dated.................... (version............) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my clinical care or legal rights being affected.	
3	I understand that anonymised data collected during the study may be looked at by individuals from University College London (UCL), from regulatory authorities, or from North East London NHS Foundation Trust (NELFT). I give permission for these individuals to have access to my records.	
4	I give consent for my interview to be audio recorded.	
5		
5	I understand that my participation in the study will remain confidential and that identifiable information will be removed from transcripts of the interview. I understand that if the researcher has concerns about my safety, they may break confidentiality and share information with my referring clinician.	
6	I understand what to do if I am unhappy with aspects of the study, and how to make a complaint (Participant Information Sheet- point 8).	
7	I agree for anonymised quotes from my interview to be used in the write-up of this study.	
8	I agree to take part in the above study.	
9	I agree for the members of the research team to access personal information relevant to my taking part in the project. This includes a summary of routine pre-therapy clinical assessments for Narrative Exposure Therapy (trauma and severity of post-traumatic reactions) and my primary diagnosis.	
10	*I give consent to be contacted at the end of the study to give feedback on the outcomes of the research (Additional - see point 4 on the Participant Information Sheet for more information).*	
11	*I would like to receive a summary of the results of this study via email once the project has ended. (Additional).*	

Name of Participant Date Signature

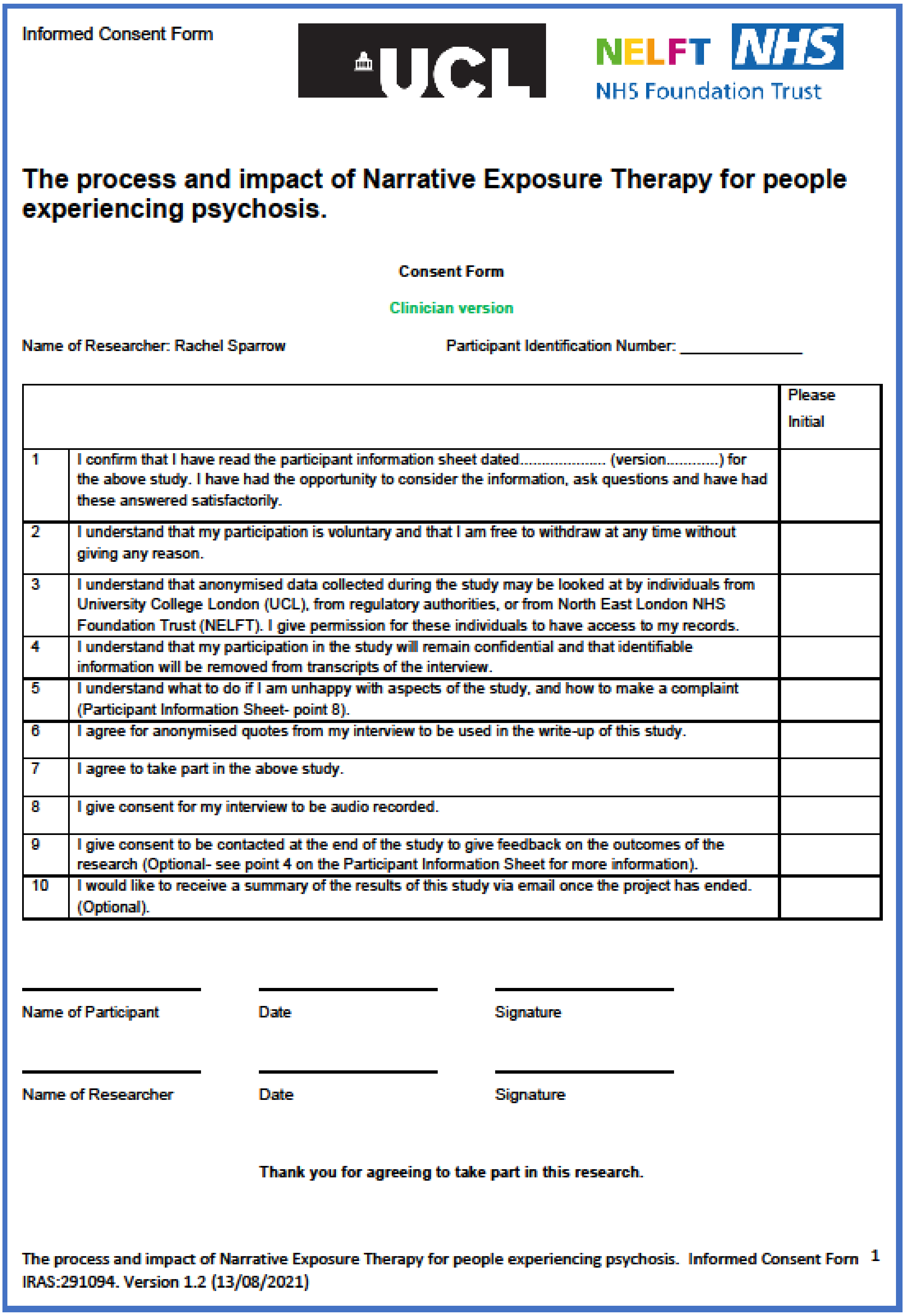
Name of Researcher Date Signature

Thank you for agreeing to take part in this research.

The process and impact of Narrative Exposure Therapy for people experiencing psychosis. Informed Consent Form. IRAS:291094. Version 2.1 (13/08/2021)

1

Appendix F. Informed consent form (clinicians)



Informed Consent Form

UCL

NELFT NHS
NHS Foundation Trust

The process and impact of Narrative Exposure Therapy for people experiencing psychosis.

Consent Form

Clinician version

Name of Researcher: Rachel Sparrow

Participant Identification Number: _______________

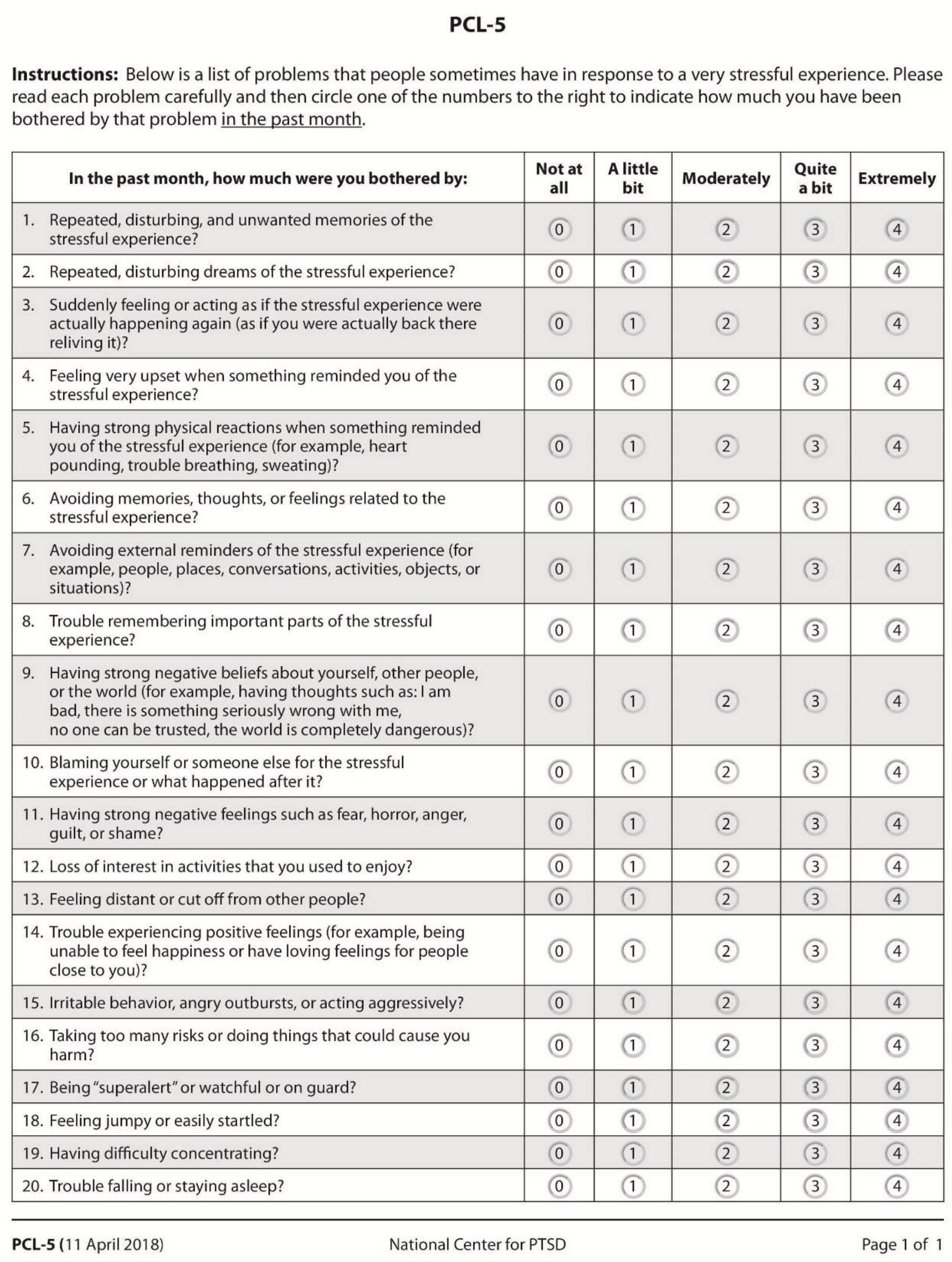
		Please Initial
1	I confirm that I have read the participant information sheet dated..................... (version............) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.	
3	I understand that anonymised data collected during the study may be looked at by individuals from University College London (UCL), from regulatory authorities, or from North East London NHS Foundation Trust (NELFT). I give permission for these individuals to have access to my records.	
4	I understand that my participation in the study will remain confidential and that identifiable information will be removed from transcripts of the interview.	
5	I understand what to do if I am unhappy with aspects of the study, and how to make a complaint (Participant Information Sheet- point 8).	
6	I agree for anonymised quotes from my interview to be used in the write-up of this study.	
7	I agree to take part in the above study.	
8	I give consent for my interview to be audio recorded.	
9	I give consent to be contacted at the end of the study to give feedback on the outcomes of the research (Optional- see point 4 on the Participant Information Sheet for more information).	
10	I would like to receive a summary of the results of this study via email once the project has ended. (Optional).	

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

Thank you for agreeing to take part in this research.

The process and impact of Narrative Exposure Therapy for people experiencing psychosis. Informed Consent Form 1
IRAS:291094. Version 1.2 (13/08/2021)

Appendix G. PTSD Checklist for DM-5 (PCL-5; Weathers et al. 2013)



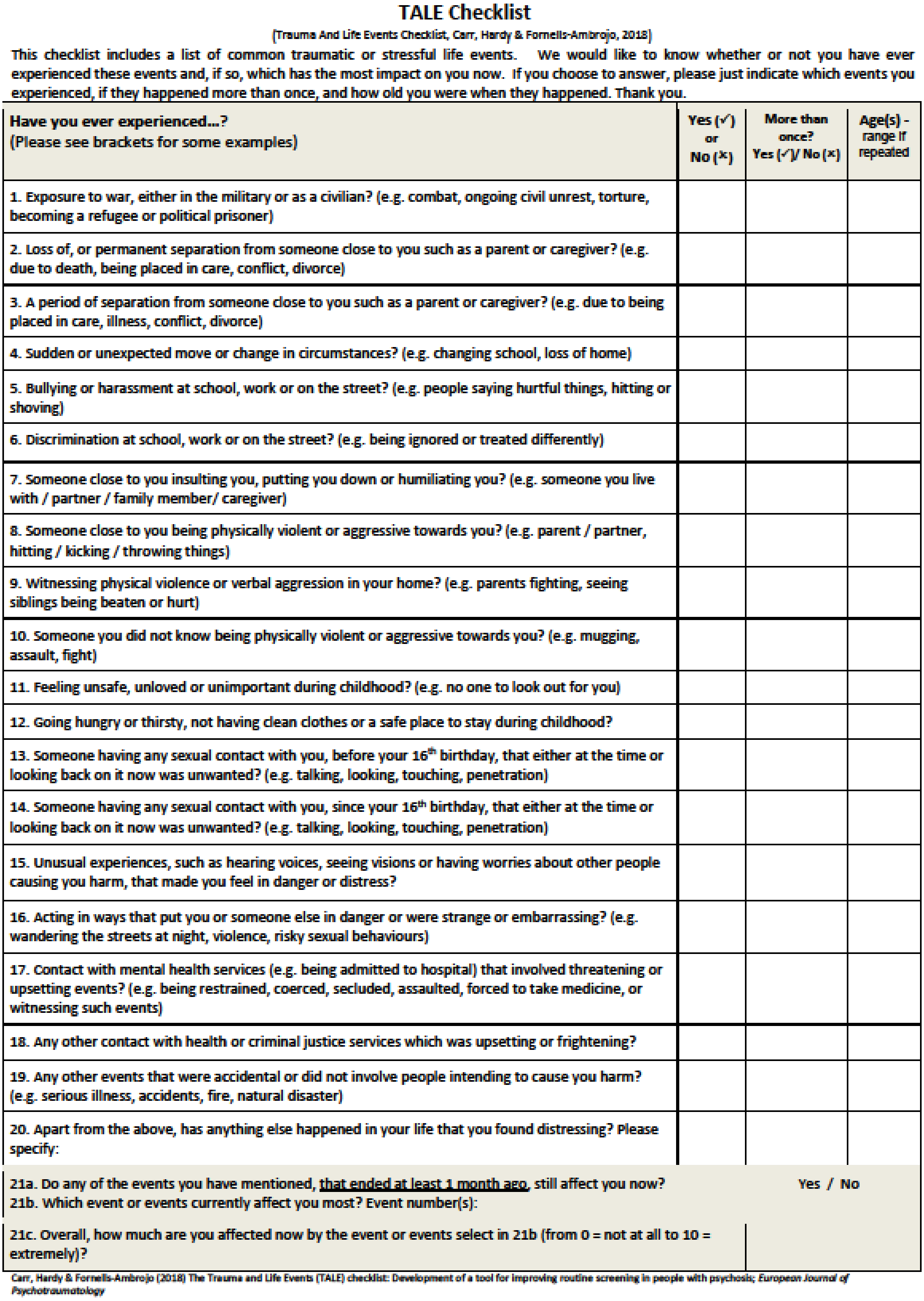
PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	⓪	①	②	③	④
2. Repeated, disturbing dreams of the stressful experience?	⓪	①	②	③	④
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	⓪	①	②	③	④
4. Feeling very upset when something reminded you of the stressful experience?	⓪	①	②	③	④
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	⓪	①	②	③	④
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	⓪	①	②	③	④
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	⓪	①	②	③	④
8. Trouble remembering important parts of the stressful experience?	⓪	①	②	③	④
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	⓪	①	②	③	④
10. Blaming yourself or someone else for the stressful experience or what happened after it?	⓪	①	②	③	④
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	⓪	①	②	③	④
12. Loss of interest in activities that you used to enjoy?	⓪	①	②	③	④
13. Feeling distant or cut off from other people?	⓪	①	②	③	④
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	⓪	①	②	③	④
15. Irritable behavior, angry outbursts, or acting aggressively?	⓪	①	②	③	④
16. Taking too many risks or doing things that could cause you harm?	⓪	①	②	③	④
17. Being "superalert" or watchful or on guard?	⓪	①	②	③	④
18. Feeling jumpy or easily startled?	⓪	①	②	③	④
19. Having difficulty concentrating?	⓪	①	②	③	④
20. Trouble falling or staying asleep?	⓪	①	②	③	④

PCL-5 (11 April 2018)   National Center for PTSD   Page 1 of 1

Appendix H. Trauma & Life Event Checklist (TALE; Carr et al., 2018)



TALE Checklist

(Trauma And Life Events Checklist, Carr, Hardy & Fornells-Ambrojo, 2018)

This checklist includes a list of common traumatic or stressful life events. We would like to know whether or not you have ever experienced these events and, if so, which has the most impact on you now. If you choose to answer, please just indicate which events you experienced, if they happened more than once, and how old you were when they happened. Thank you.

Have you ever experienced…? (Please see brackets for some examples)	**Yes (✓) or No (×)**	**More than once? Yes (✓)/ No (×)**	**Age(s) -** range if repeated
1. Exposure to war, either in the military or as a civilian? (e.g. combat, ongoing civil unrest, torture, becoming a refugee or political prisoner)			
2. Loss of, or permanent separation from someone close to you such as a parent or caregiver? (e.g. due to death, being placed in care, conflict, divorce)			
3. A period of separation from someone close to you such as a parent or caregiver? (e.g. due to being placed in care, illness, conflict, divorce)			
4. Sudden or unexpected move or change in circumstances? (e.g. changing school, loss of home)			
5. Bullying or harassment at school, work or on the street? (e.g. people saying hurtful things, hitting or shoving)			
6. Discrimination at school, work or on the street? (e.g. being ignored or treated differently)			
7. Someone close to you insulting you, putting you down or humiliating you? (e.g. someone you live with / partner / family member/ caregiver)			
8. Someone close to you being physically violent or aggressive towards you? (e.g. parent / partner, hitting / kicking / throwing things)			
9. Witnessing physical violence or verbal aggression in your home? (e.g. parents fighting, seeing siblings being beaten or hurt)			
10. Someone you did not know being physically violent or aggressive towards you? (e.g. mugging, assault, fight)			
11. Feeling unsafe, unloved or unimportant during childhood? (e.g. no one to look out for you)			
12. Going hungry or thirsty, not having clean clothes or a safe place to stay during childhood?			
13. Someone having any sexual contact with you, before your 16th birthday, that either at the time or looking back on it now was unwanted? (e.g. talking, looking, touching, penetration)			
14. Someone having any sexual contact with you, since your 16th birthday, that either at the time or looking back on it now was unwanted? (e.g. talking, looking, touching, penetration)			
15. Unusual experiences, such as hearing voices, seeing visions or having worries about other people causing you harm, that made you feel in danger or distress?			
16. Acting in ways that put you or someone else in danger or were strange or embarrassing? (e.g. wandering the streets at night, violence, risky sexual behaviours)			
17. Contact with mental health services (e.g. being admitted to hospital) that involved threatening or upsetting events? (e.g. being restrained, coerced, secluded, assaulted, forced to take medicine, or witnessing such events)			
18. Any other contact with health or criminal justice services which was upsetting or frightening?			
19. Any other events that were accidental or did not involve people intending to cause you harm? (e.g. serious illness, accidents, fire, natural disaster)			
20. Apart from the above, has anything else happened in your life that you found distressing? Please specify:			
21a. Do any of the events you have mentioned, that ended at least 1 month ago, still affect you now? 21b. Which event or events currently affect you most? Event number(s):		Yes / No	
21c. Overall, how much are you affected now by the event or events select in 21b (from 0 = not at all to 10 = extremely)?			

Carr, Hardy & Fornells-Ambrojo (2018) The Trauma and Life Events (TALE) checklist: Development of a tool for improving routine screening in people with psychosis; *European Journal of Psychotraumatology*

Appendix I. Semi-structured interview schedule (EbE)

Interview Schedule: Your experience of NET

Welcome

Thank you so much for agreeing to take part in this research. How are you this morning/afternoon? (Informal chat).

My name is Rachel, I'm a trainee clinical psychologist and I am doing this research as part of my doctorate in clinical psychology.

Before we begin, I would first just like to re-cap a bit about what the research is about. So, the purpose of this research is to understand a bit more about what it is like doing sessions of Narrative Exposure Therapy for people in early intervention in psychosis services. We hope the research will help us to understand a bit more about how we can best support people with psychosis who have experienced traumatic events in their lives.

So I'd like to spend some time today hearing about your experience of Narrative Exposure Therapy- or NET- which I believe was the type of talking therapy you did (/are doing) with (therapist name).

In Early Intervention services there might be a few different people you meet and talk about different things with- I just want to mention that this interview is **only** about the NET (or Narrative Exposure Therapy) sessions, when you constructed a lifeline of different life experiences *(show photo of generic lifeline*). Does that make sense?

- *(Prompt) Do you remember making a lifeline like this in therapy, using stones, flowers or other objects?*
- *(Prompt) Do you remember talking to (Name) about upsetting or traumatic things that have happened in your life?*
- *(Prompt) At the end of your therapy, your therapist might have read out a testimony of all of the events you spoke about in therapy?*
- *(Prompt) Questions locating in time etc- Just started? Ongoing? How many sessions?*

We'll be focusing on how you found different aspects of the NET therapy. I won't be asking any questions about the personal things you shared in therapy. The questions will focus on what it was like having the NET sessions, any changes you noticed, and parts of the therapy you thought were helpful or unhelpful. There are no right or wrong answers- it's your own views that I'd like to hear about. What you share today won't have any impact on the care you receive in EIP, in fact I'm not actually a part of the EIP service at all.

The interview will last for up to one hour. You are free to stop the interview at any point and you do not have to answer any questions that you don't feel comfortable answering.

Thank you for sending over the consent form. Did you get a chance to look at the information sheet? Is there anything that you would like to check before we begin?

I have a voice recorder here that I'll be using to record the interview; it will also be recorded on Microsoft Teams. We haven't started recording yet, but I'll tell you when I'm about to start – is that OK?

Are you happy for me to start the interview? Okay, I will start the recording.

I'd like to start by asking some questions about when you started NET therapy.	
1. Have you done any other therapy before NET?	*P: Was this your first time having therapy?*
2. Why did you decide to start NET?	*P: Who's idea was it?* *P: How did you feel about starting the therapy?*
3. How were you feeling before you started the NET sessions with (therapist name)?	*P: What did you want help with?*
Thank you. The next few questions are about what it was like having sessions of NET therapy.	
4. Could you tell me a bit about what happened in the NET therapy sessions?	*P. How would you describe what NET is to someone who was thinking about starting this type of therapy?*
5. How did you feel when you were having the NET therapy sessions? • **What was it like talking to (therapist name)?**	*P. What was this like for you?*
6. Were there any times that you wanted to stop the NET sessions?	*P. What was this like for you?*

• **Did you continue with the sessions?** • **Why/why not?** ○ **(If relevant) Is there anything that could have been said or done to help you continue?**	
7. Types of therapy might connect differently with people's identities, for example their culture, religion, ethnicity. **Were there parts of the NET sessions that didn't fit with aspects of who you are as a person?** • **What were they?** • **What was that like for you?**	*P. What part of your identity did that clash with?*
Thank you for answering those questions and sharing your experiences. Now I'm going to ask you some questions about what impact, if any, you feel the NET sessions might have had on you and your life.	
8. Usually people report benefits from NET 6 months after finishing the therapy, but I wanted to ask so far- what changes, if any, have you noticed after having the NET sessions?	*P. Was there anything that got better during the NET sessions?* *P. Was there anything that got worse?* *P. What was the most important change to you?*

9. [You've told me a bit about some of the changes you noticed after having NET]. **I'd like to ask about other possible types of changes. Talking therapies affect people in different ways, so it's okay if you did or didn't notice any changes in these areas.** **After the NET sessions finished, did you notice any changes in:** • **The way you feel?** • **The things you do, or avoid doing?** • **The way you see yourself and others?** • **How you remember upsetting or traumatic events?** • **Any intrusive memories you might have, like nightmares or flashbacks?**	*P. How did that change?* *P. What was that like?*
10. Is there anything you would have liked to have changed after the therapy that hasn't changed?	*P. Why might that not have changed?*
We want to understand if there are certain aspects of NET that are particularly helpful for people. I'm going to ask some questions about how you found parts of the therapy- this might be things the therapist said or did, things you and the therapist did together, or something about the relationship you had with the therapist.	
12. What, if any, was helpful about NET in addressing traumatic memories?	

	P. What about the NET sessions helped bring about any changes you were hoping for? *P. Why was that part of the therapy was helpful?* *P. How do you think it helped you?*
13. What aspects of the therapy, if any, did you value or enjoy the most? - **Why was that?**	*P. What was that like for you?*
14. What aspects of the therapy, if any, did you dislike? - **Why was that?**	*P. What was that like for you?*
15. Were there any aspects of the NET sessions that felt unhelpful? - **What happened?** - **What was that like?**	*P. By unhelpful, perhaps anything that made you upset and felt unnecessary to making progress.* *P. Could you tell me a bit more about why that part of the therapy was unhelpful?*

14. Were there any specific moments that you think helped change things? • **What happened?** • **How did that help?**	*P. Why does that moment stick out in your mind?*
Thank you for all of the experiences and feedback that you have shared with me today. To finish off, I have a couple of questions about NET generally, and what it has been like talking about the NET sessions with me today.	
15. Would you recommend NET to a friend or family member? • **Why/why not?**	
16. Is there anything else you would like to tell me about your experience of NET that we have not covered in the interview today?	
17. Are there any questions about NET that you think would be helpful for us to ask people in future interviews? • **Do you have any feedback for me about the interview?**	

Thank you for your time, and for what you've shared today.

How are you feeling? [Note to use breathing exercises… if needed here]

Before we finished today…

I’d like to ask if you like to be sent a summary of findings of the study when the research has finished (around May 2022)? If so I will send this to you on the email address your provided earlier.

(If consented to member checking) One of the questions we asked in the consent form is whether you would like to be contacted at the end of the study for feedback about the findings of the research- you indicated that you would be happy for us to contact you about this. If you are still happy with this, I will be in touch in early next year to talk about this further. You are able to change your mind about this at any time.

Thanks again, I hope you have a good rest of the day.

Appendix J. Semi-structured interview schedule (clinician)

Interview: Clinician experience of NET

I'm going to ask some questions about your experience of using Narrative Exposure Therapy- or NET- with the clients you work with in psychosis services.

We are interested in finding out more about therapists' experiences of delivering the therapy with people with psychosis, and ideas you have about what parts of the therapy, if any, are important in bringing about change. We are also interested to hear your perspectives on how these clients you have worked with have experienced the therapy. Just to note, the clients we would like you to answer about are only those with a diagnosis of psychosis- not other non-psychosis clients you may also have done NET with.

Please answer openly and honestly- your responses are confidential, and we hope to develop more of an understanding about both the benefits and challenges of using NET with this client group. We appreciate that discussing one's work as a therapist can come with some anxiety, but I want to emphasise than I am not assessing your competence in NET, or how 'successfully' individual courses of therapy have gone.

The interview should last around an hour. If you would like to take a break at any point or if you would prefer not to answer one of the questions, just let me know and we can stop, or skip to the next question. If you would like to end the interview, please let me know and we can do so at any time.

Demographic sheet- start with orienting questions.

Do you have any questions?

Are you happy for me to start the interview?

The first few questions are about your experiences of delivering NET with people with a diagnosis of psychosis.

1. What, if anything, do you like about NET?
2. What, if anything, do you dislike about NET?
3. What are the strengths of using NET with people with psychosis?
4. What are the barriers of using NET with people with psychosis?
5. What do you think is different about using NET with this client group, compared to other trauma-focussed therapies?
6. What things are important to consider when using NET with this client group?
7. What adjustments, if any, did you make to the NET protocol?
    a. What other adjustments, if any, might you make in the future?

The next few questions are about how you think the clients you have worked with have experienced NET.

8. What feedback, positive or negative, have clients shared with you about what it was like for them to have sessions of NET?
9. Have you experienced clients declining to try NET? If so, what reasons have they shared for this?
10. What components of NET, if any, do you think clients have struggled with, or found difficult?

11. Have you experienced clients dropping out of NET early? If so, what reasons have they shared about this?
12. How has NET fit (or not) with the identity of the clients you've worked with? For example, identity might refer to culture, religion, personal or family values?

The next few questions are about the impact- good or bad- of NET on service users.

13. What changes (good or bad, if any) have the clients you've worked with described having noticed following NET?
14. What impact, if any, have clients noticed in the following areas?
    a. The nature and impact of their trauma memories (including flashbacks)
    b. Emotions they experience
    c. Their behaviour
    d. Their sense of self
    e. Their lives more broadly
15. What negative consequences of NET (if any, even if temporary) have clients reported experiencing?

I am interested in hearing you views on what components of the NET sessions you think might have been important in the changes and impacts you have described occurring.

16. What part or parts of NET, or the therapeutic process, do you think are important in bringing about the changes you have described?
17. What part or parts of NET, if any, have felt unhelpful?
18. Are there any adaptations to the NET protocol that you think might be helpful in bringing about change?
19. Would you recommend NET to a friend or family member with psychosis? Why/why not?

Thank you for everything you have shared today. These final few questions are about your general experience of using NET with EIP clients, and your experience of speaking about them in this interview.

20. Is there anything else you would like to share about your experience of NET, or that of service users, that we have not covered in the interview today?
21. Are there any questions about NET that you think would be helpful for us to ask in future interviews?
22. Do you have any feedback for me about the interview?

Thank you so much for your time, and for everything you’ve shared today.

Would you like to be sent an overview of the findings of the study when the research has finished?

We would like to speak to some of the people who took part in the study when we have finished all the interviews (March 2022) to get some feedback about the findings- is this something you would like to be contacted about in the future? We will be giving a £10 voucher to anyone who gives feedback as a thank you for your time.

Thanks again, I hope you have a good rest of the day.

Appendix K. Debrief form (EbE)

The process and impact of Narrative Exposure Therapy for people experiencing psychosis.

Debrief Sheet: Client

Thank you for taking part in this study. For some people, answering questions about therapy might be stressful, upsetting, or raise concerns. Below are some contact details and resources which may help. After these details there is a debrief sheet will summarise the full details of the research study you have taken part in, as well as some information about what comes next.

If you feel concerned, or want support after the research has ended:

If you continue to feel concerned after taking part in the study, we recommend you speak to your allocated clinician in EIP, or a friend or family member. Some of the topics discussed may have brought about difficult thoughts and feelings. Therefore, we have included some relaxation exercises on the following page which may help manage any difficult feelings.

Additionally, the following helplines and websites provide helpful support and advice for people who have experienced traumatic or difficult life events, and may be useful for managing any difficult feelings you may have.

Telephone Helplines

Samaritans – **08457 90 90 90 –** Open 24 hours, 7 days a week but call charges apply. These can be found on their website below.

National Rape Crisis Helpline – **0808 802 9999** – Run by Rape Crisis South London (RASASC), a Croydon-based Appendix190ion who provide support for female survivors of sexual violence. The helpline is open 12pm – 2:30pm and 7pm – 9:30pm 365 days of the year and is free of charge.

National Association for People Abused in Childhood helplines:
0800 085 3330 for free from landlines, 3, Orange and Virgin mobile phones.
0808 801 0331 for free from O2, T-Mobile and Vodafone mobile phones

SurvivorsUK: **0845 122 1201** A service designed for male survivors of rape and sexual abuse.

General Websites

www.samaritans.org– Samaritans can give you someone to talk to at any time, as well as in times of distress and crisis. Their website has information about local branches or you can call them 24 hours a day, 7 days a week on the number below.

www.mind.org – the Mind website has lots of useful information about a variety of things people may struggle with including trauma.

Trauma Websites

http://www.rcpsych.ac.uk/expertadvice/problems/ptsd/copingafteratraumaticevent.aspx – Information about how to cope after a traumatic event. This website also has information about PTSD and various other problems that people can struggle with.

http://oneinfour.org.uk/ - A London based charity designed to help those who have experienced sexual abuse and/or violence. They have numerous exercises designed to aid recovery as well as listings of other potentially useful websites for support.

http://www.havoca.org/HAVOCA_home.htm – A non-profit Appendix191ion who support adult survivors of child abuse. They have lots of information about the effects of abuse and related psychological distress. They also have forums where survivors can support each other and offer advice (http://www.havoca.org/phpBB3/).

http://www.dabsbooks.co.uk/ - Directory of support for those concerned with abuse and sexual violence.

http://www.napac.org.uk/ - National Association for People Abused in Childhood (NAPAC) has a helpline and leaflets about identifying and dealing with child abuse.

http://www.survivorsuk.org/ - A service designed for male survivors of rape and sexual abuse.

Progressive Muscle Relaxation

Our bodies respond automatically to stressful situations and thoughts by becoming tense. The opposite relationship also works: a good way of relaxing the mind is to deliberately relax the body.

In a progressive muscle relaxation each muscle group is tensed in turn, and the tension is then released. This relaxes the muscles and allows you to notice the contrast between tension and relaxation.

Relaxation should be enjoyable so if any part of the exercise is too difficult skip it for the moment. If you have any injuries you may wish to leave out that part of the exercise.

Preparation

Lie down flat on your back, on a firm bed, a couch, or on the floor. Support your head and neck with a pillow or cushion. Alternativelty sit in a comfortable chair with your head well-supported. Close your eyes if you are comfortable doing so.

Instructions

Focus your attention on different parts of your body in sequence. Go through the sequence three times:

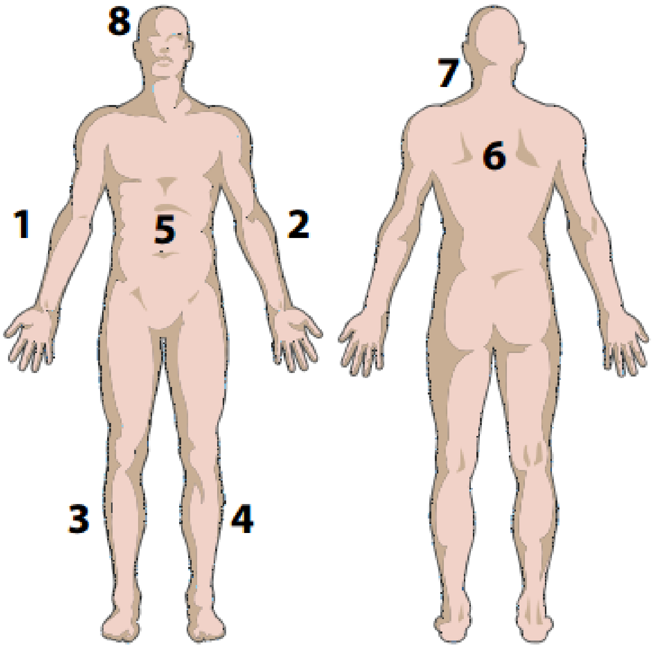
1) Tense & release: Tense that body part, hold it for a few moments, then relax

2) Lightly tense & release: Tense that body part with just enough tension to notice, then relax

3) Release only: Just pay attention to each muscle group and decide to relax it

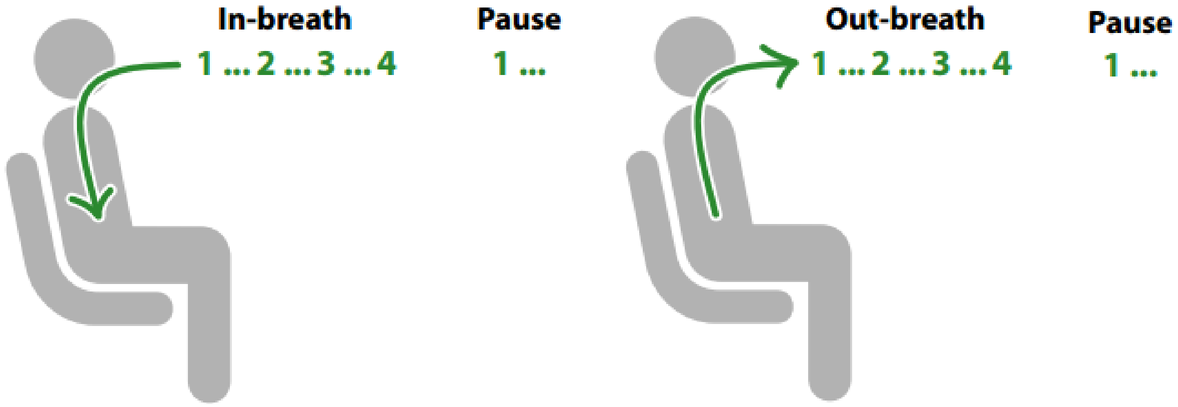
Recommended sequence

1 Right hand & arm
(clench the fist & tighten the muscles in the arm)
2 Left hand & arm
3 Right leg
(tense the leg, lifting the knee slightly)
4 Left leg
5 Stomach & chest
6 Back muscles
(pull the shoulders back slightly)
7 Neck & throat
(push the head back slightly into the pillow/surface)
8 Face
(scrunch up the muscles in your face)



Relaxed Breathing

When we are anxious or threatened our breathing speeds up in order to get our body ready for danger. Relaxed breathing (sometimes called abdominal or diaphragmatic breathing) signals the body that it is safe to relax. Relaxed breathing is *slower* and *deeper* than normal breathing, and it happens lower in the body (the belly rather than the chest).



How to do relaxed breathing

- To practice make sure you are sitting or lying comfortably
- Close your eyes if you are comfortable doing so
- Try to breathe through your nose rather than your mouth
- Deliberately slow your breathing down. Breathe in to a count of 4, pause for a moment, then breathe out to a count of four
- Make sure that your breaths are *smooth*, *steady*, and *continuous* - not jerky
- Pay particular attention to your out-breath - make sure it is smooth and steady

Am I doing it right? What should I be paying attention to?

- Relaxed breathing should be low down in the abdomen (belly), and not high in the chest. You can check this by putting one hand on your stomach and one on your chest Try to keep the top hand still, your breathing should only move the bottom hand
- Focus your attention on your breath - some people find it helpful to count in their head to begin with (*"In ... two ... three ... four ... pause ... Out ... two ... three ... four ... pause ..."*)

How long and how often?

- Try breathing in a relaxed way for at least a few minutes at a time - it might take a few minutes for you to notice an effect. If you are comfortable, aim for 5-10 minutes
- Try to practice regularly - perhaps three times a day

Variations and troubleshooting

- Find a slow breathing rhythm that is comfortable for you. Counting to 4 isn't an absolute rule. Try 3 or 5. The important thing is that the breathing is slow and steady
- Some people find the sensation of relaxing to be unusual or uncomfortable at first but this normally passes with practice. Do persist and keep practising

The process and impact of Narrative Exposure Therapy for people in Early Intervention services.

Debrief Sheet: Client

The purpose of this study is to understand the experiences of people using Early Intervention in Psychosis (EIP) services who have undertaken Narrative Exposure Therapy (NET)- a type of talking therapy designed to help people who have experienced a number of difficult or traumatic life events. There has been limited research exploring what the therapy is like for people who use EIP services- we think the feedback of service users is very important in understanding how types of therapy work, and how they can be improved in the future.

The answers you gave in the interview will be written up by the researcher (Rachel). Once all of the interviews are complete, the feedback from all the participants will be analysed to help us understand the experiences of the participants about what NET is like for people, and whether making adaptations to the therapy might help people who do the therapy in the future. We want to make sure the themes the researcher constructs from the interviews fit with the experiences you have shared- therefore, if you have given additional consent, the researcher will get in contact with you at the end of the study (Spring 2022) to ask for your feedback on the themes. If you help with this part of the research, you will receive an additional £10 in payment to thank you for your time. If you have asked not to be contacted about this part of the research, then your participation in the study has now come to an end. We will have discussed arrangements for your £10 payment at the end of the interview. We will also send you a summary of the results once the research has been written up (late Summer/ Autumn 2022) if you told us you would like this.

Thank you again for taking part in this study. If there is anything you would like to discuss about the study, please contact the researcher Rachel Sparrow on

[redacted]

Appendix L. Debrief sheet (clinicians)

The process and impact of Narrative Exposure Therapy for people experiencing psychosis.

Debrief Sheet: Clinician

Thank you for taking part in this study. This debrief sheet will summarise the full details of the research study you have taken part in, as well as some information about what comes next.

The purpose of this study is to understand the experiences of clinicians who have used Narrative Exposure Therapy (NET) as a trauma intervention with individuals experiencing psychosis. There is limited research exploring the use of NET with this client group, and we hope that your experiences will help to build an understanding of the acceptability of the intervention, the process of delivering NET and its impact. We hope also that this will inform adaptations to the intervention when used with individuals experiencing psychosis.

The researcher will transcribe and analyse the interviews and construct a set of themes from the data. We want to make sure these themes fit with the experiences you have shared- therefore, if you have given consent, the researcher might get in contact with you at the end of the study (Spring 2022) to ask for your feedback on the themes. If you help with this part of the research, you will receive an additional £10 in payment to thank you for your time. If you have asked not to be contacted about this part of the research, then your participation in the study has now come to an end. We will however send you a summary of the results once the research has been written up (Late Summer/ Autumn 2022) if you told us you'd like this.

Thank you again for taking part in this study. If there is anything you would like to discuss about the study, please contact the researcher Rachel Sparrow on [redacted]

Many thanks,

Rachel Sparrow (Researcher & Trainee Clinical Psychologist, UCL)

Dr Miriam Fornells-Ambrojo (Chief Investigator & Clinical Psychologist, UCL & NELFT)

Appendix M. Letter of HRA approval

Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

N/ADr Miriam Fornells-Ambrojo
Research Department of Clinical, Educational and
Health Psychology,
University College London, 1-19 Torrington Place
London
WC1E 7HBN/A

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

05 October 2021

Dear N/ADr Fornells-AmbrojoN/A

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title: **The process and impact of Narrative Exposure Therapy for people experiencing psychosis**
IRAS project ID: **291094**
Protocol number: **139858**
REC reference: **21/LO/0525**
Sponsor **University College London**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **291094**. Please quote this on all correspondence.

Yours sincerely,
Georgia Copeland

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Mr Maurice Griffin*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [291094 Evidence of peer review_v1 18.6.94]	1	18 June 2021
Copies of materials calling attention of potential participants to the research [Client Flyer v4.1]	4.1	30 July 2021
Copies of materials calling attention of potential participants to the research [Clinician Flyer v4.1]	4.1	02 August 2021
Covering letter on headed paper [291094 Cover letter v1_18.6.21]	1	18 June 2021
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [291094 UCL - Insurance Confirmation VOI 20-21]	1	18 June 2021
Interview schedules or topic guides for participants [291094 NET in psychosis clinician interview_v4 18.6.21]	4	18 June 2021
Interview schedules or topic guides for participants [291094 NET in psychosis client interview_v11 28.6.21]	10	03 March 2021
IRAS Application Form [IRAS_Form_22062021]		22 June 2021
IRAS Application Form XML file [IRAS_Form_22062021]		22 June 2021
IRAS Checklist XML [Checklist_13082021]		13 August 2021
IRAS Checklist XML [Checklist_15092021]		15 September 2021
Letter from funder [291094 Funding declaration letter_v1 18.6.21]	1	18 June 2021
Letters of invitation to participant [Clinician Invite Email v1 CLEAN]	1	28 July 2021
Letters of invitation to participant [Clinician Invite Email v1 TRACKED]	1	28 July 2021
Organisation Information Document [291094 OID v.1.2 CLEAN]	1.2	09 September 2021
Organisation Information Document [291094 OID v1.2 TRACKED]	1.2	09 September 2021
Other [291094 Signature_And_Delegation_v1 18.6.21]	1	18 June 2021
Other [Protocol v1.1 CLEAN]	1.1	28 July 2021
Other [Protocol v1.1 TRACKED]	1.1	28 July 2021
Other [REC committee additional information]	1	02 August 2021
Other [Cover Letter v1.1]	1.1	02 August 2021
Other [Client Contact Form v1.1 CLEAN]	1	13 August 2021
Other [Client Contact Form v1.1 TRACKED]	1	13 August 2021
Other [Client Debrief Form v1.2 CLEAN]	1.2	13 August 2021
Other [Client Debrief Form v1.2 TRACKED]	1.2	13 August 2021
Other [Clinician Debrief Form v1.2 CLEAN]	1.2	13 August 2021
Other [Clinician Debrief Form v1.2 TRACKED]	1.2	13 August 2021
Other [Cover Letter v1.2]	1.2	13 August 2021
Other [REC committee additional information 13.8.21]	1.1	13 August 2021
Other [REC committee additional information 9.9.21]		09 September 2021
Participant consent form [Client Informed Consent Form v2.2 CLEAN]	2.1	13 August 2021
Participant consent form [Client Informed Consent Form v2.2 TRACKED]	2.1	13 August 2021
Participant consent form [Clinician Informed Consent Form v1.1]	1.1	30 July 2021
Participant consent form [Clinician Informed Consent Form v1.2 CLEAN]	1.2	13 August 2021
Participant consent form [Clinician Informed Consent Form v1.2	1.2	13 August 2021

TRACKED]		
Participant information sheet (PIS) [Client Participant Information Sheet v4.2 CLEAN]	4.2	13 August 2021
Participant information sheet (PIS) [Client Participant Information Sheet v4.2 TRACKED]	4.2	13 August 2021
Participant information sheet (PIS) [Clinician Participant Information Sheet 2.2 CLEAN]	2.2	13 August 2021
Participant information sheet (PIS) [Clinician Participant Information Sheet 2.2 TRACKED]	2.2	13 August 2021
Schedule of Events or SoECAT [291094 SoE_v1 18.6.21]	1	18 June 2021
Summary CV for Chief Investigator (CI) [291094 Chief Investigator CV_v1 18.6.21]	1	18 June 2021
Summary CV for student [291094 Researcher CV_v2_18.6.21]	2	18 June 2021
Summary CV for supervisor (student research) [291094 Chief Investigator CV_v1 18.6.21]	1	18 June 2021

IRAS project ID	291094

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
There is only one participating NHS organisation therefore there is only one site type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	No external study funding will be sought.	A Principal Investigator should be appointed at study sites	No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtaina Letter of Access based on standard DBS checks and occupational health clearance.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.

The applicant has indicated that they intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix N. EbE analysis structure (before integration)

EbE analysis

Theme	Example codes
Fear of revisiting the past and feeling unsure about what good it might do	
Different to cultural norms	Sharing problems seen as a weakness culturally; Sharing family secrets
Avoiding thinking about the past	Pushing memories away; avoid thinking of past
Things feeling so difficult, and being willing to try anything	NET as a last resort; Tried other options
Facing the fear throughout the NET process	Avoidance reducing through NET; Skill of facing fears
Trust in the therapeutic relationship enabled me to try NET, in spite of fear	
A caring, personal relationship helped to build trust with therapist	Therapist cared about me; Therapist went the extra mile
Therapist giving choice and control over the process helped to build trust	Knowing what to expect helped engagement; Could stop if I wanted
A process of organising my memories	
Lifeline put difficult life events in context, showing ‘how much I had been through’	Seeing how much I had been through; The good amongst the bad
NET helped memories feel clearer and more organised	Clearer about what happened and when; Cupboard metaphor
Memories not going away, but their impact being less intense	Control over responses; Less emotions attached to memories
Changing my relationship with past memories, and my role within them	
Sharing my story helped to look at events from a (slightly) different perspective	New ideas about what happened; Seeing strength and resilience
‘It wasn’t my fault’	Self-blame reduced after narration; Realising it wasn’t my fault
Building self-compassion helped to put my own wellbeing first	Making changes in relationships; Being kinder to myself
Reconnecting with past emotions as painful, but potentially helpful	
Emotions resurfacing during and after narration is a painful process	Emotional impact could last a long time; Thrown back in time
Connecting to past emotions as an alternative to ‘carrying’ them	A weight lifted; Not carrying emotions
When emotions are high, an attuned support network is crucial	Routine after NET helped; Support network was crucial
Through NET, I developed skills that can help me in the future	
Slowing down and thinking things through	Slow process of reflection; Considering other people’s histories
Connecting to, and sharing, emotions	Trusting others with emotions; Feeling emotions not avoiding
Noticing avoidance, and facing the fear instead	Facing fears in general life; Notice avoidance outside of NET

Appendix O. Clinician analysis structure (before integration)

Clinician interviews

Themes	Codes
The process of NET: sharing a story and making new meaning	
Mapping out their life coherently and seeing how much they have been through	Realising how much they've been through; Situating trauma in life context
A trusted relationship gives people a reparative experience of sharing their story	Therapist not rejecting client; Responding with empathy can be reparative
Self-made links between the past and the present help understanding of 'unusual experiences'	Making links themselves was more authentic; Chronology helping to link past and present
Narration as an embodied process which uses the senses to differentiate the past form the present	Sensory weaving differentiates past from present; Impact of NT on body
Noticing and building strengths can be empowering	Noticing resilience; Connecting to a core sense of self
Feeling 'unhooked' from the past and taking control of the future	Distance from memories; Memories less unwanted
Deciding carefully whether or not to offer NET	
Trauma work is hard	NET causing dysregulation; Facing the past is distressing
Discussing whether NET is a good fit for the clients wants and needs	Wanting to talk about the present; NET as culturally appropriate
Considering the feasibility of NET for clinicians	Emotional impact on clinician; Time demands of NET
A whole-system approach is required	Family support is important; MDT understanding approach helps implementation
Psychosis-specific dilemmas encountered when using NET	
The impact of psychosis on cognition	Thought disorder disrupting flow of narration; Reliance on language/verbal
The impact of 'unusual experiences' on sessions	Voices intensifying; Grounding helps with voices
Dilemmas when choosing and narrating stones	Lots of stones; Unsure about level of emotional processing
Tension between following the NET protocol and being flexible/client-led	Wanting to talk about the present; Giving clients some control

Appendix P. DSM-5 criteria for PTSD (APA, 2013)

Criterion A	Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: 1. Directly experiencing the traumatic event(s) 2. Witnessing, in person, the event(s) as it occurred to others 3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental. 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g. first responders collecting human remains; police officers repeatedly exposed to details of child abuse).
Criterion B	Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred: 1. Recurrent, involuntary and intrusive distressing memories of the traumatic event(s) 2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s) 3. Dissociative reactions (e.g. flashback(s) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings). 4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s) 5. Marked psychological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)
Criterion C	Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following: 1. Avoidance of or efforts to avoid distressing memories, thoughts or feelings about or closely associated with the traumatic event(s) 2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts or feelings about or closely associated with the traumatic event(s)
Criterion D	Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following: 1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol or drugs) 2. Persistent and exaggerated negative beliefs or expectations about oneself, others or the world (e.g. ‘I am bad’, ‘no one can be trusted’) 3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame themselves or others 4. Persistent negative emotional state (e.g. fear, horror, anger, guilt, shame) 5. Markedly diminished interest or participation in significant activities 6. Feelings of detachment or estrangement from others 7. Persistent inability to experience positive emotions (e.g. inability to experience happiness, satisfaction or loving feelings)
Criterion E	Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following: 1. Irritable behaviour and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects 2. Reckless or self-destructive behaviour 3. Hypervigilance 4. Exaggerated startle response 5. Problems with concentration 6. Sleep disturbance