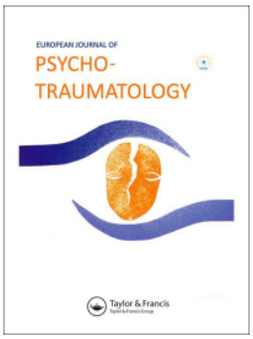

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CLINICAL RESEARCH ARTICLE

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Two people making sense of a story: narrative exposure therapy as a trauma intervention in early intervention in psychosis

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ABSTRACT

Background: Narrative exposure therapy (NET) is a recommended intervention for people with multiple trauma histories; however, research is lacking into its use with people experiencing psychosis, many of whom report multiple trauma histories.
Objective: This study aimed to explore experiences of NET in early intervention in psychosis (EIP) services.
Method: Eight clinicians and four experts with lived experience (experts by experience) of psychosis and multiple trauma were interviewed on a single occasion using two versions (clinician and expert by experience) of a semi-structured interview schedule. Data was analysed using thematic analysis.
Results: Five overarching themes were generated, relating to fear and avoidance of memories, importance of trust, organizing memories and making new meaning, reconnecting with emotions, and considerations when delivering NET in EIP.
Conclusions: Directly addressing the impact of multiple trauma in people experiencing first episode psychosis is frightening and emotive, but helps to address painful memories and organize them into a personal narrative. Increases in distress and anomalous experiences were carefully considered by clinicians, but typically outweighed by the benefits of NET. Challenges were comparable to those described in non-psychosis research. Implications for clinical practice and future research are outlined.

Dos personas dando sentido a una historia: la terapia de exposición narrativa como intervención para el trauma en la intervención temprana en psicosis

Antecedentes: La terapia de exposición narrativa (NET, por sus siglas en inglés) es una intervención recomendada para personas con antecedentes de traumas múltiples; sin embargo, faltan investigaciones sobre su uso en personas que experimentan psicosis, muchas de las cuales reportan antecedentes de traumas múltiples.
Objetivo: Este estudio tuvo como objetivo explorar experiencias de la terapia de exposición narrativa (NET) en los servicios de intervención temprana en psicosis (EIP, por sus siglas en inglés).
Método: Ocho médicos y cuatro expertos con experiencia vivida (EbE) de psicosis y trauma múltiple fueron entrevistados en una sola ocasión utilizando dos versiones (médico y EbE) de un programa de entrevista semiestructurada. Los datos se analizaron mediante análisis temático.
Resultados: Se generaron cinco temas generales: relacionados con el miedo y la evitación de los recuerdos; importancia de la confianza; organización de recuerdos y creación de nuevos significados; reconectar con las emociones y consideraciones al entregar la NET en EIP.
Conclusiones: Abordar directamente el impacto del trauma múltiple en personas que experimentan un primer episodio de psicosis es aterrador y emotivo, pero ayuda a abordar los recuerdos dolorosos y organizarlos en una narrativa personal. Los clínicos consideraron cuidadosamente el aumento de la angustia y las experiencias anómalas, pero generalmente los beneficios de la NET los compensaron. Los desafíos fueron comparables a los descritos en investigaciones no relacionadas con la psicosis. Se describen las implicancias para la práctica clínica y la investigación futura.

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PALABRAS CLAVE
Psicosis; trauma; intervención en trauma; trauma múltiple; terapia de exposición narrativa; cualitativo; experiencia vivida; NET; intervención temprana en psicosis; experiencia clínica

HIGHLIGHTS

- Many people experiencing psychosis report multiple trauma histories. Narrative exposure therapy (NET) is a recommended intervention for people with multiple trauma histories, but research into its use with people experiencing psychosis is limited.
- This qualitative study found that clinicians and experts by experience in early intervention in psychosis services valued NET for its effect on organizing memories, reducing their emotional impact, and making new meaning around experiences, and that challenges of NET were similar to those described in non-psychosis research.
- Some participants described experiencing distress and dysregulation during NET, including an increase in anomalous experiences. Although this was typically temporary and

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outweighed by NET's benefits, careful assessment before and flexibility during the intervention are considered important for building engagement and trust.

1. Introduction

Childhood trauma is associated with the severity of anomalous experiences (e.g. voice-hearing, paranoia) and increased risk of psychosis, in a dose–response relationship (Alameda et al., 2021; Bailey et al., 2018; Bentall et al., 2012; Schäfer & Fisher, 2022). Traumatic events are defined broadly to include any event that the individual perceives as involving a significant physical and/or psychological threat to the self (Brewin et al., 2019). These include both objective events, such as threatened or actual death, injury, or sexual violence, but also subjective experiences.

The experience of psychosis itself, such as persecutory voices and restrictive practices (e.g. involuntary hospitalization), can also be traumatic, particularly during a first episode (Fornells-Ambrojo et al., 2016; Rodrigues & Anderson, 2017). Therefore, it is not surprising that individuals with lived experience of psychosis value a trauma-informed understanding of their intrusive experiences (Campodonico et al., 2022; Martin et al., 2023). Despite this, psychosis-spectrum diagnoses have been historically excluded from trauma therapy trials and services (Ronconi et al., 2014).

Psychotic intrusions and post-traumatic stress disorder (PTSD) (American Psychiatric Association, 2013) flashbacks are proposed to arise when the encoding of traumatic memories is inhibited by stress-induced neurobiological changes, resulting in memories high in emotional salience by lacking contextual information regarding when and where an event happened (Hardy, 2017; Morrison et al., 2003). Thus, contextualizing trauma memories seems crucial to recovery, locating the threat and distress in the past rather than the here and now. Narrative exposure therapy (NET) is based on psychological models of PTSD and memory (Brewin & Burgess, 2014), but is also a testimonial therapy (Cienfuegos & Monelli, 1983). After assessment and psychoeducation, clients create a physical 'lifeline' with stones (traumatic events), flowers (positive events), and candles (deaths) along a rope, contextualizing traumatic events in their personal timeline and connecting people with positive memories alongside these events. Events are then narrated to integrate sensory–perceptual information with time, place, and context, reducing the current threat. A written testimony is shared and amended during each session, and can be used in legal proceedings (Schauer et al., 2011).

In England and Wales, the National Institute for Health and Social Care Excellence (NICE, 2014, 2018) recommends trauma assessment for people with a first episode of psychosis and following PTSD treatment guidelines if trauma is reported, which includes exposure-based interventions such as NET and eye movement desensitization and reprocessing (EMDR) (Shapiro, 2001). Research on emerging PTSD interventions shows their promise in alleviating PTSD symptoms and psychotic experiences (Brand et al., 2018; Swan et al., 2017).

NET has small-to-medium effect sizes on PTSD symptom scores in the short term, and large effect sizes in the long term ($\geq$ 6 months) (Siehl et al., 2021). Research on NET for psychosis is limited. Case studies report improvements in PTSD symptoms and paranoia (Breinlinger et al., 2020; Katsounari, 2015), while a study with a mixed sample of people with 'serious mental illness' (SMI) showed reductions in PTSD symptoms and dissociation, and improvements on secondary mental health problem scores (Mauritz et al., 2021). However, only four out of 23 participants in the SMI sample had a schizophrenia-spectrum diagnosis.

Nonetheless, NET seems potentially suitable for people experiencing psychosis, as it addresses the impact of multiple traumatic experiences on identity and personal narrative, which are commonly reported concerns. NET has a brief and flexible training model (Neuner et al., 2020), which could help to overcome the limited implementation of trauma interventions in psychosis (Álvarez et al., 2012), although mental health professionals report lacking confidence and expertise in this area, which may therefore present a barrier (Chadwick & Billings, 2022).

Qualitative methods provide insight into newer areas of research and practice, enabling a deeper understanding of participants' experiences (Barker et al., 2016). First-hand perspectives of psychological interventions from experts by experience (EbEs) and clinicians are crucial to understanding the process of therapeutic interventions, as well as mechanisms of change and adaptations for specific groups (Skivington et al., 2021). Qualitative NET research with asylum-seeking individuals (Cicconi, 2018) and unaccompanied minors (Said et al., 2021) has highlighted the significance of trust in sharing traumatic memories. Further research exploring how people accessing and using early intervention in psychosis (EIP) services experience NET is crucial in informing future implementation.

This study aims to understand how NET is experienced by EbEs and clinicians in EIP services, including

perspectives on its acceptability and impact, and ideas about change-facilitating factors. Understanding this may inform adaptations, so that NET can best meet the needs of people experiencing psychosis, as well as future randomized controlled trials (RCTs).

2. Method

2.1. Procedure and ethics

This study received National Health Service (NHS) Health Research Authority ethical approval from the Dulwich Research and Ethics Committee (ref. 21/LO/0525). Recruitment took place in four EIP services in a London NHS Trust, which offer intensive multidisciplinary outpatient support for people aged 14–65 years who have experienced psychosis (i.e. anomalous experiences such as voice-hearing, paranoia, distressing beliefs, or confused thinking) for the first time within the past 12 months (McGorry et al., 2008).

Nine eligible EbEs and 10 clinicians (Table 1) were approached about the study, of whom four EbEs and eight clinicians provided written informed consent to participate. Interviews took place between December 2021 and May 2022, either remotely (clinicians $n = 8$; EbEs $n = 2$) or face to face (EbEs $n = 2$), depending on the preference of the participant.

Semi-structured interviews (lasting for 1 h) were recorded on an encrypted electronic device, transcribed using Scrintal, and pseudonymized. After debriefing, participants were compensated with £10 vouchers, and audio files were destroyed after transcription.

2.2. Semi-structured interviews

After reviewing the literature, two interview schedules (for either EbEs or clinicians) were created through a process of refining and reviewing questions with a supervisor, professional experts, and EbEs. The final schedules (Supplementary material 1) explored the process of delivering and receiving NET, its impact, and ideas about change factors. The schedule was used flexibly to support participants in sharing (Smith et al., 2009).

2.3. Routine outcome measures

Measures were retrieved with consent from EbE participants' clinical files for descriptive purposes. The PTSD Checklist for DSM-5 (PCL-5) is a 20-item self-report measure assessing PTSD symptoms (Weathers et al., 2013). The Trauma and Life Events (TALE) questionnaire is a 21-item checklist asking whether participants have experienced common traumatic or stressful life events, including psychosis-related trauma (Carr et al., 2018).

2.4. Analysis

Interview transcripts were analysed using reflexive thematic analysis, following Braun and Clarke's (2006; 2013) six-step methodology (Table 2). Thematic analysis is an appropriate method for change process research, aiming to identify similarities, differences, and patterns in how participants describe their experiences (Braun et al., 2014). Quotations were

Table 1. Inclusion and exclusion criteria for study participants.

Inclusion criteria	Exclusion criteria
Experts by experience	
Aged ≥ 18 years	Unable to consent to the study under the Mental Capacity Act
Having a primary diagnosis of psychosis	Having a primary diagnosis of intellectual disability or cognitive impairment
Reporting a history of multiple traumas	
In receipt of NET under the care of EIP. Operationalized as: (i) having had a minimum of one 'lifeline' and one 'narration' session of NET, or (ii) if interviewed after dropping out from NET, having completed at least the lifeline session	
Clinicians	
HCPC qualified clinicians	None
Undertaken training in NET	
Delivered NET with at least one individual with a primary diagnosis of psychosis	

Note: NET = narrative exposure therapy; EIP = early intervention in psychosis; HCPC = Health and Care Professions Council.

Table 2. Braun and Clarke's six-step methodology for thematic analysis (Braun & Clarke, 2006; 2013).

Step	Method
1. Familiarization	Reading and rereading transcripts and making notes of initial analytical 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 data set, and that each theme has a distinct central organizing 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 analytical narrative and vivid data extracts

selected in discussion with the research supervisor (MFA) after the analysis to ensure that they illustrated themes generated from the analysis, and that all participants were represented (Lingard, 2019).

Transcripts were coded after each interview by the first author (RS), with initial codes shared and discussed with the research supervisor (MFA). Owing to the recruitment schedule, the clinician interviews were completed and analysed first, followed by the EbE interviews. To prioritize the voice of EbEs, the themes and codes generated from clinician analysis were revisited using the thematic framework generated from the EbE analysis to determine whether and how each of EbE themes presented in clinician accounts (Galloway & Pistrang, 2019). One theme (delivering NET in EIP) came from clinician interviews only, in addition to the four themes that were generated across both groups.

2.5. Validity checks

Validity checks were used to ensure rigour and transparency. Bracketing interviews and a research journal[1] were used to consider the researcher's own position, biases, and assumptions. Codes and themes were discussed between the author and research supervisor to identify inconsistencies, overlaps, or biases; the thematic structure was iteratively developed until agreement was reached on the final thematic structure. Member-checking was used to check that the overall synthesized data from the analysis still fitted with individual participants' experiences. All participants consented to being contacted for member-checking. Two EbEs and one clinician who responded within the study time-frames felt that their experiences were represented in the analysis.

2.6. Reflexivity statement

The first author, a white British female, was training as a clinical psychologist during the research period. From professional and personal contexts, she generally favours talking therapies and has had both positive and negative experiences in delivering and receiving therapy. She actively invited both positive and negative perspectives on NET.

Being aware of racial disparities in the diagnosis and treatment of people experiencing psychosis (Schwartz & Blankenship, 2014), the researcher aimed to pay attention to the effect that the power and privilege afforded by her own social identities shaped the research, and strived to make space for diverse perspectives while prioritizing participant safety.

The research adopted a critical realist epistemology, acknowledging that experiences shared may reflect a truth about NET, but cannot be directly examined outside the context of the participants' perceptions (Willig, 2013).

3. Results

Demographic information on the participants is shown in Table 3. EbEs and clinicians were aged between 29 and 40 years. Clinicians were clinical psychologists, predominantly female and white British/European, whereas EbEs had an even gender split and were of Black, Asian, and mixed ethnic backgrounds.

Clinical information is shown in Table 4. All EbEs reported multiple traumas, including loss/

Table 3. Demographic data.

	Experts by experience ($n = 4$)	Clinicians ($n = 8$)
Age (years)	34.75 (29–40)	34 (29–38)
Gender		
Female	2 (50)	7 (87)
Male	2 (50)	1 (13)
Ethnicity		
White British/European	0 (0)	5 (63.5)
Black British/African	1 (25)	2 (25)
British Asian/Pakistani	2 (50)	1 (12.5)
Mixed ethnicity[a]	1 (25)	–

Note: Data are shown as mean (range) or *n* (%).
[a]Caribbean/European.

Table 4. Clinical information.

Experts by experience ($n = 3$)[a]	
Length of time with EIP (months)	23.3 (17–30)
Number of NET sessions attended	11.7 ± 3.5
Format of NET sessions	
Face-to-face	4 (100)
Online	0 (0)
Status of NET intervention at time of interview	
Completed	3 (75)
Mid-intervention	1 (25)
Traumatic events (TALE)	
Loss/separation events	3 (75)
Interpersonal abuse	3 (75)
Change of circumstances	3 (75)
Victimization/abuse	3 (75)
Neglect	2 (50)
Accident	2 (50)
Psychosis-related trauma	3 (75)
PTSD (PCL-5)	55.8 ± 19.4
Clinicians ($n = 8$)	
Profession	
Clinical psychologist	8 (100)
Experience using NET	
≤ 2 years	6 (75)
3–8 years	2 (25)
Experience using NET with psychosis	
≤ 2 years	8 (100)
Number of clients with psychosis seen for NET	
1–5	8 (100)
Confidence with NET (0–10)[b]	4.57 (3–7)
Training in other trauma therapy	
EMDR	2 (25)
tfCBT (/CPD)	3 (38)
tfCBT (part of DClinPsy training)	5 (62.5)

Note: Data are shown as mean (range), mean ± *SD*, or *n* (%).
[a] Clinical data available for $n = 3/4$ EbEs. [b] Self-report Likert scale (0 = low to 10 = high).
EbE = expert by experience; EIP = early intervention in psychosis; NET = narrative exposure therapy; TALE = Trauma and Life Events questionnaire; PTSD = post-traumatic stress disorder; PCL-5 = PTSD Checklist for DSM-5; EMDR = eye movement desensitization and reprocessing; tfCBT = trauma-focused cognitive behavioural therapy; CPD = continued professional development; DClinPsy = doctorate in clinical psychology.

separation, abuse, sudden changes to life circumstances, victimization/discrimination, and psychosis-related events. Traumatic events had taken place between the ages of 3 and 37 years. Psychosis symptoms were not formally assessed for this study, but all participants met the criteria for first episode psychosis, as part of the inclusion criteria for early intervention services (Supplementary material 3). The presence of anomalous experiences at the time of interview was neither an inclusion nor an exclusion criterion for the study. Participants had capacity to consent, and were not in acute crisis or requiring hospitalization.

NET sessions undertaken by EbEs were all face to face, with three interviewed post-intervention and one mid-intervention.

Clinicians were experienced in working with an EIP client group. Six (75%) of the clinicians had less than 2 years' experience in delivering NET. All clinicians accessed specialist NET supervision.

3.1. Thematic analysis

The analysis generated five superordinate themes (comprising 16 themes), related to fear of revisiting the past, the importance of trust, organizing and making meaning around memories, reconnecting with emotions, and considerations when delivering NET in EIP (Tables 5 and 6). Some themes and subthemes were derived only from clinician or EbE accounts, as noted.

3.2. Superordinate theme 1: Fear of revisiting the past

Theme 1.1: Fear and avoidance of revisiting the past

Traumatic events were often pushed to the back of a person's mind before starting NET, and the prospect of revisiting the past generated fear. Fear continued throughout NET, contributing to a wish to avoid more difficult 'stones'. Some clinicians feared that speaking about traumatic events may exacerbate anomalous experiences. After facing memories in NET, some EbEs started to face feared situations in life generally, and this was a skill that they hoped to carry into the future.

Some EbEs felt that trying NET was a last resort for them. A drive to 'get better', coupled with a sense that many other avenues of support had been tried, helped them to face the fear of revisiting memories.

Theme 1.2: Sharing traumatic events – cultural norms

Clinicians felt that the 'storytelling style' of NET was relevant, familiar, and depathologizing, and reminded clients of 'storytelling' family members. Some felt that it made space for considering sociopolitical contexts such as racism, while others felt that it was more individualistic. Sharing difficult experiences and private family stories clashed with cultural norms for some participants, generating guilt.

Table 5. Summary and description of themes.

Theme	EbE summary	Clinician summary
1. Fear of revisiting the past	Fear of revisiting memories (particularly those related to private family matters) before NET and continued throughout. A drive to 'get better' helped EbEs to face this	Fear that revisiting memories would exacerbate anomalous experiences. Some feared that the intervention was individualistic and might not fit culturally
2. Trust was key in trying NET	Choice, collaboration, and clinicians demonstrating care about their life outside NET helped to build trust, as did having an existing relationship with the therapist	Having an existing relationship helped to build trust, and building the lifeline in particular felt collaborative. Clients sharing their story in a trusting relationship was reparative in itself
3. Organizing memories and relating to them differently	The lifeline helped to organize events, clarify 'what happened and when', and show how much people had been through. Weaving between the past and present helped with grounding. Stories were seen differently, with self-blame reducing over time. Memories caused fewer problems	The lifeline helped to make links between past events and present experiences. This was new for many EIP clients, and helped to generate new understanding around psychosis, and build self-compassion. Repeated exposure to memories reduced flashbacks. Some clients did not see significant benefit owing to elevated distress
4. Reconnecting with emotions can be both painful and helpful	Reconnecting with memories generated temporary emotional distress and a sense of being 'thrown back' in time. The intensity of this varied, and was significant for some. Grounding, family support, and noticing benefit over time helped	The distress generated for clients ranged from minimal (fuelling queries about the impact of psychosis factors and clinician competence) to intense (requiring additional stabilization and formulation sessions). For some, this included dysregulation and an increase in anomalous experiences (e.g. voice-hearing). NET was also emotionally intense for clinicians
5. Considerations when delivering NET in EIP	–	Dilemma between sticking to protocol and having flexibility, which was valued by clients and fits with EIP ethos. Difficulties with memory, concentration, and language for clients presented challenges. Uncertainty about how to help clients to prioritize which stones to narrate, especially where they less clearly linked to flashbacks and anomalous experiences

Note: EbE = expert by experience; NET = narrative exposure therapy; EIP = early intervention in psychosis.

Table 6. Structure of superordinate themes and themes for all participants (experts by experience and clinicians) with illustrative quotes.

Superordinate theme	Theme	EbE quotation	Clinician quotation
1. Fear of revisiting the past	1.1. Fear and avoidance of revisiting the past	'I was scared to revisit certain things that I'd probably pushed aside and not dealt with in the past […] It was just feeling like I was going to have to bring up those things that I pushed back.' (EbE_4)[a]	'S/he was talking about avoiding those memories, like pushing them back when s/he noticed them. And now s/he's not avoiding, it was helping him/her realize that it was not actually as bad.' (C_4)[b]
	1.2. Sharing traumatic events – cultural norms	'When you're all out of options, you'll try anything. I said, "I'll give it a go".' (EbE_3)	
2. Trust was key in trying NET	2.1. Care and thoughtfulness	'I think I felt quite comfortable with all my NET sessions. 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.' (EbE_2)	'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.' (C_3)
	2.2. Choice and control	'The fact that I got the choice to do or not do. Because … [pause] I wasn't given a lot of choices. If I come into the session and I don't want to talk about a stone – 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, it is going to be the barrier for me. Because that's what I've done all my life.' (EbE_1)	'I think there is something about NET that feels more empowering because 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 object, putting it down.' (C_8)
	2.3. Sharing a story can feel reparative (*clinician only*)	–	'I think there's something really important about 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.' (C_3)
3. Organizing memories and relating to them differently	3.1. Mapping out life events and realizing 'how much I have been through'	'I think that I like the fact that you can step back and just look at it. […] I saw all my stones, the bigger stones. And it was just like, "Wow, I've been carrying quite a bit with me".' (EbE_4)	'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 normally very much focused on the episode.' (C_7)
	3.2. Organizing memories and locating them in the past	'Imagine, like a film theatre where you're watching something on the screen. […] 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 what was going on in those events.' (EbE_4)	'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.' (C_2)
	3.3. Making new meaning (about memories and psychosis)	'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. […] It showed me that in between all the period of positive and negative, I was growing. And I was affecting changes.' (EbE_3)	'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. 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.' (C_4)
	3.4. From self-blame to self-compassion	'Some of the things … 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. […] It would take weeks 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".' (EbE_1)	'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. […] 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.' (C_2)
	3.5. Memories not going away, but feeling less held back by them	'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_2)	'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.' (C_3)
4. Reconnecting with emotions can be both painful and helpful	4.1. Impact on emotions, anomalous experiences, and the body	'When you're really speaking about it openly … everything resurfaces, the emotions that the … tenseness in your body and things like that, and so it can be quite overwhelming.' (EbE_4) '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 […] that was when I was able to detach myself from the session, put myself in the bathroom again.' (EbE_1)	'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 the voice got more intense.' (C_4) '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.' (C_1)

	4.2. A whole-system approach is important	'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. Everybody around me knows, "every [weekday] she goes to her session. And sometimes when she comes back, she's not … she's always worse off." So they'll keep coming, until I come out of my shell again.' (EbE_1)	'With a case in my team, the amount of work that goes around this client now because she's a bit dysregulated, so she has one of the support workers seeing her, the care-co[ordinator] is off this week so now I'm also seeing her, because that's literally what you do when you've got somebody in a trauma intervention.' (C_5)
	4.3. Connecting with emotions as an alternative to 'carrying' them	'Now 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 […] I'm not carrying it with me any more.' (EbE_2)	'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.' (C_5)
5. Considerations when delivering NET in EIP (*clinician only*)	5.1. Flexibility in NET delivery (*clinician only*)	–	'You do have to have someone on board and committed to work on trauma. Whereas generally, when you're doing other psychosis work […] 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. But having said that most people did take to it quite well.' (C_7) 'We would just walk up and down doing the memory to stop the voices being so distractible. Sometimes I've stopped and done a few side sessions around what might be going on, what's happening, trying to help them formulate a bit why it's [voices] getting worse now and where that's coming from.' (C_5)
	5.2. The demands of NET (*clinician only*)	–	'Cognitively, we have to think how well they are at the time. Because in terms of processing, obviously if someone is acutely psychotic at the time, it will be really hard for them understand the psychoeducation, remember it … they might jump from topic to topic, really hard to stay. Even doing the narration, I can imagine with some people it would be really difficult for them to be able to have their thoughts in order in that way, to be able to remember.' (C_6)
	5.3. The nature of 'stones' selected (*clinician only*)	–	'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 traumas 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.' (C_2) '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.' (C_4)

Note: [a] EbE_4 = EbE participant 4; [b] C_4 = clinician participant 4.
EbE = expert by experience; NET = narrative exposure therapy; EIP = early intervention in psychosis.

3.3. Superordinate theme 2: Trust was key in trying NET

Theme 2.1: Care and thoughtfulness

Care and thoughtfulness built trust, which strengthened further as NET progressed. Talking about daily life and helping with practical tasks made EbEs feel known as a 'whole person'. Most EbEs had worked with their therapist before starting NET, and some doubted that they would have tried NET without their existing trusting relationship. Clinicians felt that trust was particularly crucial with this client group, as many had experienced multiple breaches of trust.

Theme 2.2: Choice and control

EbEs valued choice, control, and collaboration. Preparation for what to expect, encouragement, and reminders of the rationale of NET empowered EbEs to try NET. Not feeling forced was important, which some linked to past experiences of disempowerment. Clinicians found NET to be collaborative, especially co-constructing the lifeline together on the floor.

Theme 2.3: Sharing a story 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, EIP clients had not often been able to 'share their story' meaningfully with services, or in important relationships. NET gave people autonomy over which events they focused on, and allowed the story to be received with a warm and empathetic response. Having stories witnessed, and not rejected, was felt to reduce shame.

3.4. Superordinate theme 3: Organizing memories and relating to them differently

Theme 3.1: Mapping out life events in and realizing 'how much I have been through'

The lifeline mapped out events that felt jumbled, facilitating discussions about past experiences that may otherwise have been missed. It visualized 'how much' people had been through, which contextualized current distress, generating both self-compassion and sadness. The lifeline also connected people to positive memories and relationships amid extensive trauma.

Theme 3.2: Organizing memories and locating them in the past

Detailed narration of events helped to consolidate a clearer picture of 'what happened, when', reducing the distress around intrusive memories and increasing safety. Clinicians particularly emphasized the role of differentiating the past from the present by connecting to past and present sensory–emotional experiences. EbEs also valued this 'sensory-weaving' process as a grounding technique, with some hoping to continue using it.

Theme 3.3: Making new meaning (about memories and psychosis)

NET helped to generate new perspectives on past events, such as noticing strengths, and reappraising oneself as someone who has survived a lot while still creating valued relationships. EbEs emphasized the reflection that took place after narration sessions, which some found intentional and others felt was 'out of control'. Skills in slow, thorough reflection were developed through NET, and some EbEs noticed feeling 'less rash' and more able to think things through before acting.

As anomalous experiences tended to fall later on the lifeline (as typical onset of psychosis occurs in early adulthood), clinicians found that approaching the lifeline chronologically helped clients to notice patterns between past events and later anomalous experiences (e.g. themes from traumatic events featuring in voice-hearing). Clinicians noted that most EIP clients had not previously considered anomalous experiences in relation to past events (some clinicians compared this to experiences working in specialist trauma services); this helped to generate new understandings of anomalous experiences and an increased sense of control (e.g. 'standing up' to voices).

Theme 3.4: From self-blame to self-compassion

Clinicians valued the human rights stance of NET, reiterating that what happened to people was not their fault. Shifting self-blame helped to build self-compassion in relation to past events, and in life more broadly. Connecting to strengths built hope for the future, a more positive sense of self, and, for some, self-confidence. Self-compassion also allowed clients to generally prioritize their own needs (e.g. boundary-setting, lifestyle changes), which boosted well-being.

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

Although they did not disappear, memories became less intense and frequent, and people felt less hooked by them. Clients noticed fewer problems associated with memories, such as flashbacks and self-blame, and more positive states of being, such as happiness and calmness; this felt like a significant step forwards, even where there was still a 'way to go' with recovery.

One EbE who was interviewed mid-interview spoke about balancing the benefits with the temporary distress of NET. Clinicians also recalled past clients who did not see significant benefit from the intervention owing to significant distress or unmet hopes that memories would disappear. Clinicians noted that

complex life circumstances, such as housing and unemployment, could limit the possible impact of any individualized intervention.

3.5. Superordinate theme 4: Reconnecting with emotions can be both painful and helpful

Theme 4.1: Impact on emotions, anomalous experiences, and the body

Reconnecting with emotions and bodily sensations, which, for some, included embodied responses such as physical pain and bleeding, was sometimes painful. Distress was temporary, although sometimes extreme : one EbE interviewed mid-intervention reported significant distress and a sense of being 'thrown' back in time. Repeated exposure to the narrative, grounding techniques, check-ins, and noticing some benefit from NET all reduced the intensity of distress. The timing and appropriateness of NET were carefully considered with regard to the vulnerability of EIP clients.

Dysregulation and anomalous experiences sometimes intensified during NET (e.g. for some, voices encouraging clients not to come to NET sessions), particularly immediately before and after appointments. Clinicians noted the need for stability before starting, and some started with stabilization sessions. Some clinicians discussed challenges in assessing the emotional impact of narration with clients (e.g. clients appearing calm, but later reporting having felt overwhelmed), and wondered about the impact of psychosis-specific factors (e.g. 'negative symptoms', numbing from antipsychotics), and also their own relative newness to NET.

NET was found to be more intense than other trauma-focused therapies for clinicians owing to the level of detail in the narration, but most clinicians valued the intervention and did not find this to be a barrier to its use. Some wondered how many concurrent NET clients were feasible in EIP, given the emotional intensity of the work.

Theme 4.2: A whole-system approach is important

Consistent and personalized support from loved ones helped EbEs to cope with distress between sessions. One EbE emphasized that without this, the distress may have outweighed the benefit of NET. Clinicians felt that including families in NET preparation was important.

A deeper understanding of the rationale and potential impact (distress and benefit) of NET within the EIP team would help the team to offer appropriate support and encouragement. Clinicians felt that this understanding was not as widely embedded as in a specialist trauma service. Clinicians also identified service-level requirements (e.g. equipment, adequately sized rooms, time for longer sessions and administration, specialist supervision) to enable the safe and effective implementation of NET in EIP.

Theme 4.3: Connecting with emotions as an alternative to 'carrying' them

Reconnecting with emotions allowed them to be put aside rather than 'carried', leaving individuals feeling lighter and more able to move forward. Clinicians helping to notice, name, and regulate emotions normalized emotional expression, and helped EbEs to develop skills that they hoped to continue using beyond NET.

3.6. Superordinate theme 5: Considerations when delivering NET in EIP (clinician only)

Theme 5.1: Flexibility in NET delivery (clinician only)

Delivering NET in EIP required flexibility. Anomalous experiences sometimes increased during sessions, which 'pulled' clients out of their narration. Sensory and grounding strategies (e.g. walking laps around the room together throughout the session, using strong scents), imagery work (e.g. imaging a fortress around the therapy room to keep voices out), and additional sessions to formulate the increase in anomalous experiences helped to reduce their impact.

Clients sometimes wanted to focus on social stressors (which are common in an EIP setting) or current worries in sessions, rather than NET tasks. Clinicians valued having flexibility, but also questioned its impact on the effectiveness of NET.

Theme 5.2: The demands of NET (clinician only)

Cognitive difficulties commonly seen in EIP (e.g. memory, focus, concentration) presented challenges during NET. NET was found to be 'speaking-heavy' and difficult for some clients, particularly those for whom 'thought disorder', 'jumbled memories', or 'fixed beliefs' obstructed the flow of narration. Moreover, clinicians felt confused about the coherence of memories when clients also presented with 'unusual beliefs'.

The concentration required for longer sessions and detailed narration exceeded what was felt possible for some participants, and clinicians sometimes struggled to generate the level of detail that they felt was required for effective narration. Reviewing the previous narration at the start of each session aided memory and allowed clients to make amendments. Using a physical lifeline helped NET to feel less verbal, which improved accessibility.

Theme 5.3: The nature of 'stones' selected (clinician only)

EIP clients often emphasized the importance of an accumulation of multiple adverse life events, not just

discrete traumatic events. Clinicians questioned which of the many stones to narrate, especially where links between 'stones' and anomalous experiences were less obvious (e.g. compared to flashbacks) but later found to be significant. This made choosing stones based on relevance difficult. Longer and/or multiple lifeline sessions were sometimes needed owing to the large number of 'stones' and individual communication styles, which could lead to lengthy interventions. Clinicians also wondered whether 'stones' linked to anomalous experiences should be narrated in the same way as those linked to flashbacks, or differently.

4. Discussion

EbE and clinician experiences of NET in EIP suggest that directly addressing the impact of multiple trauma in people with first episode psychosis can be frightening and emotive, but can help to address painful memories and organize them into a personal narrative. This is encouraging, given that multiple trauma and PTSD is often associated with worse psychosis outcomes (Berry et al., 2013), and that other trauma interventions (e.g. EMDR) have been found to address not only PTSD, but also psychosis (van den Berg & van der Gaag, 2012). Protocols of the competencies required to implement NET in this population need to be developed. The current study suggests prioritizing the role of trust, flexibility, social support, and EIP team involvement to manage potential symptom exacerbation during NET. This fits with current calls to consider both personal and familial resilience (DeLuca et al., 2022) and its influence on post-traumatic growth (Campodonico et al., 2021)

4.1. Mechanisms of change: exposure and meaning-making

EbEs described memories as being jumbled and confusing prior to NET, and the lifeline and narration helped them to clarify 'what happened', and 'when', which reduced distress. Following NET, memories felt less intrusive and more distant, and they emerged less frequently and had fewer 'problems' attached to them. These observations align with NET theory and literature about change mechanisms in trauma-focused interventions, which propose that weaving between sensory–perceptual information and contextual autobiographical memory linked to the memory reintegrates 'hot memory' (sensory–perceptual information). This prevents the 'hot memory' from resurfacing intrusively and out of context as a flashback, and recontextualizes it in time and place (Brewin et al., 2010; Schauer et al., 2011).

Although NET has predominantly been shown to be effective at the 6 month follow-up (e.g. Patel et al., 2016), participants in the present study noticed improvements as the therapy progressed. This may help to mobilize hope and build expectations of success, which have been linked to better engagement and therapeutic outcomes (Tsai et al., 2012).

The lifeline was helpful in contextualizing memories within participants' personal histories, as noted in qualitative research into clinicians' perspectives on the NET lifeline (Dix & Fornells-Ambrojo, 2023). This may be particularly relevant in EIP services, as people with psychosis often have temporally incoherent narrative identities lacking in detail and context (Cowan et al., 2021). The review also identified a difficulty in making links between past experiences and the present self for people experiencing psychosis. The NET lifeline may support the development of a coherent and connected narrative identity, which could be a therapeutic outcome in itself (France & Uhlin, 2006).

Clinicians valued the role of NET in making connections between past traumatic experiences and present anomalous experiences, believing that it allowed clients to have greater control over their responses to anomalous experiences. EbEs did not comment specifically on the impact of NET on anomalous experiences, although they also did not seem to differentiate between anomalous experiences (e.g. voice-hearing) and intrusive memories (i.e. flashbacks) as definitively as clinicians. This is in line with Hardy's model of psychosis (Hardy, 2017), which proposes that post-traumatic intrusions fall on a continuum of fragmentation, ranging from flashbacks (lower fragmentation) to anomalous experiences such as voices (higher fragmentation).

4.2. Pain and complexity of trauma work in psychosis

All participants described challenging aspects of NET; and emotional experiences, from EbE and clinician accounts, varied from moderately challenging to overwhelming. Clinicians wondered whether emotional disconnection and/or the numbing effects of antipsychotics (Moncrieff et al., 2009) may limit the emotional impact of narration. Breinlinger et al. (2020) observed that antipsychotics could 'dampen' the 'subjective experience and presentations' during NET, but noted that modifying medication was not necessary.

One EbE experienced significant distress during and immediately after NET sessions, noticing fear, shame, and exhaustion. Similar experiences have also been reported in other qualitative research into how trauma-focused interventions are experienced by people accessing EIP services and people diagnosed with PTSD (Shearing et al., 2011; Tong et al., 2017). Existing qualitative NET research has also noted that narration sessions could generate high levels of distress, but that this was described by clients as being

less than the pain of the original event (Cicconi, 2018; Said et al., 2021). Distress was typically described as temporary, and reduced as the intervention progressed and people started to notice benefit. EbEs emphasized the importance of a supportive network, as previously highlighted in the broader qualitative trauma-focused therapy literature (Shearing et al., 2011).

Clinicians' concern about the potential distress of trauma-focused interventions, while well intentioned, is a barrier to implementation in EIP (Chadwick & Billings, 2022). Elevated distress during trauma-focused interventions has been reported previously for a minority of participants, and interventions were described as being generally safe and tolerable. Moreover, twice as many waiting-list controls experienced symptom exacerbation and distress as those in an experimental group, and participants who experienced distress still reported improvements following intervention (Larsen et al., 2016). The potential distress and potential benefit must be weighed up collaboratively before, and monitored during, the intervention.

4.3. Trust and therapeutic alliance at the core of NET

Most participants emphasized the importance of trust, control, and collaboration in enabling EbEs to try NET despite their apprehension about revisiting the past and the sensitivity of the stories being shared. This aligns with existing research, which highlights the significance of shifting the balance of power and having a 'personal touch' in building trusting relationships with people who have experienced psychosis (Laugharne et al., 2011).

A strong therapeutic alliance has also been found to predict positive therapeutic outcomes, and is associated with reduced global and psychosis-related symptoms (Bourke et al., 2021). Given the emphasis on trust in trauma-informed care (Isobel et al., 2021) and psychosis services (Laugharne et al., 2011), it may be especially important in this context, especially when working with people who have experienced traumatic events involving breaches of trust (Ormhaug et al., 2014).

4.4. NET in EIP: the whole person, the whole service

NET, and especially the lifeline, was seen as encompassing 'the whole person', and enabled the sharing of both positive and negative stories across the lifespan. The 'person-centred' approach was also noted in research into clinicians' views of the lifeline (Dix & Fornells-Ambrojo, 2023), and was seen to fit the EIP ethos. EbEs valued clinicians taking an interest in their lives beyond what was directly relevant to the NET process, and appreciated their help with practical tasks related to daily living; this, referred to by Laugharne et al. (2011) as 'the personal touch', has been noted in existing psychosis research (Laugharne et al., 2011). However, clinicians faced a conflict between making space for concerns that arose in people's present-day lives and sticking to the protocol, which required them to keep sessions focused on NET-related tasks. This dilemma has also been described in non-psychosis settings (Coope, 2019), but was felt to be particularly relevant in EIP, where support is typically flexible in its focus.

4.5. Limitations

This study aims to contribute to a literature base exploring the use of trauma therapies in psychosis services, with the hope of improving access and effectiveness for people with experiences of psychosis and trauma. A strength of the analysis was the prioritization of EbE accounts in the analysis, and the use of member-checking to ensure that participants' views were reflected in the analysis.

Although similar themes were generated across the EbE accounts, the EbE sample size was small. Moreover, five EbEs declined to take part in the study, either themselves or via their recruiting clinician, and it may be that these individuals were more unwell or had less favourable views on NET. A larger sample, including those who decline or drop out of NET, would provide a more nuanced analysis of different experiences and the impact of intersectional factors, such as culture, social support, gender, and specific trauma histories. Collecting data about medication use and specific psychosis experiences may build understanding of the impact of these factors on the NET process, and the impact of NET on anomalous experiences. Future research may also specifically explore the impact of NET on anomalous experiences and other psychosis-related symptomology.

One EbE was interviewed mid-intervention; although the interview will not have captured their experience of the full NET intervention, the rationale for including people who were mid-way through the intervention was to capture the experience of carrying on the challenging exposure work, before symptom remission had been achieved.

Despite emphasizing that the interviews were confidential and that the researcher was independent from the EIP service, it is possible that by recruiting through EbEs, clinicians may have discouraged participants from sharing negative experiences of NET, and those who refused to take part may have held more critical views. However, efforts were made to foster a warm, collaborative relationship, and explicitly to invite critical feedback.

Most clinicians had been trained in NET within the past 2 years, and most speculated on the role of their own competence and confidence in the challenges that they encountered. Adherence to the treatment protocol was monitored through the specialist NET supervision attended by all clinician participants, as no published NET adherence scale was available. Therefore, it is unclear whether these challenges were related to psychosis factors or therapist factors (e.g. confidence, training). Nevertheless, the study's strength lies in its ecological validity: the study highlights clear needs (e.g. training, specialist supervision) to support the implication of NET, as recommended by NICE (2014, 2018), in EIP. Future research should also monitor NET treatment adherence using published scales, when available.

The clinician sample primarily consisted of white European women (5/8, 63.4%), and therefore the themes related to clinician experiences of the intervention were viewed largely through a white Western lens. This is a particular issue given that EbE participants, and EIP clients broadly, are often from minority ethnic backgrounds. The researcher's identity as a white British woman may have been a barrier to participants' sharing perspectives linked to their racial or cultural identity, although these were shared by some.

5. Conclusions

This study provides detailed insights into the process and impact of NET for people accessing EIP services. As this is a naturalistic study, these insights reflect the day-to-day reality of working clinically in an NHS setting, and may be more generalizable than results from RCTs (Philips & Falkenström, 2021).

NET provided an opportunity for two people – an EbE and a clinician – to make sense of a life story, which led to a decrease in intrusive memories and related problems. The present study suggests that this could be delivered safely; the challenges it presented (although significant for a minority) were in line with research from non-psychosis settings, and were typically outweighed by the benefit of the intervention. Insights from EbEs and clinicians suggested that a flexible approach to the NET protocol was felt to be in line with the EIP ethos, and helped to build trust, which aided the delivery of NET.

Note

1. Bracketing interviews (Tufford & Newman, 2012) took place with a group of co-researchers, and involved a co-researcher who was not involved with the project asking the author (RS) a series of questions to prompt reflection on their own relationship with the research topic, with the aim of bringing any areas of bias or preconception to the researchers' attention. This allows the researchers to consider the impact of bias on the research process and to mitigate this, where possible. The research journal was a continuation of this process: a self-completed reflective journal through which the author noted observations and reflections from the research (including bias), enabling reflection on the research process as a whole.

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No potential conflict of interest was reported by the authors.

Data availability statement

The participants of this study did not give written consent for their data to be shared publicly; therefore, owing to the sensitive nature of the research, supporting data are not available.

References

Alameda, L., Christy, A., Rodriquez, V., Salazar de Pablo, G., Thrush, M., Shen, Y., Alameda, B. M., Spinazzola, E., Iacoponi, E., Trotta, G., Carr, E., Veguilla, M. R., Aas, M., Morgan, C., & Murray, R. M. (2021). Association between specific childhood adversities and symptom dimensions in people With psychosis: Systematic review and meta-analysis. *Schizophrenia Bulletin*, *47*(4), 975–985. https://doi.org/10.1093/schbul/sbaa199

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed). American Psychiatric Publishing.

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. https://doi.org/10.1097/NMD.0b013e318257cdf2

Bailey, T., Alvarez-Jiminez, M., Garcia-Sanchez, A. M., Hulbert, C., Barlow, E., & Bendall, S. (2018). Childhood trauma is associated with severity of hallucinations and delusions in psychotic disorders: A systematic review and meta-analysis. *Schizophrenia Bulletin*, *44*(5), 1111–1122. https://doi.org/10.1093/schbul/sbx161

Barker, C., Pistrang, N., & Elliott, R. (2016). *Research methods in clinical psychology: An introduction for students and practitioners* (3rd ed.). 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

Berry, K., Ford, S., Jellicoe-Jones, L., & Haddock, G. (2013). PTSD symptoms associated with the experiences of psychosis and hospitalisation: A review of the literature.

Clinical Psychology Review, *33*(4), 526–538. https://doi.org/10.1016/j.cpr.2013.01.011

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

Brand, R., 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. https://doi.org/10.1016/j.schres.2017.08.037

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

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

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* (pp. 183–197). 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., & 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

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), 210–232. https://doi.org/10.1037/a0018113

Brewin, C. R., Rumball, F., & Happé, F. (2019). Neglected causes of post-traumatic stress disorder. *BMJ*, *365*, l2372. https://doi.org/10.1136/bmj.l2372

Campodonico, C., Berry, K., Haddock, G., & Varese, F. (2021). Protective factors associated with post-traumatic outcomes in individuals with experiences of psychosis. *Frontiers in Psychiatry*, *12*. https://doi.org/10.3389/fpsyt.2021.735870

Campodonico, C., Varese, F., & Berry, K. (2022). Trauma and psychosis: A qualitative study exploring the perspectives of people with psychosis on the influence of traumatic experiences on psychotic symptoms and quality of life. *BMC Psychiatry*, *22*(213). https://doi.org/10.1186/s12888-022-03808-3

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

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*(2), 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).

Cienfuegos, A. J., & Monelli, C. (1983). The testimony of political repression as a therapeutic instrument. *American Jounral of Orthopsychiatry*, *53*(1), 44–51. https://doi.org/10.1111/j.1939.0025.1983.tb03348.x

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, University College London). https://discovery.ucl.ac.uk/id/eprint/10086225/

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*, 102067. https://doi.org/10.1016/j.cpr.2021.102067

DeLuca, J. S., Rakhshan Rouhakhtar, P., Klaunig, M. J., Akouri-Shan, L., Jay, S. Y., Todd, T. L., Sarac, C., Andorko, N. D., Herrera, S. N., Dobbs, M. F., Bilgrami, Z. R., Kline, E., Brodsky, A., Jespersen, R., Landa, Y., Corcoran, C., & Schiffman, J. (2022). Psychosis-like experiences and resilience: A systematic and critical review of the literature. *Psychological Services*, *19*(Suppl 1), 120–138. https://doi.org/10.1037/ser0000585

Dix, J., & Fornells-Ambrojo, M. (2023). Therapists' experience of the lifeline in narrative exposure therapy. *Journal of Traumatic Stress*, *36*(1), 106–116. https://doi.org/10.1002/jts.22886

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: Theory, Research and Practice*, *79*(1), 53–67. https://doi.org/10.1348/147608305X41001

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

Hardy, A. (2017). Pathways from trauma to psychotic experiences: A theoretically informed model of posttraumatic stress in psychosis. *Frontiers in Psychology*, *8*, 697. https://doi.org/10.3389/fpsyg.2017.00697

Isobel, S., Wilson, A., Gill, K., & Howe, D. (2021). 'What would a trauma-informed mental health service look like?' Perspectives of people who access services. *International Journal of Mental Health Nursing*, *30*(2), 495–505. https://doi.org/10.1111/inm.12813

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

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. https://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. https://doi.org/10.1177/0020764011408658

Lingard, L. (2019). Beyond the default colon: Effective use of quotes in qualitative research. *Perspectives of Medical Education*, *8*(6), 360–364. https://doi.org/10.1007/S40037-019-00550-7

Martin, D., Philips, M., Greenstone, H., Davies, J., Stewart, G., Ewins, E., & Zammit, S. (2023). Examining the

relationship between trauma, post-traumatic stress disorder and psychosis in patients in a UK secondary care service. *Psychiatric Research and Clinical Practice*, *5*(2), 51–59. https://doi.org/10.1176/appi.prcp.20220028

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

McGorry, P. D., Killackney, E., & Yung, A. (2008). Early intervention in psychosis: Concepts, evidence and future directions. *World Psychiatry*, *7*(3), 148–156. https://doi.org/10.1002/j.2051-5545.2008.tb00182.x

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

Morrison, A., Frame, L., & Larkin, W. (2003). Relationships between trauma and psychosis: A review and integration. *British Journal of Clinical Psychology*, *42*(4), 331–353. https://doi.org/10.1348/014466503322528892

National Institute for Health and Care Excellence. (2014). *Psychosis and schizophrenia in adults: prevention and management* (NICE clinical guideline CG178). 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 NG116). https://www.nice.org.uk/guidance/ng116

Neuner, F., Elbert, T., & Schauer, M. (2020). Narrative exposure therapy for PTSD. In L. F. Bufka, C. V. Wright, & R. W. Halfond (Eds.), *Casebook to the APA clinical practice guideline for the treatment of PTSD* (pp. 187–205). American Psychological Association.

Ormhaug, S. M., Jensen, T. K., Wentzel-Larsen, T., & Shirk, S. R. (2014). The therapeutic alliance in treatment of traumatized youths: Relation to outcome in a randomized 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.

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

Ronconi, J. M., Shiner, B., & Watts, B. V. (2014). Inclusion and exclusion criteria in randomised controlled trials of psychotherapy for PTSD. *Journal of Psychiatric Practice*, *20*(1), 25–37. https://doi.org/10.1097/01.pra.0000442936.23457.5b

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*. Hogrefe & Huber.

Schäfer, I., & Fisher, H. L. (2022). Childhood trauma and psychosis- what is the evidence? *Dialogues in Clinical Neuroscience*, *13*(3), 360–365. https://doi.org/10.31887/DCNS.2011.13.2/ischaefer

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://doi.org/10.5498/wjp.v4.i4.133

Shapiro, F. (2001). *Eye movement desensitization and reprocessing (EMDR): Basic principles, protocols and procedures*. Guilford Press.

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*(4), 458–475. https://doi.org/10.1111/j.2044-8341.2010.02012.x

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*, n2061. https://doi.org/10.1136/bmj.n2061

Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. 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. https://doi.org/10.3389/fpsyg.2017.00341

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*(6), 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

Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative Social Work*, *11*(1), 80–96. https://doi.org/10.1177/1473325010368316

van den Berg, D. P., & van der Gaag, M. (2012). Treating trauma in psychosis with EMDR: a pilot study. *Journal of Behavior Therapy and Experimental Psychiatry*, *43*(1), 664–671. https://doi.org/10.1016/j.jbtep.2011.09.011

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.

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