“Shame is at the root of everything, it’s been a part of me since I can remember”.
Online therapy and disclosures of shame: An exploration into the experiences of clients presenting with PTSD

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D.Clin.Psy Thesis (Volume 1) 2024

University College London

UCL Doctorate in Clinical Psychology

Thesis declaration form

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

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Overview

The efficacy of digitalised trauma interventions has long been evidenced, however, mental health services in the UK only began to offer remote interventions as a result of the COVID-19 pandemic. This led to considerable levels of reactive changes in the current health system, leading to multiple challenges and areas of concern.

Part One: Narrative Synthesis

This narrative synthesis explored how digital technology is utilised for engagement in remote trauma therapy. Twelve studies of varied digital therapy approaches were included. Findings indicate that digital technology can facilitate engagement with remote therapy, particularly when following structured protocols and providing both synchronous and asynchronous contact to the therapist. Future research should explore the use of digital technology in remote therapy using controlled trials and attending to sample size and diversity of populations in order to explore barriers and facilitators to engagement.

Part Two: Empirical Paper

This qualitative study explored clients' and clinicians' experiences of disclosure of shame-based emotions in remote trauma therapy. Semi-structured interviews were conducted with five clients and four clinicians and analysed using thematic analysis. Findings suggest that strong therapeutic relationships which facilitate disclosures of shame and related emotions can be developed in remote therapy. Considerations should be made regarding client choice in therapy delivery alongside formulations of the suitability of the delivery method. Adaptations can be made to remote therapy practice to further enhance connection and disclosure in therapy. However, future research should explore experiences of blende delivery methods and management of risk remotely.

Part Three: Critical Appraisal

This part presents a critical appraisal of the journey along the research process. It explores dilemmas encountered and reflections made in relation to the conceptualisation of ‘digital therapy’ and ‘therapist-delivered’ procedural issues of conducting research in the NHS, and transitioning into the role of a researcher while considering the intersectionality of power and social identities.

Impact Statement

While digital therapy has been evidenced to be an efficacious delivery method for trauma treatment, to date, to the author’s knowledge, there have been no synthesis of the impact of digital therapy on engagement with remote trauma interventions. The findings of Part 1 of this thesis attempts to understand how technology impacts engagement with digital trauma therapy.

1. **Academics and researchers:** Digital technology can be effective in engaging clients with digital therapy. Research would benefit from a consistency in language used to describe digital therapy. Additionally, increased sample size and the use of in-person control groups can improve the understanding of digital trauma care.
2. **Health Care Providers:** Research suggests that health services should continue to offer digital therapy as part of their care pathways. Services would benefit from a broad use of technology in their digitalisation of care, including the use of web-accessed materials alongside the use of video technology.
3. **Clinicians working with trauma populations:** This research suggests that mode and frequency of contact with the therapist is important in effective remote interventions. Though in some cases relationships may take longer to

build, adapting communication and session frequency can facilitate engagement. This research also indicates that specific subgroups, such as those who present with prolonged and continued exposure to trauma, may require more tailored interventions to improve engagement.

4. **People accessing trauma therapy:** This research suggests that an increased understanding into the barriers and facilitators of using digital technology that can improve engagement with remote trauma therapy.

Given the COVID-19 pandemic acted as a catalyst for the digitalisation of trauma therapy in the UK, to date, to this authors knowledge, there has not been a qualitative exploration of experiences of building relationships in remote trauma therapy and how they facilitate disclosures of shame-based emotions. The research discussed in Part 2 is a naturalistic study, where challenges and experiences encountered reflect the real world understanding of conducting research in mental health services in the UK. These findings may benefit the various groups below.

1. **Academics and researchers**: Both client and clinician experiences can inform adapting trauma interventions for remote delivery. These can be useful for future explorative and effectiveness studies, such as randomised controlled trials. Research may consider a comparative analysis of in-person and remote therapy to further explore experiences and what adaptations may be useful.
2. **Healthcare providers:** This thesis suggests that access to remote trauma therapy is a delivery method valued by both clients and clinicians. Given the importance placed on client choice and suitability, services should consider the ongoing treatment option of remote therapies with the use of formulation

to determine treatment pathways. Services would warrant continued training and supervision in digital therapy adaptations to ensure efficacy of treatment and client safety. Moreover, general mental health services would benefit from increased specialist training and supervision on recognising and working with trauma populations.

3. **Clinicians working with trauma populations**: An increased understanding of client experiences of remote trauma therapy may support clinicians to tailor and adapt interventions to meet the needs of clients. For example, adapting approaches to build a trusting relationship in remote therapy. Shared understanding of the therapeutic process and how it can increase anxiety, and how clients establish safety in therapy, can improve engagement and therapy outcomes.
4. **People accessing trauma interventions:** A developing literature on digital trauma therapy may inform guidance on remote trauma-focused interventions, further increasing access to services. Improved clinician understanding of working with trauma, both in-person and remotely, across specialised and general health services, may ensure appropriate treatment pathways are accessed, improving trauma therapy effectiveness and client outcomes.

Table of Contents

List of Tables

Part One: Narrative Synthesis

Part Two: Empirical Paper

List of Figures

Part One: Narrative Synthesis

Acknowledgements

I would first like to acknowledge the generosity of everyone who participated in this research. My deepest gratitude goes to the clients who took the time to share their experiences with me, without whom, this project could not have existed. I am truly humbled and inspired by your openness to share so much of your experiences, yourselves, and your lives with me. I hope I have honoured your trust in me and done justice in the sharing of your stories. I am also eternally grateful to the clinicians who shared their personal experiences with me, with such candour. Your commitment to the continued improvement of services for this population is inspiring and goes beyond the realms of clinical practice. I am also extremely grateful to all the clinicians and members of the team across services who supported in the recruitment process including liaison, and arranging team presentations. Without your support, recruitment could not have been achieved.

To my research supervisors, Dr Fran Brady and Dr Justine Bush, thank you for sharing your respective knowledge in the field of trauma to develop this research from the initial idea inception. Your continued support throughout multiple challenges and accessibility outside of work hours has been truly valued.

To my family, thank you for your unwavering support in my psychological journey. Without you all by my side and your belief in me, I would not have made it to this level in my career. To my sisters who provided their editorial skills in reviewing my psychological work, a huge thank you. To my friends, thank you for providing an endless supply of support, for being there to hold me up in times of stress, and for being there to celebrate my successes with me.

Part One: Systematic Review

How are digital technologies used for those engaging in therapist facilitated trauma therapy and are they helpful?

Abstract

Aims. Digital therapy interventions for trauma have long been evidenced as an efficacious method of trauma treatment. However, there is no review of the literature exploring the use of digital technology in engagement with remote therapist-facilitated interventions. This narrative synthesis aimed to explore this by examining treatment efficacy and engagement with treatment.

Method. Studies were identified through a systematic literature search of PsychINFO, Medline, and Embase from inception to 25th October 2023. The search identified 842 studies which were reviewed by two independent raters against a pre-specified eligibility criteria including research design, intervention characteristics, population characteristics, and the type of outcome measures. This process yielded 13 eligible studies that are included in this review.

Results. A narrative synthesis demonstrated that internet-delivered trauma interventions vary considerably in treatment approach, symptom reduction, attrition rates, and therapist contact. Results were impacted by study design, sample size, and consistency of therapeutic approach.

Conclusions. In conclusion, although digital therapies for PTSD have been found to be effective, continuous research is crucial to refine methodologies, improve clinical application, and gain a deeper understanding of the factors affecting treatment effectiveness and patient engagement.

Introduction

Post-traumatic stress disorder (PTSD) is recognised as a serious mental health condition across clinical, community, and epidemiological samples (Kessler, 2000; Schonfeld et al., 1997), with lifetime prevalence rates estimated to be between 7-12% within the general population (Keane, Marshall & Taft, 2006; Sareen et al., 2007). Higher prevalence rates of PTSD are noted within professional groups considered as high-risk, such as military service members and first responders (Sareen et al., 2013; Wilson, 2015) and highest within populations affected by conflict (Steel et al., 2009). PTSD is classified as an anxiety disorder that can develop following exposure to a traumatic event, whereby the person relives the traumatic event through flashbacks and nightmares. As well as re-experiencing, symptoms of PTSD are characterised by avoidance of trauma reminders, levels of hypervigilance and hyperarousal, and negative alterations in cognition and mood (American Psychological Association [APA], 2019; World Health Organization [WHO], 2022).

The International Classification of Diseases (ICD), 11th revision (WHO, 2022) has recently recognised another trauma diagnosis termed Complex PTSD (CPTSD); that may develop as a response to prolonged, repeated, and multiple experiences of exposure to trauma (Cloitre et al., 2013). In addition to the core subgroups of PTSD symptomology, the ICD-11 diagnosis of CPTSD is comprised of additional disturbances in self-organisation: severe and pervasive problems with affect regulation, negative self-beliefs, and persistent difficulties in sustaining relationships and feeling close to others (WHO, 2022).

Treatment Approaches

Several effective talking therapies have been evidenced and recommended in the treatment of PTSD (National Institute for Health and Care Excellence [NICE], 2018). NICE guidelines recommend eye movement desensitisation and reprocessing (EMDR); trauma-focused cognitive behavioural therapy (TFCBT); or narrative exposure therapy (NET) in the treatment of trauma. Recommended session length varies depending on whether it is a single incident or multiple incident trauma. NICE recommendations for treatment of CPTSD are similar with more flexibility in terms of sessions and increased importance of safety planning (NICE, 2018). These recommendations reflect those recommended by other international guidelines on PTSD treatment (International Society for Traumatic Stress Studies, 2018; Australian Centre for Posttraumatic Mental Health 2021; American Psychological Association 2017; Department of Veteran Affairs 2017; United Kingdom Council for Psychotherapy [UKCP], 2021).

EMDR treatment stipulates that traumatic memories have been ineffectively processed and stored in the brain (Shapiro & Maxfield, 2002). To process these traumatic memories, clients are required to recall the traumatic memory, without verbalisation, while engaging in a bilateral stimulation task. The “dual attention” engages the brain’s natural information processing mechanisms, helping to process these fragmented trauma memories (Shapiro & Maxfield, 2002).

TFCBT can be categorised into three distinct protocols or approaches, those based on Cognitive Therapy (TFCT) (Ehlers, Clark, Hackmann, McManus & Fennell, 2005), Cognitive Processing Therapy (CPT) (Resick et al., 2008), and Prolonged Exposure (PE) (Foa et al., 1999). Within TFCT, the therapist engages the client in a narration of the trauma to enable the client to identify idiosyncratic unhelpful appraisals of the traumatic event that requires cognitive restructuring to update the trauma memory (Ehlers, Clark, Hackmann, McManus & Fennell, 2005). CPT builds upon these techniques, however, it requires the client to instead produce a written narrative (rather than verbal) of the traumatic event, enabling the client to re-evaluate their thoughts and beliefs of the event (Resick et al., 2008). The primary function in PE protocols is to habituate to the emotional fear of the trauma stimuli (Foa & Kozak, 1986). Importantly, Imagery Rescripting (IMRS) is an innovative alternative to traditional reliving that has been increasing in evidence base, though not currently recommended within NICE (2018) guidelines. The IMRS technique aims to alter the meaning of the trauma memory by imaging a different outcome to the trauma memory (Steel et al., 2022) Finally, Narrative Exposure Therapy (NET) developed by Schauer, Neuner and Elbert (2012), is another core therapeutic approach recommended for PTSD treatment. Within NET, the client is engaged in a chronological narration of their whole life, including their traumatic experiences to process the traumatic memories in context and in sequence, with the aim of reducing the emotional impact of these (Robjant & Crombach, 2021).

Digital Therapy

Internet-based psychological therapies have been evidenced as an efficacious treatment method for trauma populations for many years (Sijbrandij, Kunovski & Cuijpers, 2016). Computerised TFCBT was recommended by NICE (2018) in lower severity presentations. Where concerns of dissociation or risk to self are present, computerised TFCBT is not recommended. Furthermore, digitally delivered trauma therapy should be based on an evidenced-based treatment programme (i.e. memory processing, cognitive restructuring, and adaptive functioning), between eight to ten sessions, and delivered by a trained practitioner who encourages treatment completion and provides feedback on homework and reviewing progress (NICE, 2018). Despite this, internet-based delivery of psychological therapies for PTSD treatment remained limited in comparison to other disorders, predominantly due to concerns of effectiveness of remote treatment of PTSD (Lewis, Pearce & Bisson, 2012). However, the COVID-19 pandemic acted as a catalyst for digital therapy offered as routine treatment (APA, 2021). Since then, a plethora of studies have further evidenced the adaptation of trauma therapies for remote delivery (McGowan, Fisher, Havens & Proudlock, 2021; Wild et al., 2020; Wells et al., 2020; Kaltenbach et al., 2021). Internet-delivered interventions can be largely categorised into guided self-help, non-guided self-help, and therapeutic intervention. These can be delivered through a variety of platforms including mobile applications and web applications (Simon et al., 2021).

Accessibility to Therapeutic Care

With widening access to therapeutic interventions, digitally delivered therapy addresses some logistical barriers to accessing trauma treatment, such as reduced transportation costs and travel time (Bose, McLaren, Riley & Mohammedali, 2001), while also enhancing access to treatment for individuals with serious injuries, or who struggle with management of employment or childcare responsibilities (Morland et al., 2015). Social barriers have also been documented to impact attendance rates for in-person therapy which is particularly salient for those with experiences of sexual trauma (Valentine et al., 2020). Poor attendance and adherence rates are notably documented in the literature for veterans and military personnel due to stigma and fear of judgement (Valentine et al., 2020). Fear of judgement, of the nature of trauma disclosed and/or for seeking treatment, are particularly documented within veteran trauma research, as barriers to help-seeking (Turchik, Bucossi & Kimerling, 2014). Furthermore, some veterans have reported discomfort in seeking treatment from facilities associated with the military (Valentine et al., 2020). Remotely delivered therapy therefore offers a solution to some of these challenges, in offering trauma-focused therapy to populations who might otherwise be reluctant to engage with it.

Importantly, digital therapy can also increase potential barriers to therapeutic care. This digital divide is documented across the literature and was amplified during the digitalisation of healthcare during the COVID-19 pandemic (Watson et al., 2021). Digital exclusion relates to access to technology, ability, and skills in using technology. These are impacted by issues of income inequality and financial means to access technology or private and confidential space to seek care. Those in rural locations and access to poorer internet connection, the elderly, and those whose primary language is not English have also been recognised at higher risk of digital exclusion (Watson et al., 2021).

Nevertheless, despite the existence of the efficacy of digitally delivered therapy, there is a lack of consistency in terms of digital platform and digital tools utilised, therapy modes, and length of treatment as recommended by NICE (2018). Furthermore, research is lacking in the use of technology itself, within digitally delivered trauma interventions and the impact this might have on engagement with treatment.

Previous Reviews

A small number of systematic reviews have evidenced the efficacy of digitally delivered trauma therapy. These are primarily limited to Randomised Control Trials

(RCT) excluding non-controlled or randomised studies. Furthermore, reviews tend to focus on internet delivered CBT (iCBT) treatment approaches, excluding the wider range of trauma-focused treatment interventions. The iCBT reviews also include the breadth of internet-based treatment options of non-guided, self-guided, and therapeutic interventions. Two Cochrane reviews were found during a systematic search of the Cochrane database. Lewis, Roberts, Bethell, Robertson and Bisson (2018) explored the feasibility and efficacy of iCBT informed studies that were predominately therapist assisted. The authors included studies of mixed technological approach such as the use of smartphone apps and purpose-built websites. They included studies where 70% or more of participants met a threshold for PTSD diagnosis. There primary outcome was the efficacy of iCBT for PTSD treatment. Simon, Robertson, Lewis, Roberts, Bethell, Dawson and Bisson (2021) found varied results in their review of the efficacy of iCBT studies. Most studies were found to be effective in reducing PTSD symptoms in comparison to waitlist controls. Though, a small number of studies found iCBT to be inferior to in-person therapy and a minority of studies were no more effective than other internet-based therapies for PTSD. However, the authors expressed concern over the lack of validated measures used across studies in determining efficacy of interventions.

To the author’s knowledge, there are no existing reviews pertaining to the use of digital technologies and how they facilitate engagement with therapist-delivered trauma therapy specifically. Particularly, reviews inclusive of non-randomised controlled trials, from a broad range of internet-based therapies for trauma that are facilitated by a therapist and where participants reach a PTSD diagnosis.

Method

Inclusion and Exclusion Criteria

Inclusion and exclusion criteria were developed with reference to research design, intervention characteristics, population characteristics, and the type of outcome measures.

Research Design

Included studies were RCTs, non-randomised trials, and uncontrolled pre/post designs. Case studies and small *N* designs (fewer than five participants completing the study) were excluded due to concerns over statistical power impacting the generalisability of small sample studies. Additionally, there were concerns over an increased potential for bias and variability in small *N* designs that would impact comparisons with larger, more representative sampled studies included. However, small *N* designs are valuable within this field and future reviews may wish to consider their inclusion. Qualitative and mixed methodology data designs were also excluded.

Intervention Characteristics

Only studies offering remotely delivered interventions (i.e. via teleconferencing or via a web-based programme) were included. Interventions offered via mobile applications, virtual reality, and via telephone only, were excluded.

Interventions delivered or facilitated by a therapist were included. Assisted or self-guided therapeutic interventions were not included.

Studies where evidence-based and non-evidence-based psychotherapeutic studies of individual treatment intervention for PTSD had been delivered, i.e. iCBT, internet PE (iPE), internet TFCT (iTFCT), internet delivered CPT (iCPT), internet delivered EMDR (iEMDR), stabilisation, exercise, and relaxation, were included. Studies with mixed methods of intervention were also included. Group interventions were not included.

Population Characteristics

Included studies were required to have:

i) An adult sample, i.e. 18 years or above.

ii) Participants who met DSM-V or ICD-11 criteria for a primary diagnosis of PTSD or CPTSD to a single or multiple traumatic events experienced during childhood or adulthood.

Outcome Measures

To evaluate the impact of treatment on PTSD and CPTSD outcomes, it was imperative that studies included a validated, self-report diagnostic measure of PTSD as the primary outcome and/or a diagnostic structured clinician interview.

Publication Details

Only peer-reviewed journal articles published in English were included in this review. No date limits were set. Review articles and study protocols were excluded.

Search Strategy

Searches of electronic databases PsychINFO, Medline, and Embase were conducted using the Ovid interface on 25th October 2023, retrieving references from earliest available dates to the present day. Searches on Cochrane Library and PTSD Pubs were also conducted. See Table 1 for full search terms used. Search terms centralised on the four main topics in relation to the research question: remote therapy, trauma, engagement, and effectiveness. These were developed in collaboration with the University research librarian and refined with the research supervisors to ensure suitability and rigour.

Table 1

Search terms

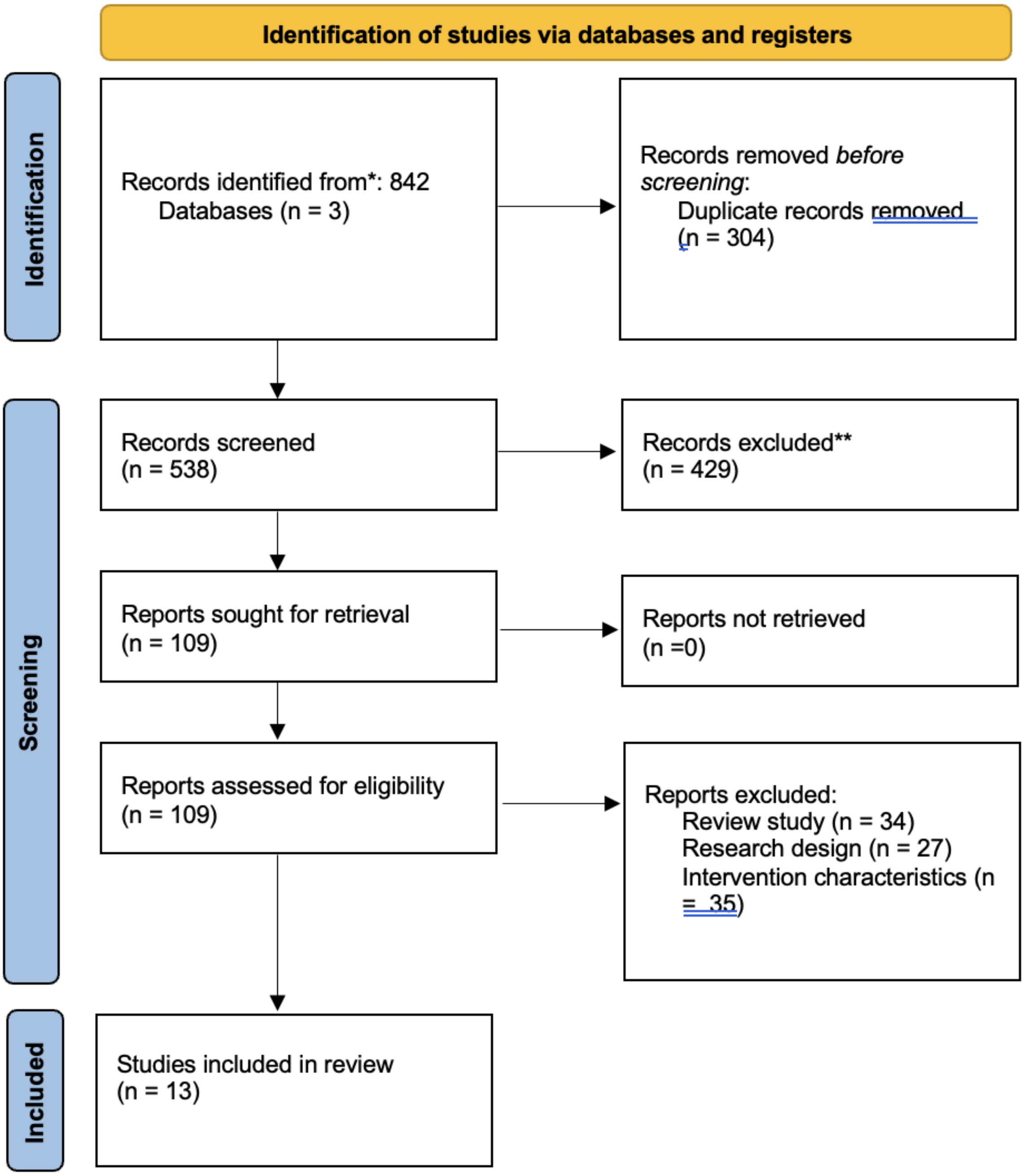
Remote therapy	AND	Trauma	AND	Engagement	AND	Effective
internet adj1 (based or intervention* or tool* or treatment* or therapy))		PTSD* OR		Engage OR Engagement		Effective
(online adj1 (based or intervention* or tool* or treatment* or therapy))		post-traumatic stress* OR		Experience of OR Motivation		
(web adj1 (based or intervention* or tool* or treatment* or therapy))		complex trauma* OR		treatment completion OR 'treatment outcomes' OR Attrition OR drop out		
computer-assisted therapy OR computer-based therapy OR eTherapy OR mobile OR mHealth OR mHealth OR eHealth OR cell phone OR cellular phone OR digital OR		CPTSD* OR				

Apps OR App Or Internet						
		post-traumatic stress* OR				
		post-traumatic stress* OR				
		complex PTSD* OR				

A total of 842 papers were retrieved from the above searches. All titles and abstracts were screened to see if they met the inclusion criteria. After removal of duplicates and exclusion of papers that did not meet criteria, 109 full-text articles were retrieved and reviewed for inclusivity. Thirteen articles met the inclusion criteria and are included in the current review. The screening procedure can be seen in Figure 1 below.

Figure 1

PRISMA Flow Diagram



Study Quality Assessment

The quality of studies was assessed using Kmet, Cook and Lee (2004) Quality Assessment criteria (see Table 2 below for full details of the assessment). This assessment is designed to evaluate quantitative studies with a variety of research design and methodology. Studies are rated on 14 items pertaining to clarity and suitability of research design, sample and rigour of methodology, and analysis and results discussion. Studies are rated on a three-point scale (0 = No, 1 = Partial, and 2 = Yes) with a total possible score of 28. Studies where criteria are not applicable due to study type are identified with N/A. To calculate the total quality rating, the total sum is divided by the total possible score. Thresholds of inclusion are recommended in the literature to both consider quality scores and the time and resource constraints of the project, with recommendations of 0.75 or 75% for relatively conservative thresholds, and 0.55 or 55% for relatively liberal thresholds. Those with lower thresholds should be considered with caution.

Table 2

Quality Assessment: Kmet, Cook and Lee (2004)

Criteria	**Gawlytta et al. (2022)**	**Morland et al. (2015)**	**Wild et al. (2016)**	**Niemeyer et al. (2020)**	**Bongaerts et al. (2022)**	**Bongaerts et al. (2021)**	**Böttche et al. (2021**	**Hassija et al. (2011)**	**Maieritsch et al. (2016)**	**Valentine et al. (2020)**	**Kirk et al. (2022)**	**Murphy et sl. (2020)**	**Perri et al. (2021)**
Question / objective sufficiently described?	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢
Study design evident and appropriate?	🟢	🟢	🟢	🟢	🟡	🟡	🟡	🟢	🟡	🟢	🟢	🟢	🟢
Method of subject/comparison group selection *or* source of information/input variables described and appropriate?	🟢	🟢	🟢	🟢	🟢	🟡	🟡	🟡	🟡	🟡	🟡	🟢	🟢
Subject (and comparison group, if applicable) characteristics sufficiently described?	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡
If interventional and random allocation was possible, was it described?	🟢	🟢	🟡	🟢	🔴	⚫	🟢	⚫	🟡	🔴	🔴	⚫	🟡
If interventional and blinding of investigators was possible, was it reported?	🟢	🟡	⚫	🔴	🔴	⚫	⚫	⚫	🔴	🔴	🔴	⚫	🔴
If interventional and blinding of subjects was possible, was it reported?	🟡	🔴	⚫	🟢	🔴	⚫	🔴	⚫	🔴	🔴	🔴	⚫	🔴
Outcome and (if applicable) exposure measure(s) well-defined and robust to measurement /	🟡	🔴	⚫	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢

misclassification bias? Means of assessment reported?													
Sample size appropriate?	🟢	🟢	🟢	🔴	🟡	🔴	🟢	🟡	🟢	🟢	🟢	🟢	🟢
Analytic methods described/justified and appropriate?	🟢	🟢	🟢	🟡	🟢	🟢	🟢	🔴	🟢	🟢	🟢	🟡	🟢
Some estimate of variance is reported for the main results?	🟢	🟡	🟢	🟡	🔴	🔴	🔴	🟢	🟢	🔴	🟢	🟢	🟢
Controlled for confounding?	🟢	🟢	🟡	🟡	🔴	🔴	🟢	🟢	🟢	🟢	🟡	🔴	🟡
Results reported in sufficient detail?	🟢	🟢	🔴	🟢	🟢	🟢	🟢	🟡	🟢	🟢	🟢	🟢	🟢
Conclusions supported by the results?	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢
Sum of Scores	**25**	**21**	**18**	**20**	**15**	**13**	**19**	**12**	**20**	**18**	**19**	**18**	**20**
Quality Rating	**0.89**	**0.75**	**0.64**	**0.71**	**0.53**	**0.46**	**0.67**	**0.42**	**0.71**	**0.64**	**0.67**	**0.64**	**0.71**

Note: This table illustrates the scoring of criteria on the Quality Assessment by Kmet, Cook and Lee (2004). Criteria are scored 0 – 2, No = 0 (red), Partial = 1 (yellow), Yes = 2 (green). Non-applicable criteria are marked N/A (grey). Higher percentages indicate greater reliability.

Results

Overview of Studies

Thirteen studies met the inclusion criteria, findings of which are summarised in Table 3 below. Studies were undertaken across six countries: the UK (2), USA (4), Italy (1), Netherlands (2), Germany (3), and Canada (1).

In terms of sample characteristics, six were from a community sample and seven studies were from a clinical sample with a range of different traumas. Among the studies, populations included veterans who experienced sexual and combat related assault (4), medical-related trauma victims (2), sexual abuse (4), physical abuse (4), life-threatening situation (2), life-threatening situations (2), unspecified (2), see Table 4 below for details on type of trauma recorded on intervention.

There are inconsistencies both in terms of reporting and representation of gender and age of participants across the studies. The majority referred to two gender studies, male and female, with one study including non-binary participants, while two studies did not disclose the gender of the study. Three studies were single gender studies only, female (2) and male (1). All studies were adults and ranged from 18-70, though age range was minimally reported. Reporting on other demographic information of participants was minimal across the studies, including ethnicity, education, and employment.

Eight of the studies used an internet-based CBT approach (iCBT) including iCBT, internet cognitive therapy (iCT), and internet cognitive processing therapy (iCPT), as at least one of the active treatment groups. Four studies compared iCBT as the treatment for investigation, with one comparing iCBT as both treatment options (short and regular iCBT). While one study compared the iCT as the active treatment, two studies compared iCPT as the active treatment option, in comparison to in-person CPT. A further study compared iCPT or iPE to an in-person control of the same intervention and one study detailed an uncontrolled iCPT intervention. One study included internet EMDR (iEMDR) as one of the active treatment groups in comparison to the second treatment group internet TF-CBT (iTF-CBT). Four studies compared integrated therapy approaches, both evidenced based and non-evidenced based, where interventions combined the techniques and principles from two or more modalities. Two studies investigated iPE and iEMDR and physical exercise, with one of these comparing this to in-person treatment of the same combination. Two further studies explored iPE or iCPT, with one of these studies comparing this to in-person therapy of the same intervention. One study compared iCBT and yoga to a non-PTSD control.

Table 3

Compilation of Studies Included in Systematic Review

Study and Country	**Population and Sample Characteristics** **Sample Type, Age (*M*, median, range, *SD*)**	**Design**	**Intervention Characteristics**	**Digital Methods**	**Intervention Length and Content**	**Completion rate** **Follow up**	**Main Findings**
Internet based Cognitive Behavioural Therapy Studies							
Gawlytta et al. (2022) Germany	Community sample *N* = 50 Male 26: Female 24, Age Median: 55 Adults > 18 years old PTSD or CPTSD diagnosis	RCT	Treatment condition = iCBT provided to couple dyads *N* = 50, *k* = dyads 25 iCBT (*N*=24, *k*=12) Control condition = Waiting List (*N*=26, *k*=13)	Web portal	2 x 5 weekly 50minute writing assignments Content: 1) Background gathering 2) Exposure 3) Cognitive Restructuring	100% completion rate FU: N/A	A small effect was observed within groups showing a main effect of time No significant effect was found between groups
Wild et al. (2016) UK	Clinical sample *N* = 10 (*M* = 30.4, *SD* = 9.2)	Uncontrolled trial	Internet-based Cognitive Therapy (iCT) provided to treat PTSD symptoms (*N* = 10)	Therapist-assisted web-based programme Individualised formulations Digital contact methods:	192 minute of contact time per patient and 57 minutes for reviewing patient's	100% completion rate FU: N/A	A significant main effect of time was observed. iCBT was effective in reducing PTSD symptoms pre and post therapy

	Male: Female unknown Adults > 18 years old PTSD or CPTSD diagnosis			Telephone calls (*M* = 10.5, *SD* = 3.9), Telephone contact time of 3.2 h (*M* 191.8, *SD* = 88.6), emails *M* = 20.7 (*SD* = 11.2), mobile SMS *M* = 8 (*SD* = 10.3)	progress and messages Modules comprised of 1) Therapy contracting, 2) Reclaiming life work 3) Trauma memory processing 4) Behavioural experiments 5) Relapse Prevention		
Niemeyer et al. (2020) Germany	Community sample veterans *N* = 37 All male sample (*M* = 37.7years, *SD* = 9.8, range: 19–70) Adults > 18 years old PTSD or CPTSD diagnosis	RCT	Intervention group = (IT) iCBT, *N* = 17 Control = waitlist (WL)control group, *N* = 20	Standardised treatment protocol based on individual formulation Written feedback by the therapist	5 x 2 weekly 45minute writing assignment (10 total) 3 treatment phases: 1) bio-graphical reconstruction, 2) exposure 3) cognitive restructuring	16.2% Did not start treatment 32.3% treatment dropped out FU: 3months (*N* = 7 IT, *N* = 21 WL)	Main effect of treatment condition on PTSD symptoms
Böttche et al. (2021) Germany	Community sample *N* = 224 Male 105: Female 119	RCT	Intervention group 1 = Cognitive restructuring, and processing (iCBT-reg) *N* = 110	Dutch web-based cognitive-behavioural approach for PTSD	Both interventions comprised 2 x weekly 45-minute structured writing assignments	Attrition rates: 19.3% iCBT-short	No significant effect between groups Significant main effect of within groups – online delivered iCBT

	(M = 25.3, range 5 -51, *SD* = 9.3) Adults > 18 years old PTSD or CPTSD diagnosis		Intervention group 2 = Cognitive processing (iCBT-Short) *N* = 115	A secure pass- word-protected web application	Modules consisted of 1) Imaginal exposure 2) Cognitive restructuring 3) Cognitive processing TF Regular – 10 writing assignments TF-Short - 6 writing assignments	4.5% iCBT-reg Treatment completion(6 writing assignments) : iCBT-reg condition: 77.1%, iCBT-short condition: 82.6%	
Internet Based Cognitive Processing Therapy Studies							
Morland et al. (2015) USA	Community sample veterans and civilians Female sample *(M* = 46.4, *SD* = 11.9) Adults > 18 years old PTSD or CPTSD diagnosis	RCT	Intervention group = Internet-based Cognitive Processing Therapy (VCT) Control group = In-Person Cognitive Processing Therapy (NP) 126 total (NP condition 63 VTC 61) 21 veterans and 105 civilians	Video teleconferencing	12 x 90minute sessions Manualised EBP CPT Therapist adherence rated high on CPT specific measure Therapeutic alliance was assessed using both client and therapist versions of the 12-item Working Alliance Inventory (WAI) short form	2 weeks (NP 49, VTC 43) 3 months (NP = 45, VTC 38) 6months NP = 41, VTC = 43)	Significant main effect found in both treatment and control groups Working alliance initially lower in VTC group in session 2, but no sign differences soon at EOT

Maieritsch et al. (2016) USA	Clinical sample recruited via 2 Midwestern VA Hospitals Male: Female unknow Adults > 18 years old PTSD or CPTSD diagnosis	RCT	Treatment condition = Online Cognitive Processing Therapy *N* = 45 Control condition = In-person Cognitive Processing Therapy *N* = 45	Video teleconferencing	1 or 2 x weekly 50minute sessions	Total attrition rate = 43.3% Treatment group = 42% Control group = 44% FU: 12 weeks follow up	Main effect of time was observed across treatment conditions No interaction effect of therapy showing no superiority
Valentine et al. (2020) USA	Clinical sample recruited via a trauma clinic *N* = 171 Male 26.5 %: Female 73.5% *M* = 44.4, *SD* = 11.6 Adults > 18 years old PTSD or CPTSD diagnosis	Controlled trial	Treatment condition = iPE or iCPT (*N* = 31) Controlled condition = In-person PE or CPT (*N* = 140)	Video-teleconferencing	Approx. 12 x weekly sessions Manualised protocol	Completion rates Treatment group 32.3% Control group 50%	Both conditions were found to be effective in PTSD reduction with no significant differences found between groups
Murphy et al., (2020)	Clinical sample recruited charity for combat PTSD *N* = 27	Uncontrolled trial	Treatment condition = iCPT (*N* = 27)	Skype	Approx. 12 x weekly sessions Manualised protocol	Completion rate = 78% FU: 3months	Treatment condition was found to be effective in reducing PTSD symptoms

	Male 24 (88.9%) Female 3 (11.1%) Adults > 18 years old PTSD or CPTSD diagnosis						
Internet Based Eye Movement Desensitisation and Reprocessing Studies							
Perri et al. (2021) Italy	Community sample health professionals *N* = 38 11 Males: 27 Females T1 (*M* = 48.3, *SD* = 13.6) T2 (*M* = 52.4, *SD* =10.6) Adults > 18 years old PTSD or CPTSD diagnosis	RCT	Treatment 1 condition = iEMDR (*N* = 19) Treatment 2 condition = iTF-CBT (*N* = 19)	Skype platform link to a reserved web page for tests compilation	Both groups received 7 sessions therapy 2 x weekly for 3 weeks EMDR modules Introduction, psychoeducation, stabilisation, bilateral stimulation, review and closure TF-CBT Modules introduction to model, psychoeducation, stabilisation, prolonged verbal exposure and cognitive restructuring; brief mindfulness training, review and closure	100% completion rate One month	Main effect of time was observed across both treatment conditions No interaction effect of therapy showing no superiority
Internet Based Integrated Therapy Studies							

Bongaerts et al. (2022) Netherlands	Clinical Sample recruited via a trauma centre *N* = 73 37 Male, 36 Female *M* = 37.16 years (*SD* = 11.82) Adults > 18 years old PTSD or CPTSD diagnosis	Controlled trial	Treatment condition = Online Prolonged Exposure (PE) and online Eye Movement Desensitisation Disorder (EMDR) and relaxation physical activities and psychoeducation *N* = 73 Control condition = Face to face treatment PE, EMDR, relaxation physical activities and psycho-education *N* = 23	Delivered via Zoom	4 consecutive days of one daily PE therapy session (90 minute) and one EMDR therapy session (90 minute), 6 hours of physical activities. 3 hours of psycho-education	100% completion rate 6 months (16 lost to follow up)	Main effect of treatment group was an observed reduction in PTSD and CPTSD symptoms in treatment group
Bongaerts et al. (2021) Netherlands	Clinical Sample recruited via an outpatient trauma centre *N* = 6 2 Male, 4 female 38.7 years (SD = 16.07) Adults > 18 years old	Uncontrolled trial	Treatment condition = Online PE and online EMDR and relaxation physical activities and psychoeducation *N* = 6	Video-teleconferencing	4 consecutive days online PE (90 minutes) and an EMDR therapy session (90 minutes), 6 hours of physical activities, and 3 hours of psycho-education	100% Completion rate One month	Significant main effect of treatment on reduction in PTSD symptoms maintained at follow up

	PTSD or CPTSD diagnosis						
Hassija et al. (2011) USA	Clinical sample recruited from Wyoming Trauma Telehealth Treatment Clinic *N* = 15 Female sample *M* = 30.20, *SD* = 9.25) Adults > 18 years old PTSD or CPTSD diagnosis	Uncontrolled trial	Treatment condition = Evidenced-based PE or Cognitive Processing therapy (*N* = 15)	Video-teleconferencing	Weekly 60–90 minute sessions dependent on treatment offered Client satisfaction measure	86.67% Treatment completion rate N/A	Significant main effect of time on PTSD symptoms
Kirk et al. (2022) Canada	Community sample recruited via University *N* = 22 Male 2, Female 18, Non-binary 1 *M* = 26.4, 18-35, *SD* = 4.45 Adults > 18 years old	Controlled trial	Treatment condition = CBT and trauma informed yoga (*N* = 22) Control condition = non-PTSD (*N* = 49)	Pre-recorded CBT-MY minute web-based session	Treatment condition = Weekly sessions 8 CBT-themed modules (e.g., cognitive distortions, negative self-talk, mindfulness exercises, breadth and progressive muscle relaxation, trauma-informed yoga videos	81.82% Treatment completion rate FU: N/A	A significant main effect of treatment was found with reduction rates in PTSD symptoms and psychological symptoms

	PTSD or CPTSD diagnosis Control characteristics not documented				Control condition completed psychophysiological protocol – detail not documented		

Table 4

Type of trauma recorded in studies

Type of trauma	Count	Studies
Military trauma (combat) Military trauma (sexual abuse)	3 1	Maieritsch et al. (2016); Niemeyer et al. (2020); Murphy et al. (2020). Valentine et al. (2020)
Medical Trauma	2	Gawlytta et al. (2022); Perri et al. (2021)
Domestic violence and sexual abuse	5	Bongaerts et al. (2022); Bongaerts et al. 2021; Böttche et al. (2021); Kirk et al. (2022); Hassija et al. (2011)
Sexual experiences prior to 18	1	Böttche et al. (2021)
Life threatening situations	3	Bongaerts et al. (2022); Böttche et al. (2021); Kirk et al. (2022)
Not disclosed	2	Morland et al. (2015); Wild et al. (2016)
Physical abuse	3	Bongaerts et al. (2022); Bongaerts et al. (2021); Kirk et al. (2022)
Other	1	Bongaerts et al. (2022)

In terms of study design, six were identified as RCT’s (see Table 3 above for ratings on randomisation procedures) comparing the treatment to an active or inactive control condition. Three were of a controlled trial design without randomisation procedures taking place and four further studies employed an uncontrolled (pre-post) design.

Intervention length varied widely across studies with some having strict protocols for number of sessions as a minimum or maximum, or minutes spent on various modules of therapy. Other studies referred to “treatment completion” based on therapist clinical judgement and scores on PTSD scales. Measurement of PTSD varied across studies which are summarised in Table 5 below. The findings and limitations of the studies follow.

Table 5

Included studies and use of PTSD symptom measurement tool

PTSD Measurement Tool	**Studies Included**
PCL 5	Bongaerts et al. (2021); Gawlytta et al. (2022); Hassija et al. (2011); Kirk et al. (2022); Maieritsch et al. (2016); Niemeyer et al. (2020); Perri et al. (2021); Wild et al. (2016); Murphy et al. (2020).
PSS-I	Wild et al. (2016)
Clinically Adult administered PTSD Scale for DSM-5 (CAPS 5)	Bongaerts et al. (2022); Bongaerts et al. (2021); Kirk et al. (2022); Maieritsch et al. (2016); Morland et al. (2015); Niemeyer et al. (2020); Valentine et al. (2020)
Life events checklist	Bongaerts et al. (2022); Niemeyer et al. (2020);
The Posttraumatic Stress Diagnostic Scale (PDS)	Böttche et al. (2021)
Structured Clinical Interview (SCID)	Morland et al. (2015); Maieritsch et al. (2016)
ITQ	Bongaerts et al. (2022); Bongaerts et al. (2021)
Clinician Administered PTSD Scale for DSM-5	Bongaerts et al. (2022)

A narrative synthesis of the studies is presented below with regard to treatment efficacy (therapeutic approach and symptom reduction) and engagement with treatment (treatment completion and attrition rates, and therapist contact), across the four primary categories of intervention studies, iCBT, iCPT, EMDR and integrated therapies, which involved a combination of one or more evidenced-based and non-evidenced based treatment being offered within the intervention protocol.

Treatment Efficacy

Therapeutic approach

Three iCBT studies explored the effectiveness of online written exposure treatment: Niemeyer et al., (2020), Gawlytta et al., (2022), and Böttche et al., (2021). All three studies followed a similar module procedure of exposure (written and imaginal), cognitive restructuring, and cognitive processing through twice weekly written exposure assignments, over the treatment course of five weeks. Wild et al. (2016) conducted a broader iCBT intervention in their study, based on individual formulation including reclaiming life work, trauma memory processing, behavioural experiments, and relapse prevention. They hypothesise that treatment that structured internet interventions may offer an advantage of ensuring treatment consistency with clients receiving the same module content, and should be explored in future research. This contextualisation may have value, considering Böttche et al., (2021) identified the lack of consistency within treatment modules as a limitation of the study that may have impacted treatment results.

Two of the iCPT studies, Morland et al. (2015) and Maieritsch et al. (2016), compared once or twice weekly iCPT via video teleconferencing, to an in-person control group of the same frequency. The former study refers to following a manualised evidence-based practice approach over 90 minutes, while the latter offered 50-minute sessions, over the course of 12 weeks. No further detail was provided on the intervention. A further study, Valentine et al. (2020), compared iCPT or iPE via video teleconferencing to in-person CPT or PE. The authors also cite following a protocol-based 12-week session module, across treatment conditions. The uncontrolled iCPT study by Murphy et al., (2020) explored the impact of iCPT in weekly – biweekly, 60minute sessions.

Perri et al. (2021) compared two treatment conditions, iEMDR to iCBT across seven sessions which were held bi-weekly and delivered via Skype. Modules for both treatment groups were comparable to in-person therapy of psychoeducation, stabilisation, bilateral stimulation, review, and closure for the iEMDR group and psychoeducation, stabilisation, prolonged verbal exposure, and cognitive restructuring; brief mindfulness training, review, and closure for the iCBT group.

With regard to the integrated studies, in 2021, Bongaerts and colleagues conducted an uncontrolled pilot project exploring the efficacy of remotely delivered PE, EMDR, and physical activity for symptoms of PTSD within a clinical sample. Treatment was completed over four consecutive days. Daily treatment schedule consisted of 90-minute PE and EMDR sessions individually administered, six hours of physical activity, and three hours of psychoeducation. They repeated the study a year later, following identical module procedures against an in-person control group. The remote therapy conditions were delivered via Zoom. Both Hassija and Gray (2011) and Kirk et al. (2022) integrated both evidence-based and non-evidenced-based treatments and approaches in the treatment of trauma within their studies. Hassija and Gray (2011) investigated the impact of iPE, iCPT, and internet-based motivational interviewing within a small clinical sample in an uncontrolled study. Treatment procedures consisted of weekly 60-90 minutes sessions, via teleconferencing though no further information was provided on content of the intervention. Kirk and colleagues (2022) compared an integrated treatment condition of iCBT and internet-delivered trauma informed yoga, to a non-PTSD presenting control group completing trauma informed yoga. Treatment condition modules consisted of cognitive distortions, negative self-talk, mindfulness exercises, breadth, and progressive muscle relaxation, while control group modules consisted of the three latter modules.

The findings from the above studies on digital therapy indicate that effectiveness can be significantly improved by maintaining consistency in treatment modules, using structured and familiar approaches similar to in-person therapy. Consistent, protocol-based interventions, as seen in iCBT and iCPT studies, help ensure reliability, while familiar modules in iEMDR enhance patient experience.

Symptom reduction

In Niemeyer et al. (2020), participants in the treatment condition reported lower levels of trauma post-treatment in comparison to the wait-list control group, though effect sizes were small. It is important to note that some participants had experienced multiple military-related traumatic events and were still engaged in active duty during the time of treatment. This indicates that iCBT may be an efficacious treatment for those who have experienced multiple traumas and those experiencing ongoing trauma. Three iCPT studies, Maieritsch et al. (2016), Valentine et al. (2020) and Murphy et al., (2020), with military samples demonstrated similar reduction rates in PTSD compared to in-person control groups. This indicates that remote and in-person therapy have similar treatment effects, indicating that method of treatment delivery had no effect on engagement with therapy with regards to treatment reduction in this population, though this is further explored below.

Though Gawlytta et al. (2022) reported that participants experienced a reduction in trauma symptoms post-treatment, reduction rates were similar to those in the wait list control groups, indicating that iCBT was no more effective than a wait list control group. However, noted small sample sizes may have contributed to non-significant findings.

In the pilot study conducted by Wild et al. (2016), participants showed immediate benefits to treatment with the majority of clients experiencing significant improvement from PTSD symptoms within four weeks of treatment. The authors hypothesise that quick recovery rates may have been influenced by client control in relation to pace of treatment, with the majority of clients completing treatment quicker than standardised 12-week treatment programmes. The 80% recovery rate observed in their study is highly effective considering the 38% recovery rate recorded across IAPT services (NHS DIGITAL, 2019). It is too early to conclude that iCT-PTSD leads to faster recovery rates from PTSD than CT-PTSD and further studies would need to be conducted, with larger sample sizes and within an RCT design to explore relationships between rate of treatment completion and recovery rates across iCT and in-person CT groups. Further studies would benefit from an exploration into predictors of poorer treatment response. Though participants in this study presented with multiple traumas and comorbid difficulties, future studies would also need to be conducted to explore suitability of this model of therapy to more complex presentations.

Within the single iEMDR study (Perri et al., 2021), participants in both treatment groups found 30% reduction rates in PTSD symptoms; results that are in accordance with the literature (Perri et al., 2021), showing that both remote therapy treatments are as efficacious as one another. Though results indicate a positive impact of digital therapy on engagement with therapy with regards to symptom reduction, the absence of an in-person or wait list control group, make it difficult to develop narratives on the impact of the digital delivery of treatment.

Within their pilot study, Bogaerts et al. (2021), participants reported a reduction in PTSD symptoms that was maintained at follow-up. Interestingly, in

Bongaerts et al. (2022), participants within the experimental condition reported higher levels of PTSD symptom reduction when compared to the in-person control group. This indicates that remotely delivered integrated interventions for trauma can offer to improve engagement with therapy, leading to higher reductions in symptom severity. However, interpretations should be taken with caution considering that sample sizes within the in-person control group were much smaller than the experimental condition (23, 73), respectively. It is important to note that the authors utilised different PTSD symptom measures in their follow up study, compared to the initial study (see Table 5), rationale for which was not outlined in their journal paper. Though validated measures were used in both studies, interpretation should proceed with caution, with regards to symptom reduction across studies.

Participants in both Hassija and Gray (2011) and Kirk et al. (2022) studies noted significant reductions in PTSD symptoms in treatment conditions, indicating that digitally delivered integrated therapies are efficacious treatments. However, in the absence of in-person control groups, it is difficult to ascertain if method of delivery impacted engagement leading to symptom reduction. These results are interesting considering Kirk et al. (2022) was a non-evidenced based treatment and warrants further investigation into exploring factors that may have facilitated these results.

Overall, the studies above demonstrate varying levels of effectiveness in reducing PTSD symptoms, indicating potential for high patient engagement across single and multiple trauma presentations. However, interpretations should be made with caution considering small sample sizes, varying methods of PTSD symptom assessment, and lack of in-person control groups. It is also important to recognise that the rates of recovery from this study may have been influenced by confounding variables such as therapist experience and client selection criteria.

Engagement with treatment

Treatment completion and attrition rates

Studies by Wild et al. (2016), Gawlytta et al. (2022), Perri et al. (2021), and Bogaerts et al. (2021; 2022), all reported 100% completion rate, meaning that all clients completed the full intervention. This is a positive outcome compared to 18-35% drop out rates across PTSD treatments (Imel, Laska, Jakupcak & Simpson, 2013), indicating that iCBT and iEMDR may reduce barriers to engagement with trauma therapy. However, without the presence of in-person control groups in all studies this hypothesis should be considered with caution**.** Hassija and Gray (2011) and Kirk and colleagues (2022) both report high levels of participant retention rates, with 4 participants and 2 participants not completing treatment, respectively. Considering Kirk et al. (2022) is a non-evidence-based study, further investigation is warranted into factors impacting engagement with this treatment.

In contrast, Niemeyer et al. (2020) reported low levels of engagement within their study involving written exposure with veterans. 16.2% did not start treatment despite being offered it and 32.3% of participants did not complete treatment. Participants reported preference for in-person therapy and lack of alleviation from PTSD symptoms from digitally delivered therapy as rationale for treatment drop out. Similarly, in their study involving military samples, Maieritsch and colleagues (2016) experienced high dropout rates; 42% in the treatment group and 44% in the control group. Interestingly though, Valentine and colleagues (2020) also reported high levels of attrition within both the treatment group (32.3%) and in-person (50%) within a military sample. Lower attrition rates in the iCPT and iPE groups may indicate that digitally delivered interventions help to improve engagement within a military sample, when compared to in-person controls; though attrition rates remain highest amongst this sample of the population, as stated above.

Attrition rates were also experienced in the Böttche et al. 2021 study across both treatment conditions, iCBT short and iCBT regular, though differences were non-significant. Prior to beginning treatment, 19.3% of participants in iCBT short treatment condition and 24.5% in iCBT regular condition, dropped out of the study. Treatment completion rates were 82.6% and 77.1%, respectively. Treatment attrition rates reported in this study, are conducive to those reported across the literature in the treatment of PTSD (Imel, Laska, Jakupcak & Simpson, 2013). Treatment dropout rates of 16.1% in Morland et al. (2015) and 22% in Murphy et al. (2020), were consistent with the 18-35% rates reported within the literature (Imel, Laska, Jakupcak & Simpson, 2013), indicating that remote therapy has similar engagement patterns than in-person therapy.

From the above, it is clear there is a complex interaction of participant individual and treatment efficacy, with regards to treatment completion. These results indicate that although digitally delivered approaches may increase engagement with certain populations, further research is warranted to explore the participant suitability to treatment conditions including sociodemographic information, symptom severity, clinical presentation, type of traumatic event, and components of treatment.

Therapist contact

Across therapeutic approaches, mode and frequency of therapist contact demonstrated interesting results. In the pilot study by Wild et al. (2016), upon exit interview, clients reported they felt well-supported by therapists despite the asynchronous communication and 25% reduced contact time compared to that of in-person therapy.

In the single EMDR study (Perri et al., 2021), contact with the therapist was more frequent and condensed compared to in-person therapy, for single incident trauma (NICE, 2018). This may indicate that more frequent contact with the therapist, over a condensed treatment length conducted online, offers an efficacious treatment relative to those documented within the literature for in-person therapy of the same treatment procedure (Etten & Taylor, 1998). This could have clinical implications in reducing therapist hours on treatment without impacting client experience and treatment efficacy.

Participants in Niemeyer et al. (2020) reported internet connection and web page access issues. These were generally resolved through telephone support and use of the demand option with technical support. However, questions relating to assignments were resolved via written feedback from therapists. These issues alongside interest in writing, reading, and computer literacy were cited as impediments to the engagement process.

Morland et al. (2015) reported that working alliance was lower in week two in the treatment group in comparison to their in-person therapy control group. However, there was no significant difference between therapist alliances at the end of treatment across groups. This indicates that it may initially take longer to form a therapeutic relationship in online therapy, but over time, relationships are formed as strongly as those within in-person therapy.

A notable caveat of the Bongaerts et al. (2021; 2022) studies, is that each therapy session within and across treatment days was completed by a different therapist. This is interesting considering the study conducted by Morland et al. (2015) noted that building of the therapeutic relationship took longer in remote delivered interventions compared to in-person controls. The therapeutic relationship is well documented across the literature of impact engagement and overall efficacy of treatment (Howard, Berry & Haddock, 2022). Within the Hassija and Gray (2011) and Murphy and Turgoose (2020) studies, participants reported high levels of satisfaction with digitally delivered intervention. In the later study, participants reported the flexibility of remote sessions allowed to access therapy that would have otherwise been inaccessible due to commitments such as work) However, both studies were not compared to an in-person control, therefore only tentative interpretations can be made.

Overall, high levels of satisfaction were reported, indicating the potential for digital therapies to maintain strong therapist-client relationships and support patient engagement. Interestingly, digital therapies may offer opportunities for more frequent contact with the therapist, improving engagement while simultaneously reducing overall clinical contact. However, considerations to barriers to engagement such as internet issues are warranted before the commencement of intervention.

Discussion

This paper provides a narrative synthesis of the current literature on therapist facilitated digital intervention. In particular, this review explored the impact of digital technology on engagement with regard to treatment approach, symptom reduction, attrition rates, and therapist contact. This review discusses important implications across clinical, methodological, and research aspects. However, significant caution should be taken when interpreting these findings. Only three of the included 13 studies met the conservative quality assurance thresholds. Two studies fell below the liberal threshold level, though marginally. The remaining nine studies scored between conservative and liberal levels of quality assurance.

Firstly, when exploring engagement with digital therapy, it is imperative to explore the type of therapy modality offered and the internet adaptions made. Written exposure-based treatments found that employing a structured module of exposure, cognitive restructuring, and processing over five weeks improved efficacy. These studies collectively indicate that digital therapy’s effectiveness and patient engagement improve with protocol-based, consistent interventions, paralleling in-person therapy structures; a finding supported by broader literature on the efficacy of standardised treatments in digital mental health interventions.

Considerable variability was found both within and across internet treatment modalities. Participants in several studies showed reduced trauma levels post-treatment, though effect sizes were often small and sample sizes limited. Some studies indicated that iCBT was no more effective than wait-list controls, while others highlighted significant symptom improvements within a short timeframe, possibly due to the flexibility in treatment pace. Integrated digital therapies demonstrated effectiveness with some studies reporting higher reductions in PTSD symptoms compared to in-person controls, despite differences in sample sizes. Overall, while digital therapies like iCBT, iCPT, iEMDR, and integrated studies show potential for effectiveness in terms of PTSD symptom reduction and subsequent engagement, further research with larger sample sizes and robust control groups is needed to fully understand their impact.

Engagement with digital therapy was explored across these studies with regard to levels of attrition and contact with the therapist. Rates of attrition varied considerably across therapeutic approaches. Interestingly, some studies saw higher attrition rates; 42% and 44% more than reported in the literature. Imel, Laska, Jakupcak and Simpson (2013) stipulate an average of 18–35% attrition across RCTs of trauma therapy. In contrast, almost all the included studies reported 100% completion rates. Though little differences were found between controlled and uncontrolled studies, comparisons to the gold standard RCT's should be cautioned, particularly considering varying quality assurance. Additionally, military personnel populations continued to present with similar engagement issues than what is identified within the current literature. The lack of controlled trials, particularly in relation to in-person control groups, impacts levels of interpretation and whether attrition rates were related to delivery method or other uncontrolled variables.

Finally, asynchronous communication was found to offer benefits to both the therapist and client. Therapists can review progress and send messages at their convenience, while clients can contact the therapist whenever required for their individualised programme. The studies above advise that contact encourages regular engagement as therapists can respond more frequently in writing, while clients have access to written support that can be reviewed multiple times and may sustain engagement. In sum, they posit that the possibility of increased frequency of contact with their therapist, though briefer, had a positive effect in engagement with the treatment material. However, further studies would need to be conducted to explore efficacy and factors related to engagement with treatment.

Clinical Implications

Generally, digitally delivered therapies had strong evidence to support their efficacy in reducing PTSD symptoms, with the exception of a few studies. However, caution should be taken when interpreting the clinical implications of the study considering the varying level of quality in studies. Nevertheless, this reinforces NICE (2018) guidelines, that digital therapeutic options for PTSD should remain a core treatment option within services.

High completion rates in certain iCBT and iEMDR studies, such as those by Wild et al. (2016), Gawlytta et al. (2022), and Perri et al. (2021), suggest that internet-based interventions can reduce barriers to engagement. These barriers include travel time, scheduling conflicts, and geographical limitations, which are particularly relevant for populations with limited access to in-person therapy. For example, Wild et al. (2016) reported an 80% recovery rate, which they attributed to the flexibility and client control over the pace of treatment. High attrition rates in studies involving military populations (Maieritsch et al., 2016; Valentine et al., 2020) though lower attrition rates in ex-military personnel study (Murphy et al., 2020) indicate the need for additional support and tailored approaches to improve engagement in some client groups. Military personnel may also face unique challenges, such as ongoing exposure to traumatic events while still in service and specific cultural factors, which can impact their engagement with digital therapies. In addition, domestic abuse survivors, asylum seekers, and refugee populations may encounter similar challenges. Further research should explore potential barriers and facilitators to engagement for specific populations. Thus, tailored interventions that address these unique needs and preferences are necessary to enhance their efficacy.

The mode and frequency of therapist contact plays a significant role in the effectiveness of digital therapies. Studies indicate that even asynchronous communication can be effective, with clients feeling supported, despite reduced direct contact (Wells et al., 2020). This suggests that digital platforms can facilitate meaningful therapeutic relationships, although initial engagement might take longer (Morland et al., 2015). Asynchronous communication offers benefits such as allowing therapists to review progress and send messages at their convenience, while clients can contact therapists whenever required for their individualised program. However, further studies are needed to explore the efficacy and engagement factors related to asynchronous communication in digital therapies for PTSD.

Methodological Limitations

The reviewed studies on internet-based interventions for PTSD reveal important methodological considerations that impact treatment efficacy and engagement. Firstly, there are difficulties in drawing generalisable conclusions from the studies included in this review. While a number of studies were methodologically rigorous and employed an RCT design, many had multiple design problems. For example, several studies used an uncontrolled design, leaving the possibilities that study results including efficacy, engagement, and attrition, may be due to other unmeasured variables. Only four of the twelve included studies compared digital therapy to an in-person control condition, where comparisons of digital technology in the engagement to therapy can be made.

Comparing the use of technology across studies was difficult due to inconsistencies in how the methods were reported and used. Seven studies only mentioned the type of technology used without detailing its application in interventions. The other six studies showed considerable variation, using methods like telephone, emails, mobile SMS, video contact, individualised websites, pre-recorded videos, remote test site links, and other therapeutic materials. This lack of detailed discussion on digital methods hinders the generalisability of the studies. Additionally, there was significant variability in treatment methods and adherence to manualised treatments, making it hard to infer relationships between engagement and digital methods. The variation in session frequency and duration, suggests a need for standardised protocols to ensure optimal therapy intensity and engagement. Future research should focus on determining the best session frequencies and durations to maximise efficacy and engagement.

Different sample characteristics across studies highlight the importance of considering population-specific factors in intervention design and evaluation. Further research should be conducted to explore attrition rates across community and clinical samples to explore access and barriers to remote therapy for varying populations. Additionally, higher attrition rates in military samples indicate that specific subgroups may require tailored approaches, particularly those who may be considered more vulnerable or present with prolonged exposure to trauma such as those who experience domestic violence, and refugee and asylum-seeking clients.

Research Implications

Considering the above aforementioned limitations, there are a number of avenues for potential future research to explore the use of digital therapies in engagement with regard to trauma. To address the additional methodological issues, studies should aim to recruit larger sample sizes and use comparable in-person control groups to effectively compare methods of treatment delivery.

Importantly, future studies should provide detailed information on the type of digital technology used and how this was utilised for assessment, treatment, and any follow up stages. Detailed information on how digital technology is optimised, would allow for replicability to explore both efficacy and engagement. Furthermore, the lack of consistency within and across treatment approaches suggests a need for standardisation across treatment methods, including protocol and the use of consistent validated measures.

Future research should investigate predictors of treatment response and attrition. Understanding factors such as sociodemographic characteristics, symptom severity, types of traumatic events, and components of treatment, can help tailor digital interventions to individual needs. For instance, Niemeyer et al. (2020) noted that participants' preference for in-person therapy and lack of symptom reduction were reasons for treatment dropout. Research on predictors of engagement and attrition can inform the development of more effective and personalised digital interventions.

Exploring the integration of digital therapies with in-person support, could provide insights into hybrid models that may enhance efficacy and engagement. For example, integrating iCBT with in-person therapy or using multiple methods of digital technology (e.g. combining asynchronous and synchronous communication) could support clients with emotional regulation difficulties and stress management. Hybrid models may offer a more comprehensive approach to treating PTSD, combining the benefits of digital and in-person interventions.

Conclusions

In conclusion, while digital therapies for PTSD show promise, ongoing research is essential to optimise methodologies, enhance clinical application, and better understand the factors influencing treatment efficacy and engagement. By addressing these methodological, clinical, and research implications, the field can advance towards more effective and accessible treatments for PTSD.

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Part Two: Empirical Research Paper

“Shame is at the root of everything, it’s been a part of me since I can remember”. Online therapy and disclosures of shame: An exploration into the experiences of clients presenting with PTSD.

Abstract

Aims. Trauma therapy rapidly became digitalised during the COVID-19 pandemic**.** Despite long standing evidence, there is limited understanding on how clients navigate and express feelings of shame in remote therapy**.** This study aimed to understand the impact of remote therapy on the clients' experience of treatment for PTSD. Specifically, this research aimed to explore how clients build a therapeutic relationship and navigate and experience making disclosures of shame-based emotions in remote therapy.

Method. A sample of nine participants (five clients and four clinicians) completed semi-structured interviews about their experience of receiving or facilitating remote trauma therapy. Data was analysed by thematic analysis.

Results. Three superordinate themes were generated from the analysis, encompassing nine subthemes. These relate to the complexities of shame, the importance of shame-sensitive practice and how remote therapy requires rethinking of the "therapeutic room".

Conclusion. This study presents a rich insight into the experience of clients and therapists within trauma therapy. While remote therapy presents new challenges and opportunities it remains a valuable method of delivery in person-centred care to support shame-based disclosures in trauma therapy. Further research is needed on remote trauma therapy, particularly in blended approaches and management of risk in remote settings.

Introduction

Trauma and Post Traumatic Stress Disorder

The psychological impact following experiencing traumatic events is widely documented in the literature, including the development of post-traumatic stress disorder (PTSD), a recognised serious health condition (Kessler, 2000; Schonfeld et al., 1997). Classified as an anxiety disorder, PTSD can develop following exposure to a traumatic event and is characterised by intrusive memories or re-experiencing events, avoidance of reminders of the event, negative changes in cognitions, and mood and arousal symptoms (American Psychiatric Association [APA], 2013; World Health Organization [WHO], 2022). A second trauma diagnosis termed Complex Trauma (CPTSD) was recently recognised by International Classification of Diseases (ICD), 11th revision (WHO, 2022). In addition to above symptomology, CPTSD may develop following repeated, prolonged, and multiple exposures to traumatic events. These can lead to pervasive difficulties in negative self-belief affect regulation, and challenges in interpersonal relationships (Cloitre, Garvert, Brewin, Bryant & Maercker, 2013; WHO, 2022).

Rates of PTSD may vary widely across the world due to conflict and natural disasters. It is hypothesised that 50-70% of people will experience a traumatic event in their lifetime, with 20% of those likely to develop PTSD (PTSD UK, 2024). Rates of referrals to UK health services following the COVID-19 pandemic suggest that these rates are significantly increasing (PTSD UK, 2024). Several factors are known to influence the likelihood of developing PTSD following a traumatic event. The nature of the traumatic stressor is a primary factor related to PTSD development, with interpersonal trauma rated as the highest contributing factor (Cloitre, Miranda, Stovall-McClough & Han, 2005). Furthermore, the idiosyncratic appraisal of the traumatic event or appraisal sequelae as being external or internal to the individual (Ehlers & Clark, 2000) affects levels of PTSD development. The internalisation of the traumatic event can also lead to development of shame-based emotions, which further increases development and maintenance of PTSD (Gilbert, 2000), discussed further below.

PTSD has significant effects on mental health, impacting various aspects of emotional and psychological well-being, including intrusive memories, avoidance behaviours, negative changes in cognition and mood, and physical health problems which impact on a person's ability to function and their quality of life (APA, 2013). In some cases, people who present with PTSD experience dissociation, where individuals experience a detachment from their reality, thoughts, consciousness, or memory. Dissociation is thought to develop at the time of the traumatic event, as a way to protect the individual by disrupting the normal cognitive integration of consciousness, memory, and perception (The International Society for the Study of Trauma and Dissociation [ISSTD], 2011).

A number of evidenced-based therapies based on cognitive behavioural models of PTSD are recommended by National Institute for Health and Care Excellence [NICE] guidelines in the treatment of PTSD (NICE, 2018). These include cognitive therapy for PTSD (CT-PTSD; Ehlers & Clark, 2000), cognitive processing therapy (CPT; Resick & Schnicke, 1992), prolonged exposure therapy (PE; Foa, Hembree & Rothbaum, 2007), narrative exposure therapy (NET; Schauer, Neuner & Elbert, 2012), and eye movement desensitisation and reprocessing (EMDR; Shapiro & Maxfield, 2002). Computerised options of the above trauma interventions have also been recommended by NICE (2018). However, mental health services in the UK predominately only adapted to remote delivery of trauma therapy following the COVID-19 pandemic. This is discussed further below. Each of the above treatments have different emphases in the conceptualisation and treatment of PTSD, however they also share components that are likely to influence the therapeutic alliance (Schnyder et al., 2015).

Therapeutic Relationship

The therapeutic relationship has long been documented as one of the most important factors in treatment for mental health distress. Considering PTSD develops from a serious threat, building trust within the therapeutic relationship is paramount in supporting the client to feel safe, both inter- and intra-personally (Howard, Berry & Haddock, 2022), and is paramount in the treatment of PTSD and CPTSD. In particular, those who have experienced interpersonal trauma can find building trust in the therapeutic relationship more difficult (Howard, Berry & Haddock, 2022). Treatment of PTSD involves exposure to the trauma memory, which can lead to levels of distress for both the client and the therapist (Ormhaug, Jensen, Wentzel-Larsen & Shirk, 2014). This in turn can compromise the therapeutic relationship and lead to avoidance and disengagement (Ormhaug, Jensen, Wentzel-Larsen & Shirk, 2014).

Grey, House & Young (2018) outline how therapists can support to build both physical and psychological safety in the therapeutic relationship to promote alliance building, even when faced with threats. Mechanisms to build physical safety involve extending therapy sessions for reliving and ensuring enough time to support the client in emotional safeness at the end of the session. Having a consistent interpreter if required, a calm safe room, grounding materials, and offering client choice in therapist gender are all ways to build physical safety. Developing a collaborative approach is key to psychological safety and building trust within the alliance. Psychoeducation as to the rationale for PTSD treatment and transparency regarding the exposure involved is important in psychological safety. Positive interpersonal experiences of empathy and lack of judgement (Schnyder et al., 2015) are also paramount.

Defining Shame

Shame, as conceptualised within a Westernised framework, is recognised as a fear of being viewed negatively by others and the fear that these held negative beliefs are true (Gilbert, 1998). There in, shame is a response to threat, which can be both internal (self-evaluation) or external (others' evaluation of you). Shame or the sense of feeling ashamed, is associated with additional primary emotions of anger, fear, disgust, and sadness (Gilbert, 2000). Individuals that experience high levels of shame often hold self-critical thinking styles (Gilbert, 2000). This emotion can have a critical influence on levels of functioning including cognitive, behavioural and emotional, and physiological states (Gilbert, 1998; Tangney & Dearing, 2002).

Though this research centralises shame within a western-centric model, identifying shame as maladaptive and painful and centralising on the self, it is important to acknowledge alternative conceptualisations of shame. East Asian scholars view shame as a cultural emotion embedded within shared social scripts that include cultural ideals, values and norms (Hong, 2004; Kitayama & Masuda, 1995, Shi-xu, 2009). Key to these views of shame, is the recognition of shame as a key factor precipitating self-transformation. Within this view shame seen as an opportunity to improve the self (Bedford, 2004). Secondly within Asian cultures, shame is considered to be more group orientated, where the presence of shame serves as a motivator for change, in order to mimise the impact on the shamed 'other' such as family, friends etc. Shame is linked closely to role in family and community and seen as a tool for maintain social harmony and cohesion. Though Westernised and Eastern views of shame are stated in contrast above, holding diverse perspective on shame may be more commonplace both on an individual and societal level. However, a key narrative focus of this current research is the identification of shame as judgement and inherently as a negative self-perception.

Shame and PTSD

Shame is increasingly being recognised as being a key contributor in the development and maintenance of PTSD (Andrews, Brewin, Rose & Kirk, 2000; La Bash & Papa, 2014). Shame is now recognised as an intense trauma-related emotion within criterion for PTSD diagnosis, both with the diagnostic and statistical manual for mental disorders (DSM-5; APA, 2013), and ICD-11 (WHO, 2022) diagnostic tools. Negative self-evaluation and elevated self-blame are recognised as typical reactions to traumatic stress (APA, 2013), with people often experiencing shame related to the traumatic event. Those who experience shame can also experience 'shame flashbacks' which may be related to their trauma, or early childhood or adult experiences, which are characterised by the reliving of painful emotionally salient experiences, where their internal, and or external evaluations of themselves had been negatively activated, such as experiences of being criticised and degradation (Lee, 2009). Research suggests that the cognitions and associated emotions relating to the threat in PTSD are threats to the internal sense of self such as, "I'm weak", "I'm bad", which also act as a social threat in the context of the evolutionary perspective (Holmes, Grey, & Young, 2005; Grey & Holmes, 2008), and contribute to trauma-related shame flashbacks.

Across populations and types of trauma experiences, shame has been consistently documented to increase rates of development of PTSD (La Bash & Papa, 2014). Rates of shame are higher in those with interpersonal trauma experiences such as childhood abuse, due to the activation of the internal and external evaluations of the self (Keene & Epps, 2016). Badour, Resnick and Kilpatrick (2017) found that 62% of those who presented with histories of interpersonal trauma reported experiencing trauma-related shame, with shame a significantly stronger predictor of PTSD than fear. In addition to relational levels, shame can be experienced across community, institutional, and society levels, further perpetuating experiences of shame in CPTSD populations (Salter & Hall, 2022).

Shame and Therapy

Shame has been documented to have a significant impact on the therapeutic process. Affective experiences of shame are identified to be significant barriers to treatment success across modalities and approaches (Kelly, Carter & Borairi, 2014). With the development of compassion-focused therapy (CFT) by Gilbert and colleagues (Gilbert, 1998; 2000; Gilbert, Lee & Welford, 2006; Gilbert & Proctor, 2006), shame has been recognised as an important emotion to explore and treat within therapy, particularly in traumatised populations (Lee, Scragg & Turner, 2001). Gilbert (1998) suggests that individuals who experience shame often lack the ability to self-soothe, which is an essential skill to manage external and internal threats. The ability to experience safety from psychological threats (internal or external) is identified to be key in the treatment of shame-based PTSD to interrupt these maintenance cycles. CFT promotes self-soothing to build a sense of psychological safeness (Gilbert & Irons, 2005). CFT comprised both Western and Eastern perspectives in shame is an attempt to reframe shame as a tool for growth rather than judgement.

Literature suggests an intrinsic relationship between shame and anxiety of negative evaluation from others (Lewis, 1987). It is suggested that the experience of shame may impact on a person's ability to develop relationships with others, due to this fear of undesirability (Mollon, 2002). It is hypothesised that the mechanisms of shame such as beliefs and coping mechanisms, may impact the development of the therapeutic relationship. Given that the therapeutic alliance is considered to be one of the most important predictors of therapeutic outcomes (Howard, Berry & Haddock, 2022), this barrier imposed due to shame proneness has potentially concerning implications for PTSD treatment outcome. Despite this, few studies have explored the impact of shame on the therapeutic alliance (Martin, Garske & Davis, 2000).

Shame and Disclosure

Studies of non-disclosure within wider frames of psychological support have noted that themes relating to personal trauma, violence, and abuse are often not disclosed (Larson & Chastain, 1990; Norton, Feldman & Tafoya, 1974; Weiner & Shuman, 1984). Non-disclosure in therapy has been attributed to conscious inhibition to avoid confronting certain cognitions or emotions such as embarrassment or shame due to fear of judgement or negative evaluation from others (Hill, Thompson, Cogar & Denman, 1993; Kelly, 1998). Negative social reactions upon disclosure are known to increase levels of self-blame and shame, and impact disclosures and subsequent help-seeking behaviours (Ullman, 2000). Given the tendency of shame to evoke avoidance and withdrawal behaviours, shame and shame-inducing topics can be difficult to discuss in therapy, and can therefore interfere with therapeutic outcomes (Lewis, 1971; Tangney & Dearing, 2002). Nevertheless, few studies have explored rates of non-disclosure in therapy with reference to shame alongside other complex emotions or other significant therapy information. In a study by Macdonald and Morley (2001), 68% of recorded emotions in a diary, including shame, were not disclosed to the therapist, with 74% of participants referencing feeling of shame to be a primary feature in non-disclosure. This disposition to shame-proneness was identified as contributing to non-disclosure due to shame's inherent pattern for hiding oneself and imperfections (Tangney, Miller, Flicker & Barlow, 1996; Wicker, Payne & Morgan, 1983). However, few studies have explored shame responses or disclosures about shame-inducing events in the therapy room (Tangney & Dearing, 2011), particularly from the perspective of the client.

Literature has noted that culture and gender are two primary forms of one's identity that have been linked to levels of disclosure within therapeutic contexts (Gilligan & Akhtar, 2006; Montalvo-Liendo, 2009). However, culture and identity, to this author's knowledge, have been relatively neglected within research on non-disclosure in trauma therapy, both relating to the clients and the therapists, and where similarities and differences arise within the therapeutic dyad or triad, when working with interpreters.

Digital Therapy

Internet-delivered interventions including guided self-help, self-directed, and therapist-delivered therapy have been documented in the literature to be an efficacious treatment for PTSD, whilst also having a positive impact on accessibility issues (Sijbrandij, Kunovski & Cuijpers, 2016). Despite this, it remained a relatively novel trauma treatment delivery method until the worldwide transition to digital delivery of therapeutic care during the COVID-19 pandemic. Ioane, Knibbs and Tudor (2021) cited concerns about digital delivery of trauma-focused therapy, including the emotional safety of clients (particularly in discussing emotionally salient experiences regarding their trauma), and managing dissociation and risk, which may also explain the prior lag in the development and delivery of internet-based treatment for PTSD in comparison to other mental health disorders (Lewis, Pearce & Bisson, 2012). Ioane, Knibbs and Tudor (2021) also referenced concerns of security and therapist skill in offering internet therapies. Inequalities in digital inclusion and access to confidential space for therapy sessions were also raised as potential issues to this treatment method (Ioane, Knibbs & Tudor, 2021).

However, since the COVID-19 pandemic, further studies outlining the digital adaptability of CBT, EMDR, and NET have addressed these concerns (Kaltenbach et al., 2021; McGowan, Fisher, Havens & Proudlock, 2021; Wells et al., 2020; Wild et al., 2020). This, alongside practice-based evidence, further supported this transition, and these are now considered part of the therapy pathways and patient choice, as recommended by NICE guidelines (NICE, 2018).

To date, few studies have explored shame responses or disclosures about shame-inducing events in the therapy room (Tangney & Dearing, 2011), particularly from the perspective of the client. More specifically, the experience and expression of shame within the virtual therapy room is yet to be explored, particularly from the perspective of the client. Given the transition to remote delivery of trauma-focused therapy, it is pertinent to explore the experiences of clients of receiving trauma therapy remotely. More importantly, the development of the therapeutic relationship and the disclosures of shame-based emotions.

Aims of Current Study

As a result of the limitations in the existing literature, this study therefore aims to better understand the impact that digital therapy delivery may have on the client's experience of treatment for PTSD; specifically, how clients in trauma-focused therapy navigate and experience making disclosures that may be related to feelings of shame. Having a greater understanding of experiences that facilitate disclosures of shame in remote therapy, can hopefully improve online adaptations of trauma-focused treatment and overall improve therapy outcomes for trauma services and individuals seeking therapy. Given the lack of previous research in these areas, this study adopted an exploratory approach through qualitative methods guided by the following research questions.

For PTSD and CPTSD clients undergoing trauma-focused therapy and therapists facilitating remote trauma therapy:

1. What are the experiences of shame and disclosing shame, shame related feelings and shame inducing events in virtually delivered trauma focused therapy?
2. What are therapists' experiences of discussing shame, shame related feelings and shame inducing events in virtually delivered trauma focused therapy?

3. What factors impact ability to make disclosures related to shame within the context of a virtual therapeutic relationship?

Methodology

Procedure

The study recruited treatment-seeking clients, as well as clinicians from services offering internet-delivered trauma therapy. Eligibility criteria can be seen in Table 1 below.

Table 1

Inclusion and exclusion criteria for study participants

Treatment seeking sample	
Inclusion criteria	**Exclusion criteria**
● Aged 18+ years	● Non-English-speaking clients (due to funding reasons)
● Have a primary confirmed ICD-11 diagnosis of PTSD or CPTSD	● Unable to consent to the study under the Mental Capacity Act (MCA)
● Nearing completion or recently completed individual remotely delivered or hybrid trauma-focused therapy	● Participants who presented with suicidal ideation or high risk within the past 3 months or whom were at risk of destabilisation
	● Group therapy clients
Clinicians	
Inclusion criteria	
● HCPC qualified clinicians	
● Experience in delivering remote trauma therapy	

Participants were recruited through two primary mental health sites across a London NHS Trust offering remote trauma therapy. The researcher (author) presented the study at participating sites’ team meetings and sent additional information via email. Clinicians were briefed on the study and encouraged to discuss and share study material (poster and participant information sheet, with their current and recently discharged clients who meet the eligibility criteria). When consent had been provided, potential participants were contacted by the researcher, interviews were arranged, and detailed study consent obtained. Clinicians were contacted via email and invited to self-refer to the study. Study documents can be found in Appendices A – I.

In accordance with predominant literature in the field, this study sought to recruit a sample of 10-15 participants, although the researchers aimed for recruitment to be informed by data saturation (Rahimi & Khatooni, 2024). A total of ten clients were referred to the study by their therapist and contacted by the researcher about taking part in the study. Two declined to respond to invitation emails by the researcher and three declined to take part. Eight therapists were invited to take part via email invitation. Three therapists did not meet inclusion criteria (delivering remote therapy) and one therapist became unwell and was no longer able to take part in the study within the required timeframe. Interviews were arranged on Microsoft Teams. The final sample consisted of five clients and four therapists, who were interviewed between December 2023 and June 2024.

Prior to the commencement of the interview, the study information was reviewed, opportunities were provided to ask questions, and written consent was obtained. Participants were reminded of the opportunity to withdraw from the study at any time. Participants then took part in a semi-structured interview that lasted approximately one hour and were audio and video recorded as default on Microsoft Teams (interviews are described further below). Participants were reminded of their choice to turn their camera on/off for the duration. Participants were briefed at the end of the study to ensure they were not impacted by any emotionally salient information discussed. They were emailed a debrief sheet with additional service information should this be required. Participants were compensated with a voucher for their time and expertise. Interviews were transcribed, anonymising all identifying information, and recordings were then destroyed.

Semi-Structured Interview

Two semi-structured interview schedules were developed iteratively, for clients and clinicians. The interview was guided by the literature on trauma and shame-based emotions. Interview schedules were created in collaboration with research supervisors and experts by experience through a process of refining and reviewing. The final interview schedules (see appendices F and G) aimed to explore the experiences of trauma therapy more broadly, developing a therapeutic relationship in remote therapy and experiences of shame-based emotions and disclosures in therapy. The interview schedules were designed to be used flexibly, guided by participants sharing of experiences as opposed to being limited to certain questions. This aimed to allow space for nuance in conversation and for experience to be shared as per the literature (Smith, Flowers & Larkin, 2009).

Prior to starting the interview, a risk management plan was created with all participants. Client participants were provided with time to ensure their grounding tools used as part of their trauma recovery. Grounding tools are used in trauma treatment to support stabilisation when discussing traumatic memories. Though the interviews were not directly asking about the traumatic events experienced, grounding tools were advised as a precautionary measure. In addition, an alternative method of contact was agreed should the researcher become concerned about risk of the client e.g. emotional dysregulation and/or dissociation. This also served as a technological failure plan across participants. Therapists at participating sites were briefed on the time and date of their client's interview. Clients were aware that their therapists will be informed should concerns of risk arise during the interview and service risk procedures will be followed. Permission seeking to continue the interview was used at the discretion of the researcher when emotive statements had been made. Post interview, each participant was provided with a debrief which involved exploring emotional wellbeing and service information was provided on where to access additional mental health support if required.

Demographic Information

Descriptive information for clients and clinicians are shown in table 2 below combined, to preserve confidentiality. Both clients and clinicians were aged between 25 and 51 years. All but one participant were cisgender females. 60% of clients were of a non-westernised majority ethnicity, while 100% of clinicians were of a white background British/European/Irish.

Table 2

Demographic information about client and clinician participants

Participant	**Age Range (mean)**	**Ethnicity: *n* (%)**	**Gender: *n* (%)**
Total *N* = 9 Clients *N* = 5 Clinicians *N* = 4	25-51 (38)	Mixed Asian: 1 (11.11%) White European: 2 (22.22%) Black African: 1 (11.11%) North African: 1 (11.11%) Mixed African: 1 (11.11%)	Cisgender Female: 8 (%) Cisgender Male: 1 (%)

		White Irish: 1 (11.11%) White British: 2 (22.22%)	

Clinical information for clients and clinicians is presented below. All clients received remote therapy only with regards to this study, whereas therapists spoke of their experience of blended therapy, both in person and remote. One client had experience of engaging with previous remote therapy, prior to lockdown procedures of COVID-19, whereas all clinicians reported that they were new to delivering trauma therapy remotely prior to this period.

Descriptive Clinical Information

Table 3

Descriptive clinical information (Clients)

Therapy Modality Received/Offered	**Length of Therapy**	**Delivery Method**	**Prior experience of receiving therapy**	**Type of Service**
EMDR only (2) Integrated trauma therapy (3)	< 20 sessions 2 < 12 months 1 1- 2 years 2	Remote only: 5 (100%)	In person: 3 (60%) In person and remote: 1 (20%) None: 1 (20%)	Trauma Service: 3 (60%) Adult Mental Health Service: 2 (40%)

Table 4

Descriptive clinical information (Therapists)

Therapy Modality Received/Offered	Length of Therapy	Delivery Method	Prior experience of delivering therapy	Type of Service
EMDR: 4 TFCBT: 4 NET: 4 CFT: 4 ACT: 4	30 sessions: 3 60 sessions: 1	Remote only: 4 (100%)	In person: 4 (100%) Remote: 0 (0%)	Trauma Service: 4 (100%)

Ethical Considerations

This study received the required National Health Service (NHS), Health Registered Authority (HRA), and Research Ethics Committee (REC) ethical approval from Stanmore Research and Ethics Committee (reference 23/LO/0481; Appendix A). Participants provided verbal and written informed consent before taking part in the interviews and were reminded they could withdraw from the study, even during the interview, and that it would not affect their therapeutic care. Participants were given the opportunity to seek grounding tools at the start of the interview and reminded that the research does not require any discussion regarding the traumatic experiences to be discussed. Following this, approval was sought at participating sites and Research and Development departments for conduction of the study.

Quality and Validity

In accordance with literature and guidance, validity checks were employed to ensure research rigour (Elliott, Slatick & Urman, 2001). The researcher engaged in a bracketing interview at the start of the research process in order to ensure the role of researcher had been assumed. This also allowed for the consideration of the researcher’s own position and assumptions and how these may be influencing the research process. The process of reflection was engaged throughout the course of the study with the aid of a research journal. Pertinent reflections are shared below and further expanded upon in the critical appraisal. There were no significant changes made to the interview schedule and therefore this interview was included in the final analysis.

With regard to analysis, codes and themes were discussed with research supervisors throughout the analysis process in order to refine and construct the final themes, holding in mind issues of bias, inconsistencies, and overlaps.

Analysis

The transcription of the interviews was conducted by the primary researcher, verbatim. All identifying information was removed at this point. Interview transcripts were analysed using thematic analysis. Thematic analysis aims to identify patterns and themes within the data (Braun & Clarke, 2006) and allows for an exploration into the differences and similarities within described experiences (Elliott, Slatick & Urman, 2001; Levitt, 2015).

Method of analysis followed Braun and Clarke’s (2006; 2013) six step methodology: familiarisation with the data involving continual re-reading of transcripts and making initial notes and observations; systematic coding of both semantic and latent content relative to the research question through identifying patterns within the data; searching for themes, a process of clustering codes; reviewing and organising themes by checking if they “fit” against the codes and dataset and removing overlapping patterns; defining and naming themes, detailing summaries and definitions; writing of the analysis and results, interweaving data extracts and critical narratives.

Transcripts were coded iteratively as transcription was taking place. Analysis followed the Galloway and Pistrang (2019) guidance. Due to recruitment schedule, the client transcripts were coded first and clinicians' second. To prioritise the voice of the client, the themes and codes generated from the clients' accounts were then used as a thematic framework to guide the analysis of the clinician accounts. A final theme structure was developed incorporating themes across both clients' and clinician accounts, exploring both differences and similarities of experiences. Themes both centralised individual experiences as well as frequency of occurrence.

Reflexivity Statement

I am aware of my own identity, as a white Irish able-bodied female, and how this may impact the lens in which I approach this research, as the author and primary researcher of this study. I am acutely aware of how my identities align with Western privileged ideas that influence both therapy and research, within the contexts of which this research is being conducted. Racial disparities within treatment, cultural understanding of mental health, and trauma were given considerable thought by the researcher.

I am also aware of the differences and similarities of identity I share with the participants, and how this would have impacted what experiences are shared and unshared in the interview process. My experiences growing up in a rural Irish Catholic community, where shame and guilt permeate across social spaces and where mental health experiences are not disclosed or widely recognised, gave me insight into some of the social contexts that may be impacting the shame-based experiences of participants. However, I am mindful that these experiences were contextualised within a Westernised white privilege lens, which is different from that of the participants who took part. This difference in power and privilege will have likely impacted the discussions on, and reflective analysis of, wider cultural contexts and experiences of shame. This is further explored within Part III, the critical reflection.

My experience as a trainee clinical psychologist, working in a trauma service at the time of conducting the interviews, may have both enhanced and limited the approach I took as researcher. Having these dual roles and developing a greater awareness of how trauma presents, would have both impacted my questioning style, verbal and non-verbal communication. This position may also affect the lens in which I approach the analysis and reflections with.

The researcher adopted a critical realist epistemological position. While the research demonstrated awareness of the process of digital trauma therapies that may exist ontologically, it was recognised that these cannot be viewed and explored independently from the experiences and perceptions of participants. A critical realist approach was identified to be the most suitable epistemological position due to the centrality of personal meaning-making within therapy. A more in-depth exploration and reflection of the position of the therapist is detailed in Part III of this thesis.

Results

The results of the thematic analysis generated three superordinate themes, comprising a total of nine subthemes, with both client and therapist experiences represented throughout, see Table 5 below. These relate to the complexities of shame, competence in working with shame therapeutically, and the reorganisation of the therapeutic room in remote therapy practice. Themes represent experiences shared individually and collectively, as the researcher valued both nuance and shared experiences in equal measure. Themes below were generated from client experiences of discussing their current or most recent virtual therapy experience as part of this study (see table 3 above). Therapists reflected on experiences of delivering both remote and in person therapy and distinctions were drawn where relevant for their experiences. Illustrative codes for all themes can be seen in Appendix I. For more details on theme development, see Appendix I. To maintain anonymity, all participants have been provided with a pseudonym. Client participants are denoted with C followed by a number and therapist participants are denoted with T followed by a number.

Importantly, a key overall finding with regard to the aims of this study was that clients shared experiencing little difference between discussing shame and associated feelings in virtual therapy in comparison to in-person previous experiences. This is discussed below with regard to themes and research and clinical implications of this research.

Table 5

Structure of superordinate and subthemes for all participants

Superordinate theme	**Subtheme**	**Count**
1. Complexity of shame	1.1 The shame identity 1.2 Secrecy and silencing 1. 3 Shame liberation	C:5, T:4 C:3, T:2 C:4, T:4
2. Shame-sensitive practice	2.1 Healing from previous negative Care Experiences 2.2 Building a trusting alliance	C:3, T:0 C:4, T:4 C:3, T,3

	2.3 Bridging the cultural barrier gap	
3. Rethinking the "therapy room"	3.1 Breaking physical barriers to care 3.2 Therapeutic safeness 3.3 Renegotiating the therapeutic space	C:5, T:4 C:5, T:4 C:5, T:4

Superordinate Theme 1: Complexity of Shame

Prior to addressing the theme aims, it was imperative to develop an understanding of shame amongst the participant experiences. The first superordinate theme relates to the complexity of shame and was a core topic of discussion across client and therapist participants. Conversations centred on how shame manifests in the context of trauma, the powerful impact of shame on creating a narrative of silencing, and the transition of shame once addressed within therapy.

1.1 The Shame Identity

Shame was described by clients and therapists alike to be all-encompassing. Moving beyond the emotion, shame was described to be experienced both physically and cognitively, forming one's core internalised identity; "It's almost like a whole embodiment…shame as a thought, shame as a feeling, shame as a sensation" (T1). It was identified to be entrenched in a person's "core belief" (C3) and was described by one client to have formed their sense of self as a result of childhood abuse: "the shame that I experienced growing up was a part of me before I knew it was due to the trauma" (C1). Two clients discussed the weight of carrying around shame and the impact this had on their lives, noting the physical impacts shame can have on the body, reporting sleep issues, stomach problems, and high blood pressure. Notably across participants, was the recognition of the longevity of shame, “it’s at the root of everything” (C2).

Both clients and therapists identified that the associated feelings of disgust, guilt and anger formed part of shame’s complexity. Clients shared how their shame “was connected with really strong emotions like guilt…and disgust at myself because I feel responsible for what happened to me” (C3). Therapists also discussed how clients would discuss feelings of guilt, often when trauma occurs within the family context, such as following disclosures of childhood sexual abuse or following traumatic bereavements. Therapists also described how “expressed anger can be shame-based” (T3). They noted how this anger would often be misunderstood by services and that “a lot of what we do is advocate for people as well” (T3). When asked directly, therapists did not differentiate in experiences between virtual and in person therapy in relation to identifying or working with shame’s associated feelings in therapy.

Rather than developing as a response to experiences or perceptions of being negatively viewed by others, shame was identified to be an internalised experience. “Most clients will say ‘I’m not overly worried about you judging me, I just feel so bad…it’s mortifying, it's humiliating…like they have internalised that inner judge” (T1). Neither participant group spoke about fear of judgement from the therapist, but rather “self-shame and self-disgust” (C3), impacting levels of disclosure within therapy. Most participants, across groups, spoke of how their shame felt visible to others, almost like a cloak that makes it obvious to others that they have experienced trauma, “their body looks like the body that bad things happen to, that their face looks bad or dirty” (C1).

Intersectionalities of gender, culture, and sexuality were discussed as pertinent to the experience of shame, contributing to the person holding a fundamental identity of themselves as a ‘shamed’ person. Two clients spoke about how the racialised experience perpetuates the manifestation of shame, while one client identified the complexity of when sexualised trauma occurred within a racialised context and how this manifested in an intricate shame, racial, and trauma identity. “If someone racialises me differently, it is very jarring…maybe if I didn’t experience sexual abuse at the hands of my father, maybe I would feel differently about being associated with [cultural] things” (C1). Three clients spoke about non-Westernised views on gender and sexuality and how they impacted on the development of shame in relation to their trauma experience, in terms of appraisals of the traumatic event; “I come from a culture where the woman has the fault for things that happen…to tell a GP that I have been raped it is a shame, to divorce is a shame” (C2).

Theme 1.2 Secrecy and Silencing

Three of the clients spoke about the impact of shame, on creating a culture of secrecy and silencing throughout the contexts of their lives including family and community, while also impacting help-seeking behaviours. Clients identified how their experience of shame inhibited disclosures of childhood sexual abuse to their family, silencing which often continued until adulthood. This felt sense of secrecy was compounded by cultural factors such as views on sexuality, that impacted disclosures of childhood sexual abuse, particularly towards males. The intersection of gender and sexuality on secrecy and silencing in relation to trauma were recognised by therapists as factors that inhibit disclosure.

In relation to discussing the trauma itself, shame was described to create a barrier to care-seeking, “shame creates…a big barrier inside you, it doesn’t let you talk…I pretended I forgot because I wanted to hide it deep, so deep” (C2). Another client identified how seeking help felt “shameful” and “weak” (C3), especially when they have witnessed family members “suffer in silence” (C3) in reference to their own trauma experiences. Another client identified how shame perpetuates fear and anxieties with everyday behaviours: “Having a fear and then you can’t, you can’t do it” (C5). Continued validation, demonstration of acceptance, and statements of “this is not your fault..this should never have happened to you” (T2), was recognised by therapists to reduce silence. These experiences of shame as silencing were irrespective of virtual or in person therapeutic approaches to treatment with mode of delivery not see to impact levels of secrecy.

Theme 1.3 Shame Liberation

Recognising the impact shame had on the maintenance of their PTSD, all clients discussed the therapeutic benefit of addressing shame in their current remote therapy, while therapists described the journey of supporting clients to challenge these internalised shame identities during their remote trauma interventions. One client identified their journey to involve shifting the blame and guilt from an internalised experience to instead being ‘owned’ by the perpetrator of the harm; “I think people that have hurt me, they should feel ashamed from what they have done” (C2). This shift was echoed by a therapist who identified how “shame is really entrenched but it can also shift as well, because shame is all about being inside and the minute it comes outside, you can start to explore it” (T3). Several clients went on to share how their belief systems have changed and moved into acceptance, “I’ve cured myself, I'm not ashamed anymore to talk to anyone…the most important thing is, I know it's not my fault…I now see the world with other eyes" (C2). Another client spoke about the importance of learning for oneself, which as echoed by a number of therapists, is that reassurance does not help to shift shame; "I think it's not because my therapist told me, I think I learnt for myself…it's about telling yourself" (C4). Though some clients identified still being on their journey to liberation from their feelings of shame, one client described that post-therapy, she was able to reconnect with her sense of self, prior to experiencing trauma. This was described by the client to be 'identity healing' and had materialised as a result of shame work in therapy. Working with shame through remote therapy was identified by therapists to be similar to in-person therapy with regards to the techniques used, integrating compassion focused therapy into a primary trauma treatment. However, therapists did acknowledge that they found themselves being more attentive to silences and eye contact from the client, without the ability to "read the room" (T2) as they might find easier to do within in-person sessions. Therapists reported that supporting clients to notice and disclose feelings of shame, required more overt observation and acknowledgement from therapists; "sometimes they volunteer and other times it will show itself and you need to comment on it" (T2).

Superordinate Theme 2: Shame-Sensitive Practice

Clients discussed prior negative experiences across systems of care, which they attributed to the lack of skills and expertise in working with trauma in non-specialist services. All participants spoke of the importance of building a trusting alliance, acknowledging past negative experiences of therapy, and active consideration of how the remote nature of therapy might interplay with this. Finally, discussions were held on the importance of cultural humility in practice, attending to similarities and differences between the clients and therapists. This was seen as important regardless of mode of therapy delivery.

Theme 2.1 Healing From Previous Negative Care Experiences

Within this theme, clients discussed their previous negative experiences of care-seeking and the impact this had on their sense of self and their trust in, and relationship to, healthcare providers. Conversations then explored the positive impact of being supported by trauma-sensitive therapists.

The three clients who were recruited from a specialist trauma service, spoke of starting from a position of “no trust” (C2), with their current care due to negative experiences along their journey to care. One client spoke of being mislabelled and misunderstood, leading to lengthy journeys to receiving appropriate therapeutic care. They described how they had navigated services for more than a decade and had been given multiple diagnoses (including personality disorder diagnoses) before their experiences were understood from a complex trauma lens. This client described the experience of therapists “finally speaking the same language” (C2) as them when they received care from a specialist trauma service, and the positive impact of being heard and understood.

The intersectionality of gender and diagnosis was represented in clients’ journeys of misdiagnosis and reported a “lack of compassion and understanding towards women who have experienced sexual trauma” (C3). Clients spoke of feeling invalidated by their past therapists: “I have definitely had experiences in past therapy that the therapist has just kind of wanted [therapy] to be over” (C1). Clients reported feeling blamed by the therapist for their traumatic experiences, when they were told by a previous therapist: “it’s like you wear a stamp on your forehead that says abuse me” (C3). This created a deep mistrust of adult mental health services in general, that all participants reported replicated experiences of harm as part of their index traumas. One client who was recruited from primary care services reflected on the gatekeeping experience of being referred for therapeutic support and being strongly encouraged towards medication by their general practitioner as the first option for treatment, “it’s almost like what’s convenient for them” (C4).

Clients reported sometimes feeling that their previous therapists were not invested in their care beyond the realms of this being their occupation. As a result of this, within their current care, clients tentatively assessed whether they felt therapists’ genuineness in their care by offering information and waiting to see if the therapist follows up on this in subsequent sessions: “I was trying to suss her out to see if she was listening…is she just here to do a job and go home, or does she really care about you know, what she’s doing” (C3).

Furthermore, a lack of expertise in trauma care outside of specialist services was raised as particularly harmful. Clients identified the “burden” of disclosure of trauma and noticed how therapists “would sort of skirt around the issue of trauma” (C1). Clients felt they “were speaking a language that no one else knew” (C1), which created a negative relationship to help-seeking.

In other instances, they felt they were encouraged to open difficult and painful memories without the therapist possessing the necessary therapeutic skills to support them: “I would open up about trauma and they were not trained…I would dissociate in session, and they didn’t even know what dissociation was” (C1). They described how they also experienced a dissociative fall post session and experienced long-term health consequences.

The recognition of therapists possessing specialist expertise in trauma care was noted as key to supporting clients to build trust following past negative experiences of therapy. In discussing their current therapy experiences, clients spoke of how therapists helped them to put their experiences into words such as: “dissociation and hypervigilance that regular therapists were not aware of, for the lack of a better term, uhm, didn’t have a better understanding of” (C1). The “recognition and naming of shame” (C3) by the therapist, was seen as central to trauma care, removing the burden from clients. This facilitated disclosures, both when therapy was delivered in-person and remotely.

Theme 2.2 Building a Trusting Alliance

Establishment of a trusting alliance with the therapist was noted as the most paramount in relation to their trauma care, irrespective of mode of delivery, impacting levels of engagement and disclosure. Discussions centred both on therapists’ approach and knowledge of trauma care in facilitating a trusting alliance rather than delivery method of therapy. Being seen “through a compassionate lens” (C4) was recognised across participants, as being at the core of a trusting relationship. The life changing nature of being “heard and understood” (C1), though seemingly preliminary in therapist skills, had been deficient in prior experiences. Building an understanding of the person outside of their trauma was recognised as showing genuine care for the clients; “she was not just finishing her job and bye bye…she wanted to know more about my life, my family, my son, my past.” (C2). Therapists noticed the importance of building more time to connect in remote therapy in having “small talk” (T1) at the beginning and end of sessions as a way to build a strong therapeutic alliance. Mentioned by all participants, was the need for time and a slow-paced approach to therapy, in order to establish a sense of safety and trust, particularly in light of prior negative experiences within care. Therapist skills in working flexibly with models in an integrated approach was welcomed in allowing the client more autonomy on their care and supported with appropriate pacing. Therapists stressed the importance of transparency around the expectations of trauma care in building open and honest communication with their clients, which they believed supported clients to engage in ongoing and active consent to treatment, which is important for survivors of trauma who had previously experienced violations of their consent and/or bodily autonomy.

For some clients and therapists, having first built a relationship through some initial in-person appointments made the transition to remote therapy easier, with thoughts that building a relationship remotely from the beginning would have been more difficult. However, others noted that building a relationship electronically felt “normal” and was “how we communicate with others” (C4).

In building a trusting alliance remotely and to promote discussions of shame-based emotions, therapists noted exaggerating their expressions, “what I found myself doing online was...trying to say more an expression of empathy or compassion…and what I might try to convey nonverbally… So I was a bit more interfering, commenting on my own emotional response to what they’re saying” (T2). Therapists would emphasise their facial expressions, use of head movements, and vocalisations in remote therapy to convey compassion and empathy. They described feeling responsible in building trust “through the face so much more” and “being limited by body positioning” (T3). Due to fears of the lack of the “felt sense of the person in the room” (T2), therapists recognised how they would disclose their own emotional response to what the client discussed. For example, they would say “I’m really sorry this happened to you, I feel how this is making me upset for you" (T3). Therapists found that these disclosures of the emotional impact they experienced helped to build alliance in remote therapy.

More specifically, in working with shame remotely, therapists noted similar techniques in establishing safety in the therapeutic space for disclosures. However, they recognised being more hypervigilant of silence and eye contact, due to concerns of the risk of dissociation. A small number of clients noted their concerns about the therapist missing cues of being upset or dissociating in session when engaging in remote therapy, however, these fears ultimately did not materialise, and clients reported that therapists were able to notice dysregulation and dissociation and support with grounding remotely. Two clients shared concerns about self-reliance on grounding tools more than when in in-person therapy, "I would have to depend on the grounding tools that I've learned to kind of manage myself" (C3).

Theme 2.3 Bridging the Cultural Gap

The lack of cultural representation of diverse cultural backgrounds amongst therapy teams, particularly in regard to dual or mixed heritage backgrounds, was noted by client participants in their experiences of remote trauma therapy. Clients described potential benefits of having a therapist from the same cultural background as them, as it might create a sense of safety or help them feel that the therapist may better understand their experience. However, another client identified that having a therapist from the same cultural background did not equate to an understanding of experience noting how each person's experience is individualised to their own multifaceted contexts. Therapist cultural humility: an openness, self-reflection, and commitment to continued learning, was identified to be important in creating an environment where shame can be disclosed both within the virtual space and in previous experiences of in person care. This is important when both differences and similarities exist between client and therapist; “she doesn’t get it and that’s not her fault…she’s never experienced it, but she can be super compassionate and listen and feel terrible” (C1). Therapist disclosures of their experience in working cross-culturally was reported to help build safety in the therapeutic relationship, particularly when there was a lack of shared cultural or racial experience between them. There was an understanding that they “wouldn’t get it” (C3) if they haven’t experienced racism themselves, however the therapist would better understand their experience through a cultural lens, once they knew they had worked with similar communities. This also removed a “burden” (C3) of explaining about individual contexts relating to cultural experience to the therapist, “she’s done a lot of work with refugees and asylum seekers…so I think it made it easier for me not having to explain every single thing” (C3). Three therapists spoke of their experience of naming differences in the therapy room, in their attempts to bridge the cultural gap and build a culturally sensitive practice.

Superordinate Theme 3: Rethinking the “Therapy Room”

Remote therapy has necessarily impacted on what is meant by the concept of the “therapy room”. Increasing access and improving client choice were noted as positive opportunities arising from remote delivery of trauma therapy. This theme also encapsulates the understanding of therapeutic connection and how this is built remotely while navigating the impacts that are relative to remote delivery. The experience and building of therapeutic safeness remotely, is explored below from differing perspectives. Finally, this theme explores the renegotiation of the structures of the therapy room and maintaining therapeutic and professional boundaries in remote therapy.

Theme 3.1: Breaking the Physical Barriers to Care

Three clients reported that travelling into a therapy clinic would cause significant levels of anxiety due to increased levels of hypervigilance as a result of their trauma, fear of dissociation, and shame-inducing events along their journey. One client described the preoccupation of the journey which would lead to levels of avoidance and distraction in sessions; “you’re travelling to therapy, and I would be stressed from getting there and need to decompress…I would just be anxious…it does sort of impede on the process and then there’s the stress of leaving” (C4). Those who have experienced trauma, also often present with co-morbid health difficulties. Two clients discussed how remote therapy has improved their access to care that would have otherwise been inaccessible due to health concerns. Though they also noted concerns of trauma services transitioning back to in-person care; “the world has moved from Covid, but I haven’t, I still social distance and wear a mask” (C1). For others, they found remotely delivered services more flexible around work, university, and childcare, thus improving access. However, one client spoke of their “dislike of digitalisation” (C2) with regard to all technology, due to their preference for in-person connection. Therapists reported how remote therapy increased access to specialist services. The service was no longer bound by local geographical lines, expanding provision of services across the UK. Simultaneously, therapists also raised concerns that reliance on remote delivery of services might alienate people who do not have access to technology, and who are not English speakers. These experiences highlight the importance of client choice in delivery of treatment.

Some clients identified how occasional technical issues with sessions, though “awkward” (C5), was understood to be a caveat of remote therapy; “we were both patient and understood that you know, this is one of the downsides of having online therapy” (C5). Having a relationship first established in-person, helped to mitigate frustrations or concerns when such issues arose. Occasionally, internet issues were noticed to impact confidentiality in shared households. One client spoke about having to conduct therapy in shared living spaces. Although they tried to arrange this when there was no one else present, occasionally other household members would enter the space. This impacted how freely they were able to disclose certain information. Overall, technical issues appeared to be more of a concern for therapists than clients. Therapists were concerned about the impact of discussing emotionally salient information when there were internet disruptions in sessions and the impact this had in the therapeutic process. This was echoed by one client who struggled with “repeating what I said” (C5) when the connection was interrupted. Therapists also discussed the impact of internet connection issues on therapist caseload, “it adds to the day because you’d set this time aside and you still have the session because you spend all of that [session] trying to negotiate internet issues” (T3).

Despite these issues, the therapeutic relationship was noted to permeate the physical boundaries of the therapeutic room for most clients. Two clients spoke of how it felt like “the therapist was sitting on my couch” (C2). Some clients identified how remote therapy felt “more intimate” (C4), “it’s how we communicate with family and friends, it’s normal” (C4), since the pandemic of 2020. This sense of intimacy was echoed by some therapists while others found remote connection to be more distant.

Theme 3.2: Therapeutic Safeness

Moving beyond accessibility, remote therapy was experienced being emotionally safer than in-person therapy by most client participants. One client described it to be “more free, deeper, safer” (C3), while another discussed that they “didn’t feel embarrassed to be emotional” (C4) in session. Generally, clients recognised the safety of their own home to be comforting, allowing for vulnerability, calling it “a real blessing” (C1). For some, this was mitigated by having an in-person relationship with their therapist already, while others felt this safety having built the relationship entirely remotely. This sense of increased safety was noticed by therapists who would see clients “wrapped up in a blanket on the couch” (T4). They noted how their client was more open, noting the inhibition effects of remote therapy in disclosures and wondered if it was due to the “reduced intensity that eye contact in in-person therapy can have” (T4). The physical barrier of a laptop was also noted to provide a necessary barrier creating feelings of safety for disclosure. However, they recognised what establishes safety is different for each client and the importance of attending to individual differences in treatment planning.

Discussions of safety centred on management of dissociation remotely. Clients stated a preference for remote therapy when their symptoms included dissociation, reporting that being in the comfort of their own home felt safer; “I know I can just collapse on my bed, I don’t have to travel home, it’s so much safer for me” (C4). However, therapists raised considerable anxieties relating to management of dissociation remotely: “I was concerned what it would lead to…to them not being able to manage symptoms” (T1). The same therapist also raised concerns about the “risk of self-harm and suicide” (T1). Most therapists stated that they would not offer remote therapy as a treatment option to those who are at risk of dissociation, where avoidable. This was largely due to their own anxiety around managing dissociation remotely without the use of physical grounding tools and concerns over missed dissociation cues: “I’ll be checking in a bit more, sort of, if they’re going a bit quiet, I’d be much more vigilant about that” (T1), in remote therapy. This was exacerbated by the increased risk of avoidance in remote therapy, ending sessions early and not answering calls, which had occurred.

More generally, clinicians’ shared anxieties around the transition to remote working following the pandemic. Though having an evidence base, no therapists had offered remote therapy routinely before. In addition to the above, therapists were concerned about missed nonverbal cues, increased levels of avoidance and suitability, and effectiveness of remote therapy. However, some therapists reported now having an increased sense of confidence in delivering remote therapy and valued this approach. Predominantly, therapists stated their preference remains for in-person therapy and they have not continued to offer remote sessions unless necessary for the client’s access and engagement.

Theme 3.3: Renegotiating the Therapeutic Space

All participants shared views on rethinking the structures of the virtual therapy room. Clients shared differential opinions on the preparation and decompression time surrounding remote therapy. Some clients found the travel to and from therapy helpful in terms of processing, while others noted the lack of journey reduced their stress and anxiety. One client noticed how “In my own room I get distracted” (C5) and “with remote therapy I kind of put, like, less effort in” (C5). This concern over distraction was shared by several therapists who would ensure that emails and notifications were muted or signed out to avoid distractions.

The creation of therapeutic boundaries was raised as important caveats relating to the remote therapeutic space. Both clients and therapists discussed the impact of talking about trauma within their own home. Most therapists stated their preference for conducting remote therapy from their workplace due to concerns of delivering therapy from their personal space at home. For one clinician, there was a noted difference between conducting assessments and ongoing therapy remotely, the latter being more emotionally salient and impactful on the home space. Discussing child sexual abuse at home was challenging for both therapists and clients. One therapist stated that “I just don’t want to think about this in my home” (T1). This sense of “contamination” (T3) was shared across most therapists. For clients, the main concern was ensuring there was childcare. The sense of ‘contamination’ was less impactful for clients, as both they and therapists recognised how clients “live with trauma at home anyway” (T4). With regards to confidentiality, clients were concerned about “being overheard by neighbours” (C4), while therapists spoke of challenges ensuring clients have confidentiality.

Finally, some therapists wondered “how do you retain your professional boundaries without being too formal” (T1). Therapists noted how clients would understandably express increased curiosity about therapists’ personal lives during remote therapy. Attributing this either to the nature of the pandemic and a shared difficulty during the original transition to remote working, “seeing into each other’s home” (T1), or the lack of a structured clinic therapy space. Negotiating how clients prepare themselves and their environment for therapy, required more deliberation.

Therapists discussed the importance of preparedness for therapy, including dressing, while holding onto the importance of choice; “they’ve had their choices taken away…I don’t want to not treat you as an adult, and I also want you to get the most out of therapy” (T1). It was thought that autonomy over one's own shared therapeutic space “increases client control over their own care” (T2).

Discussion

This study aimed to explore the experiences of clients and therapists in disclosures relating to shame in online trauma therapy. Importantly, an overarching finding was there little felt difference between virtual and in-person therapy experiences in disclosing shame and associated emotions. The thematic analysis resulted in three overarching domains related to disclosure of shame in online therapy: the complexities of shame, shame-sensitive practice, and the rethinking of the “therapeutic room”, encompassing nine subthemes in total.

This study highlighted the multifaceted nature of shame as experienced by those who have experienced trauma. Participants reported that shame manifested as a core component of identity, particularly with regards to those who have experienced interpersonal trauma. It transcends emotional responses and is both cognitively and physically experienced. This aligns with existing literature, suggesting that shame is not merely an emotional state but a pervasive identity shaping entity (Herman, 2011). The enduring presence of shame was found to perpetuate personal and relational difficulties, unless therapeutically addressed. The ‘shame identity’ was recognised to be compounded with feelings of anger, guilt and disgust, in its complex presentation, entrenching further into someone’s identity. Shame was perceived as feeling visible to others, indicating the profound impact shame has on self-perception and the perceived judgement from others. Moreover, rather than concerns over external judgement, the complexity of shame resulted in self-shame and self-disgust (Gilbert & Irons, 2005). This internalised nature of shame is known to hinder disclosures in remote therapy, increasing the importance of establishing safety in the therapeutic relationship in supporting disclosures.

Intersections of identity such as gender, culture, and sexuality were highlighted as important factors to both understand and process shame. Clients' narratives explained how cultural contexts and experiences of racism in the community can amplify shame, particularly when sexual trauma intersects with racial identities (Walker, Hernandez, & Davey, 2012). This finding highlights the importance of services developing and delivering culturally sensitive therapeutic approaches that acknowledge and address the compounded nature of shame in minoritised populations (Sue, 2010). Shame's role in fostering a culture of secrecy and silencing was notably discussed amongst clients. This secrecy created a significant barrier to care-seeking, reinforcing the need for therapeutic environments that build a sense of safety to encourage openness. The influence of cultural and familial norms on care-seeking further highlighted the importance for therapeutic practice that is sensitive to, and valuing of, clients' background, identity, and social contexts (Crawford et al., 2016), in facilitating disclosures of shame.

The process of shame reduction through engaging with therapy was described as transformative by both clients and therapists. This process of shame liberation involved shifting blame from the self to the perpetrator, which was seen as a critical role in externalising shame and fostering acceptance of trauma, as noted in the literature (Herman, 2011). The experiences shared by both clients and therapists demonstrate how effective shame-based work can facilitate identity healing.

Therapists reported that the skills used in shame-based work were recognised to be similar both for in-person and remote trauma therapy. The key differences noted were more awareness and hypervigilance of silences and eye contact to be attuned to, when shame presents in the remote therapy space. This is an important finding due to the lack of research on working with shame remotely.

The facilitation of shame-sensitive practice was central to creating a space where clients felt able to make shame-related disclosures, with both clients and therapists reporting that they believed there was little difference in this approach between in-person and remote therapy. Clients' experiences of previous negative therapy experiences underline the importance of shame-sensitive practice in order for trauma survivors to feel effectively supported. The journey from misdiagnosis and misunderstanding, to receiving appropriate care that some clients experienced, highlights systemic issues within mental health services. The recognition of specialist expertise in trauma care with regards to healing, emphasised the need for increased training across care services, as noted in the literature (Sweeney, Filson, Kennedy, Collinson & Gillard, 2018). The establishment of a trusting therapeutic alliance was discussed by clients and therapists in effective trauma care. The importance of therapist compassion, understanding, and genuine care to facilitate engagement, and building a trusting foundation for disclosure about their traumatic experiences was paramount (Grey, House & Young, 2018). Cultural humility where cultural representation is lacking, supported the fostering of a trusting relationship, regardless of method of delivery. This finding aligns with the existing literature advocating for culturally competent care to address the unique experiences and needs of clients from diverse backgrounds and contexts (Sue, 2010).

More specific to the remote therapy context, was the experience of the "therapy room" and how this is reconsidered in remote therapy. The transition to remote therapy during the COVID-19 pandemic facilitated a rethinking of the traditional therapy room. Remote therapy was found to break physical barriers to care, increasing access to those with health concerns and logistical challenges and in reaching rural communities, as noted in previous literature (Morland et al., 2015).

Furthermore, the remote therapy room facilitated a deeper understanding about building connection. In contrast to anxieties shared in the literature (Song & Foster, 2022), remote therapy was described to be more intimate than in-person therapy due to a familiarity with how communication occurs between family and friendships. This was developed despite managing internet issues, which may indicate these are less of a concern than reported (Niemeyer et al., 2020).

Therapist anxieties in managing therapeutic safeness were similar to those referenced in the literature, namely in managing dissociation remotely (James, Schröder & De Boos, 2022). However, clients' experience of safeness within their own home is further evidence that high risk can be managed remotely (Kaltenbach et al., 2021). Therapist anxieties more generally stemmed from the nuance of remote therapy. It is important to consider the context of COVID-19 when exploring therapist anxieties, where remote therapy was a novice skill during a shared time of significant uncertainty (Lin, Stone, Heckman & Anderson, 2021). As services have largely transitioned back to in-person therapy with regard to trauma care, further studies would benefit from being conducted with therapists who routinely offer remote trauma therapy, to explore if similar anxieties remain. Finally, remote therapy involved a renegotiation of the boundaries and structures of the therapy room.

Therapist reflections on maintaining boundaries mirrored those found in James, Schröder and De Boos (2022).

Limitations

There are several limitations to the present study. Participant analysis was based on a small sample, though attempts were made to match sample sizes across clients and participants. The overall *N* remains small, and views shared may not be generalisable to that of others seeking or providing trauma care. In addition, the majority of clients were from specialist trauma services and may not be generalisable to wider primary and secondary care services. Furthermore, though themes were generated across client and therapist accounts, valuing both shared and individual experiences in equal weighting, all participants would have experienced aspects of trauma care very differently. Recruiting a larger sample would enable a more in-depth and nuanced exploration to such experiences.

Though there was some variety in cultural representation within the sample, diversity in cultural backgrounds and gender orientation is lacking, which further limits generalisability. Consequently, experiences shared, and subsequent themes generated were from a white Western lens. Experiences relevant to specific cultural backgrounds and gender identification, and the intersection of trauma and experiences, may have been inadvertently missed. Psychology research has been criticised for being conducted through a predominantly Westernised lens (Muthukrishna et al., 2020). In addition, the researchers’ identity as a white Irish woman may have impacted clients reflecting on levels of identity including culture, that relate to their nuanced experiences. More generally, psychology tends to be overrepresented by white females in the field (White, Xia & Edwards, 2020).

Therefore, future research should aim to recruit from a diverse sample in terms of gender and culture, to improve representation in research of non-dominant identities while also increasing generalisability. Research teams conducting interviews would also benefit from broader gender and cultural representation, in order to provide participant choice in who interviews them based on their own preferences.

Challenges with recruitment may have also influenced the results of this study. When recruitment began, there was a noticeable trend of a transition to in-person therapy in trauma care following relaxation of the restrictions on movement during the COVID-19 pandemic. Recruitment pools across both the specialised trauma service and adult mental health service were significantly limited due to this change and subsequent reduction of remote trauma therapy provision. Since the liberation on lockdown procedures, the specialist trauma service almost exclusively returned to in-person trauma intervention, unless where otherwise unsuitable for the client. This was reported to be mainly as a result of the aforementioned therapist preference for in-person working in managing trauma symptoms and concerns of risk management remotely. Similarly, within the primary care provision, although remote therapy is a primary method of treatment delivery across anxiety and mood presentations, therapists noted their preference for in-person working with PTSD presentations. Considering the positive experience of remote therapy noted within this study, further research would need to be conducted to explore if this is a national trend in mental health services, and the impact of this reduced method of delivery on client engagement and satisfaction with care.

In addition, recruiting clients to discuss shame-based experiences in relation to trauma is inherently challenging and may understandably make it difficult for people to agree to participate in such a study. As aforementioned, those who experience shame often have low levels of help-seeking behaviour (Ovesen, 2023). This study may have recruited a biased sample of clients who are more willing to seek care initially and who are also willing to discuss shame-based emotions. Further research could attempt to recruit from community outreach, online platforms and social media, public awareness campaigns, and through partnerships with other health professionals. A challenge remains in recruiting those whose shame experience may inhibit them from disclosing, and requires thoughtful and sensitive approaches to research. Researchers can emphasise the importance of building trust and maintenance of anonymity, provide a safe and comfortable environment for research, and recruit emphatic interviewers with an understanding of trauma and flexibility in data collection methods. Researchers can recruit experts by experience, to inform the research process and run pilot studies to refine recruitment procedures and materials to identify potential barriers before studies commence.

Furthermore, the researcher is aware of selection bias in that, experiences were explored of those who consented to remote therapy, while that of those who declined to engage with remote therapy were not explored. Future research would benefit from a comparative analysis exploring experiences of disclosures in therapy from those who opted for in-person therapy, compared to those who engaged in remote therapy.

Finally, the influence of the researcher likely impacted the research in a multitude of other ways. It is important to note that the researcher entered into formal clinical psychology training during the pandemic, with remote therapy part of formal training as a therapist, unlike the therapists who participated. Additionally, the researcher was on placement in a specialist trauma service at the time of recruitment and received specific training in trauma care. This may have impacted their approach to the interview with regard to both style and questions asked. However, this likely improved the understanding of experiences, which may have supplemented rather than limited the research. Nevertheless, codes were not made within an epistemological vacuum and the researcher’s lens would have been influenced by pre-existing knowledge in trauma theory and literature, likely impacting the codes and labels created and overall view of the data. This is reflected further in the critical appraisal.

Clinical Implications

This study is an exploration into client and therapist accounts of disclosures of shame in remote therapy practice. Even with referenced limitations above, this research provides a comprehensive insight into the intricacies of shame-based disclosures in remote therapy, as well as implications into clinical practice. The design of this research captures the everyday reality of experiences within receiving and providing care in NHS settings.

These findings suggest that shame and related emotions and experience, remain a complex entity that warrants further exploration. Shame is an intricate, multifaceted and nuanced experience that requires significant training and expertise on the part of the therapist in order to address it effectively, both remotely and in-person. Considering that the transition to remote therapy was novel for most mental health services at the time of the COVID-19 pandemic, formal training opportunities in digital trauma therapy should be developed and provided to all mental health services. Further research should be conducted to explore the impact of this on client and therapist experience. This research echoes a core finding of the rapid review conducted by Ekeleme et al. (2024) on virtual healthcare, that there is a need for high-quality training and guidance on remote therapy which can be used to influence policy.

More generally, this research highlighted a lack of awareness and expertise in trauma presentations and treatment in non-specialised services. Adult mental health services would benefit from ongoing specialised trauma training, to ensure effective care in engaging trauma survivors and signposting to appropriate care pathways. Additionally, adult mental health services would benefit from additional training and support in working with shame within trauma care. Dolezal and Gibson (2022) discuss the importance of mental health organisations fostering shame-sensitive practice. Moving beyond trauma-informed care, the authors outlined the importance of acknowledging shame both individually and systemically, addressing shame, supporting shame resilience, and fostering conditions for shame-sensitive practice.

This research also highlighted the importance of diversity of identity represented within therapists and the importance of cultural humility in practice. These findings are similar to those in the existing literature in noticing past trends of white predominance in and recommendations for increasing diversity in psychological fields (Roberts, Bareket-Shavit, Dollins, Goldie & Mortenson, 2020).

Findings also suggest that though there have been trends in returning to in-person therapy with regards to trauma care, services should continue to provide multiple methods of delivery, where patient choice is centralised as recommended by NICE guidelines (NICE, 2018). Insights from clients suggest that concerns of dissociation or avoidance in remote therapy should not exclude remote therapy as a treatment delivery option for them. Kaltenbach et al. (2021) made several recommendations for managing high risk of dissociation remotely. For example, they recommend the use of therapist assistants, a person who the client trusts that is nearby and can be contacted in suspected or actual dissociation. However, considering the differential view of managing risk in remote therapy for clients and therapists, further research is warranted in the management of risk such as dissociation in digital therapy. Furthermore, individualised formulation should move beyond realms of presentation and include mode of delivery where discussions on the benefits and challenges of delivery methods should be conversed in therapy. Finally, future research may explore experiences of clients who have had blended therapy to explore felt differences and similarities in a more comparative manner in order to continually improve internet-delivered trauma care.

Conclusion

This study aimed to explore the experiences of clients and therapists in disclosures of shame-related traumatic events in online trauma therapy. The findings highlight the multifaceted nature of shame and its deep entrenchment in personal identity, particularly for those who have endured interpersonal trauma. Thematic analysis revealed three key themes: complexities of shame, shame-sensitive practice, and the rethinking of the “therapeutic room”, encompassing nine subthemes. The findings underscore the importance of culturally sensitive therapeutic approaches, establishing a safe and trusting environment and ongoing specialist trauma training across mental health services. While remote therapy presents unique challenges and opportunities, it remains a valuable method of delivery, emphasising the need for individualised and flexible care approaches to support shame-based disclosures in trauma therapy. Further research is warranted in remote trauma therapy, particularly in relation to blended therapy and in risk management.

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Part Three. Critical Appraisal

Introduction

The critical appraisal will capture some of my personal insights from the research process, aiming to complement and elaborate on the concepts recorded in my reflective log. Following a contextualisation of the beginning of the project, I will outline various dilemmas encountered along the journey, both on completion of the systematic review and the empirical research. I will also expand on new insights and questions I am taking away from the process. Finally, I will reflect on how conducting this research has contributed to my identity as a clinical psychologist, in relation to both clinical and research aspects of the role.

The Project Conceptualisation

As we were introduced to potential research topics for our thesis in early 2022, I was clear that I wanted to complete a qualitative project. Although my teaching across undergraduate, master's, and doctorate levels predominantly focused on quantitative methods, I have always been drawn to qualitative methods. Having conducted qualitative research in my masters, I know that this type of research aligns best with my interests, beliefs, and skills. I know that a relativistic epistemological underpinning of qualitative methods and the exploration of individuals subjective experiences and understanding of their own contexts, aligns with my own world view. I saw the doctorate research as an opportunity to develop my identity as a researcher and solidify skills in the type of research I aspire to complete as a qualified clinical psychologist in the field.

Prior to being introduced to the available topics, I was keen to conduct research within the trauma field. I had some pre-existing clinical knowledge, having worked in a family-centred trauma service pre-training; though I was keen to develop both clinical and research skills in the field. I knew that specialising in trauma was my goal as a qualified psychologist and saw this as an opportunity to conceptualise my understanding from an alternate lens and establish myself in the field. I was grateful for the opportunity to truly co-develop the research topic alongside clinical psychologists specialising in trauma, drawing on my interests in complex trauma, shame, and therapeutic relationships.

Systematic Review

One of the challenges that we encountered in the planning stages of the systematic review was the conceptualisation of ‘digital therapy’ for the purpose of this review. With digitally delivered therapy being a relatively novice area for all involved in the research, we agreed to complete a number of initial scoping searches of the literature to investigate what was being conducted in the digital therapy realm, in order to develop the inclusion and exclusion criteria for the review. This incorporated scanning over 4,000 papers to understand what research had been conducted in the area and how the literature classifies ‘digital therapy’, and what the systematic review may focus on. From here, I then ran the searches outlined in Part I of this paper.

Through this review, we found ‘digital therapy’ to be conceptualised in a multitude of ways, encompassing text-based therapy, use of mobile applications, use of artificial intelligence, use of web applications, email-based therapy, and use of video-teleconferencing. Some methods involve in-vivo access to a therapist, while others provide a mechanism for non-instant contact with the therapist. The variance in breadth provided two challenges. Firstly, in ensuring the search terms are vast enough to identify all relevant papers. Secondly, in narrowing the criteria to meet the requirements of the systematic review, both in terms of PRISMA standards but also that of the University College London Doctorate, and what is feasible within the timeframe of the course. Through several meetings with supervisors, we narrowed our conceptualisation of ‘digital therapy’ and subsequently our search, to the use of teleconferencing and web applications, eliminating text-based therapy, mobile applications, and use of artificial intelligence.

Another related obstacle encountered in the planning stages of the systematic review was in relation to the definition of ‘therapist-delivered’ over ‘therapist-assisted’ or ‘therapist-guided’. The nature of this challenge was inherent in the change of contact that digitally delivered therapy provided, and what constituted a “therapy session”. For example, with written exposure-based approaches, digital therapy often involves a web application and non-instant written feedback from a therapist, while EMDR methods are delivered via a digital teleconferencing method. The lack of clarity on defining internet-supported therapeutic interventions compounded this issue (Barak, Klein & Proudfoot, 2009). They stated that the lack of standardisation, agreed terminology, and standards, has led to the fragmentation of and lack of cohesion in the digital therapy field. This was further exacerbated by the fact the type of digital technology used was not clearly stated in journals, making reviewing journals a lengthy process. The scoping of the literature was conducted in collaboration with research supervisors, determining studies that were therapist-delivered, from studies that were guided or assisted.

Empirical Research

As a relatively novice researcher, with many aspects of the research process being new or inexperienced, I explored my contentions of transitioning into the role of researcher from clinician in my reflective log. During the initial stages of project creation, I was on placement in a primary adult mental health service. However, by the time we had secured all relevant approvals for the study and I had recruited my first participant, I was working in a specialist trauma service. My knowledge on trauma, both theoretical from completing wider literature searches in the area and clinical through facilitating trauma interventions, had grown insurmountably from the days of project inception. I reflected on this accumulation of experience in my reflective logs and how it would have shaped both my approach to the research in terms of question style, and the lens in which I analyse the data through.

Prior to conducting the interviews, I had anxieties about stepping into the role of a ‘qualitative interviewer’ in contrast to my position as a warm, open, validating clinician. I had reservations in how I should ‘be’ in the interviews; how should I respond to disclosures and emotionally salient information; what follow up questions do I ask, and how do I generally respond to what is being shared? Validation is a natural part of my practice as a therapist, and although the interview was semi-structured, acts of validation contrasted with how I understood the role of the researcher to be. I was concerned about unintentionally influencing the research process with my responses and how I would balance my identity as a clinician with the new role as a researcher.

More specifically, conducting trauma research in parallel to facilitating trauma intervention while on placement, was a caveat I reflected on a lot through my reflexive log, in thinking about how they both influenced one another throughout the process. In my own practice, I prioritise the building of a trusting relationship, acutely aware of the increased importance placed on building safety in trauma therapy. Though building a trusting alliance is important in working with anyone, it is emphasised in trauma care due to the nature of the development of trauma (Howard, Berry & Haddock, 2022). Part of trust building in my practice is by adopting an authentic approach to therapy, using appropriate self-disclosure. I was concerned about the building of a relationship without the use of disclosure and within one brief encounter, while asking deep and meaningful questions about subjective experiences. Smith and Osborn (2003) propose that transparency in the setting up of a research study is important for building initial engagement and establishing a sense of safety. Lang and McAdam (1990) from systemic theory also relate the importance of the beginning stages of engagement in their phrase “well begun is half done”. Holding these in mind, I spent time during the initial setup of the interview to build a rapport with client participants and ensured time at the beginning of each interview to establish a conversation to set the tone for the interview. I felt it important to give an overview of my role as a researcher, current role as a trainee psychologist, and my interest in this area of research.

The nature of the topic also added concern in being acutely aware of emotional distress of discussing trauma, an awareness I developed through my therapeutic work with trauma populations. Though I was clear that I would not ask questions about the traumatic event(s) and emphasised this throughout, there remained a possibility that participants may be distressed by revisiting their trauma. As such, I encouraged participants to bring their grounding tools to the interview, with safety of participants paramount to the experience. This was influenced by therapeutic work with those who have experienced trauma and dissociation. Though none of the participants required the use of grounding throughout, I found myself reflecting on whether researchers without training in working with trauma would be aware of the risk of dissociation and the safety of participants in wider research.

Considering the context into the transition to digitally delivered therapy within mental health services in the UK, was imperative in reflecting on the systemic factors impacting the research development, the experiences of both clients and therapists, and the experiences of myself as a researcher and trainee clinical psychologist. This research was initially developed during the lockdown procedures of COVID-19, with transitions back to in-person therapy an uncertainty for the future. Services had been offering remote therapy for about a year when the research idea was developed, which allowed services the initial time to transition, though digitally delivered therapy was still a new experience for most involved.

In my reflective logs, I also considered the experience for clients in conducting the research remotely, similar to that of their therapy. I wondered about their experiences of building a connection, personal preferences, establishment of safety, and level of disclosures. Though clients could opt to meet in-person or remotely, all clients chose to meet remotely, even those who stated their preference for in-person connection in the interviews. As my formal training had largely been conducted during the lockdown procedures of the pandemic, my formal therapist and research skills had been developed both in-person and remotely concurrently, with the latter being the primary in some placements throughout training. My experiences would have been different to those clinicians who have been honing their skills in-person only, up to this point. My anxieties of delivering therapy relate more to my position as a trainee and development of new skills, whereas the clinicians I interviewed, shared specific anxieties to delivery method that I had a different relationship to.

My experiences of lengthy processes to relevant ethical approvals via the University, Health Research Authority (HRA), Research Ethics Committee (REC), and National Health Service (NHS) Trust level, provided me with an understanding into the challenges of the scientist practitioner role as a clinical psychologist. I encountered several administrative challenges which significantly impacted the timeline in which I could conduct the research. Considering the nature of this research conducted within a doctoral programme, there were timescales in which the research needed to be completed. However, I can draw parallels with clinical psychologists who may encounter similar obstacles while conducting research in the field concurrent to clinical practice and how these delays would impact both availability and funding of research. These obstacles had considerable impacts on the research, as by the time approvals had been attained, there was a noticeable trend back to in-person therapy, specifically in trauma treatment, both in specialised services and wider mental health services. This reduced the recruitment pool significantly. This provided an insight into the dilemmas of conducting trauma research in NHS settings.

At the end of all interviews, I turned off the recording following the final question to allow time for checking in, debriefing, and overall reflecting on the interview process. This was important considering the nature of the discussions. Though the participants were reminded that the conversation was not to centralise on their own trauma experiences, participants often chose to disclose their trauma experiences. Although I reminded participants to prepare with their grounding tools before the interview, and redirected the conversation when needed, it felt important to check in with clients and support in regulating emotions and bodily sensations. This time to debrief also provided space for the participants to ask me questions, which felt like an important shift of power that naturally exists within an interview environment.

Several of the participants used this space to ask about my own personal journey to this research, including my interest in this area and experience in working with those who have experienced trauma. They showed curiosity in who they were speaking to, and the expertise and pre-existing knowledge in the area. I was acutely aware of their experiences of harmful practice and drew parallels with their attempts to determine if I was “safe” or ‘trustworthy”. Differing narratives exist within the literature regarding therapist self-disclosure depending on the stance of the therapist and approach or school of thought (Hanson, 2005). I recall multiple discussions within lectures and seminars across the course, on the contentions of this topic and finding myself confused as to the ‘right’ way to practice. In my own practice, I have found that some services and teams align more with self-disclosure over others. For example, I may disclose more in children services as a means to build a relationship, whereas I would be more cautious with disclosure in forensic services. I registered the stressed importance of therapist self-disclosure that the participants stressed in their interviews, and shared parts of myself, my identity as a person, clinician, and researcher where relevant and felt appropriate in the building of research alliance.

This time also allowed me to thank participants deeply, for sharing their stories and trusting me with their experiences. With each interview I was humbled by their vulnerability and felt a responsibility to represent all voices within the research.

As mentioned above, I was aware of the positions of power in the researcher-participant role, though power was operating in many other ways throughout the research process. My position as a middle-class white Irish woman varied from the social identities of the participants in a multitude of ways. The similarities and differences between our identities would have undoubtedly impacted their experience of the interview and shaped the responses they felt able to share. As a white Irish woman, I wondered if this would create space for reflections related to culture or act as a mechanism for silencing. This theme was explored in detail across all interviews in relation to cultural expression of mental health, understanding of trauma, and the intersectionality with other forms of identity. One client was particularly open about their experiences of racialisation and the impact of talking about race to their white therapist. During the ‘debrief’ we reflected on how it was to talk openly about these experiences to a white Irish researcher as a Mixed Asian female. There was the sense of “you get the type of racism that exists in Ireland”, but also that I represented the oppressor which was an interesting dynamic. I wondered what this experience was like for the remainder of the participants, particularly from those of a non-Westernised majority background, and who had not openly reflected on this experience with me, both in the interview and the debrief.

Conclusion

In summary, this critical appraisal allowed for a deeper reflection into the research process and consideration of the challenges that shaped this research. The systematic review brought obstacles of conceptualisation of the terms “digital therapy” and “therapist-delivered”. This challenge helped me to make sense of the digital therapy realm and provide a greater understanding of the breadth of adaptations of digital therapies. In the empirical paper, I encountered obstacles of a more procedural nature, with regard to the pragmatics of conducting research in the NHS and establishing my identity as a researcher. Reflecting on the dilemmas that I encountered throughout this process, has given me an insight into the challenges that clinical psychologists and academic researchers would experience in conducting qualitative research in the trauma field.

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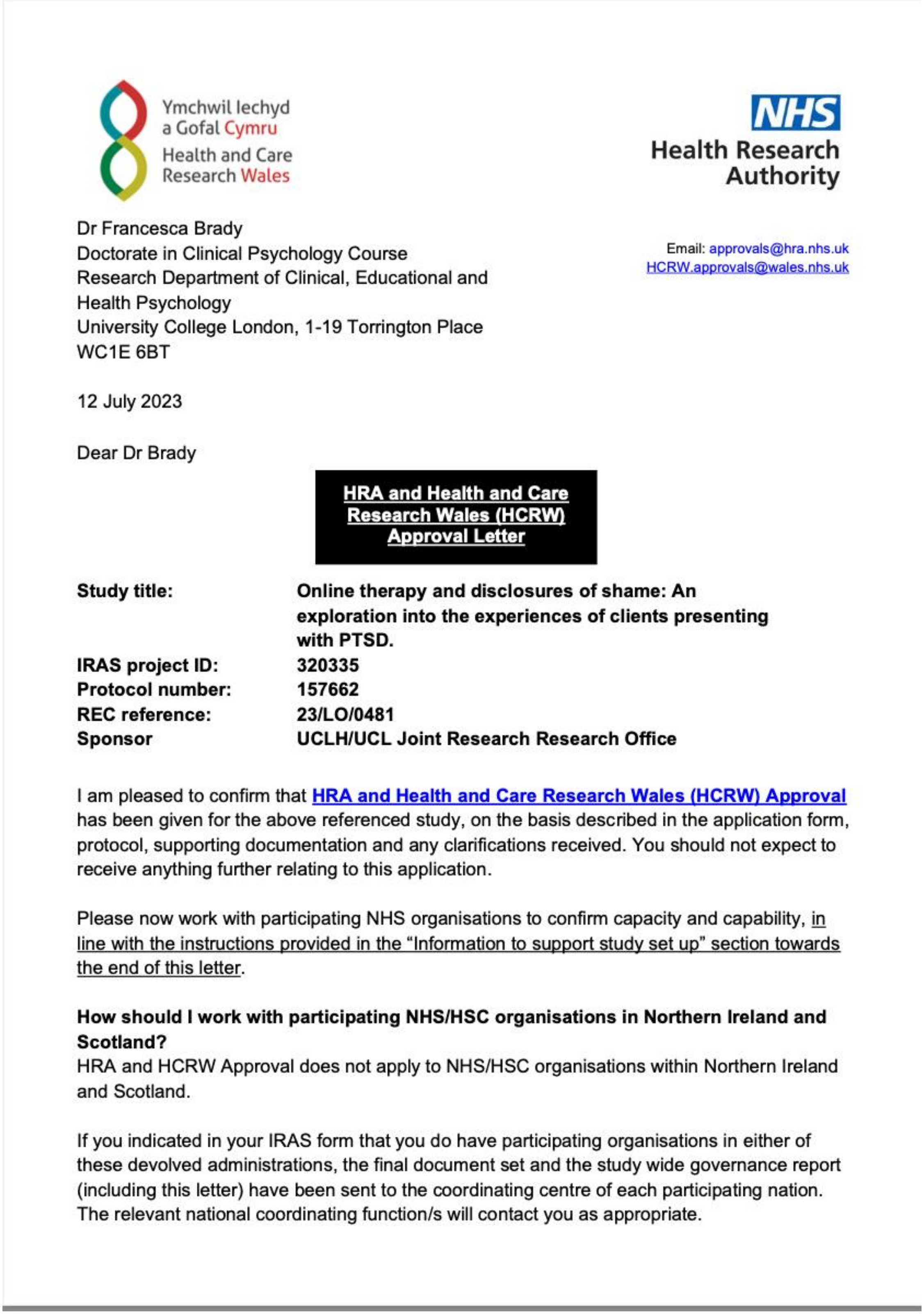
Appendices

Appendix A



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

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

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12 July 2023

Dear Dr Brady

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

Study title:	**Online therapy and disclosures of shame: An exploration into the experiences of clients presenting with PTSD.**
IRAS project ID:	**320335**
Protocol number:	**157662**
REC reference:	**23/LO/0481**
Sponsor	**UCLH/UCL Joint Research Research Office**

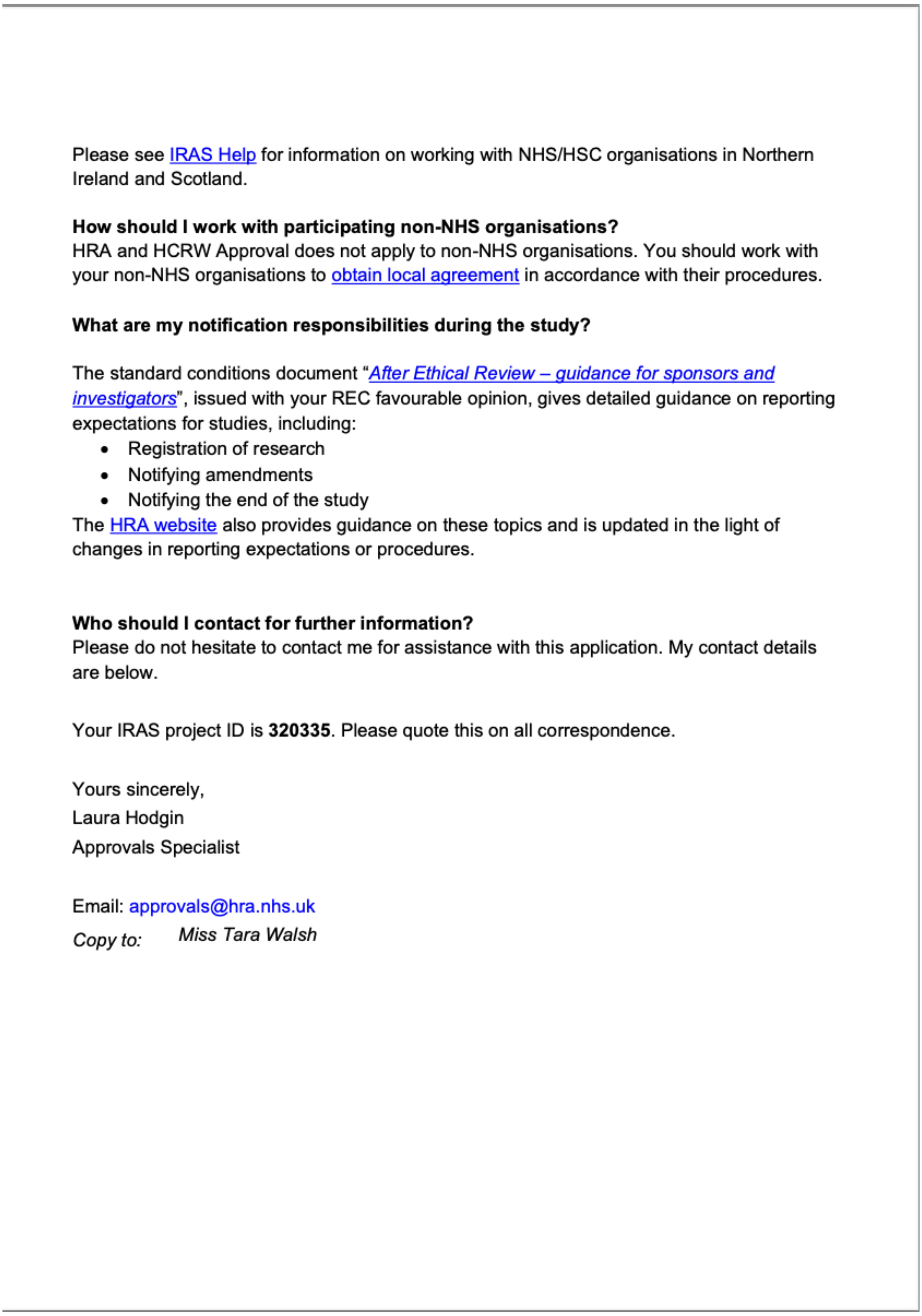
I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further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

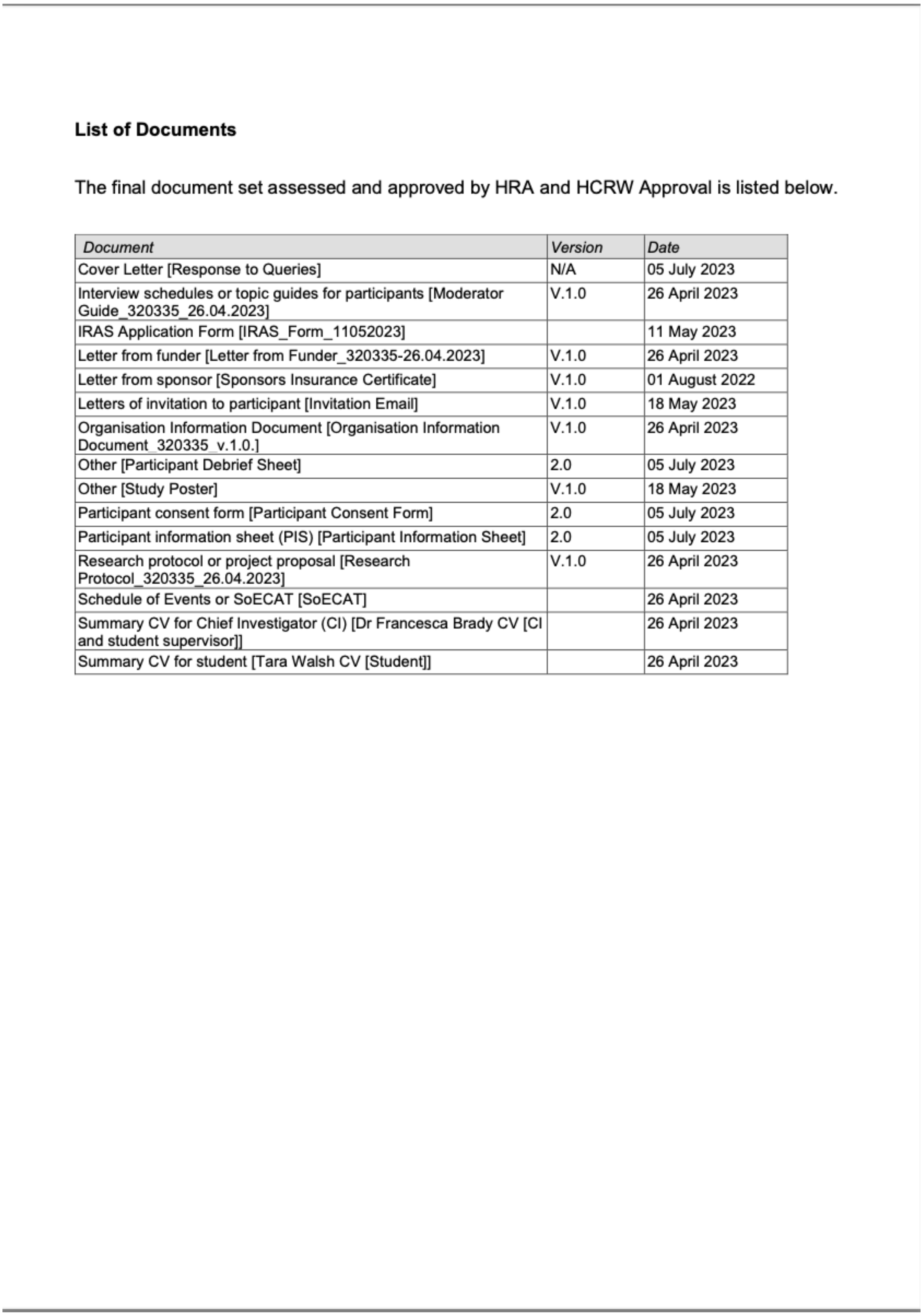
The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

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 **320335**. Please quote this on all correspondence.

Yours sincerely,
Laura Hodgin
Approvals Specialist

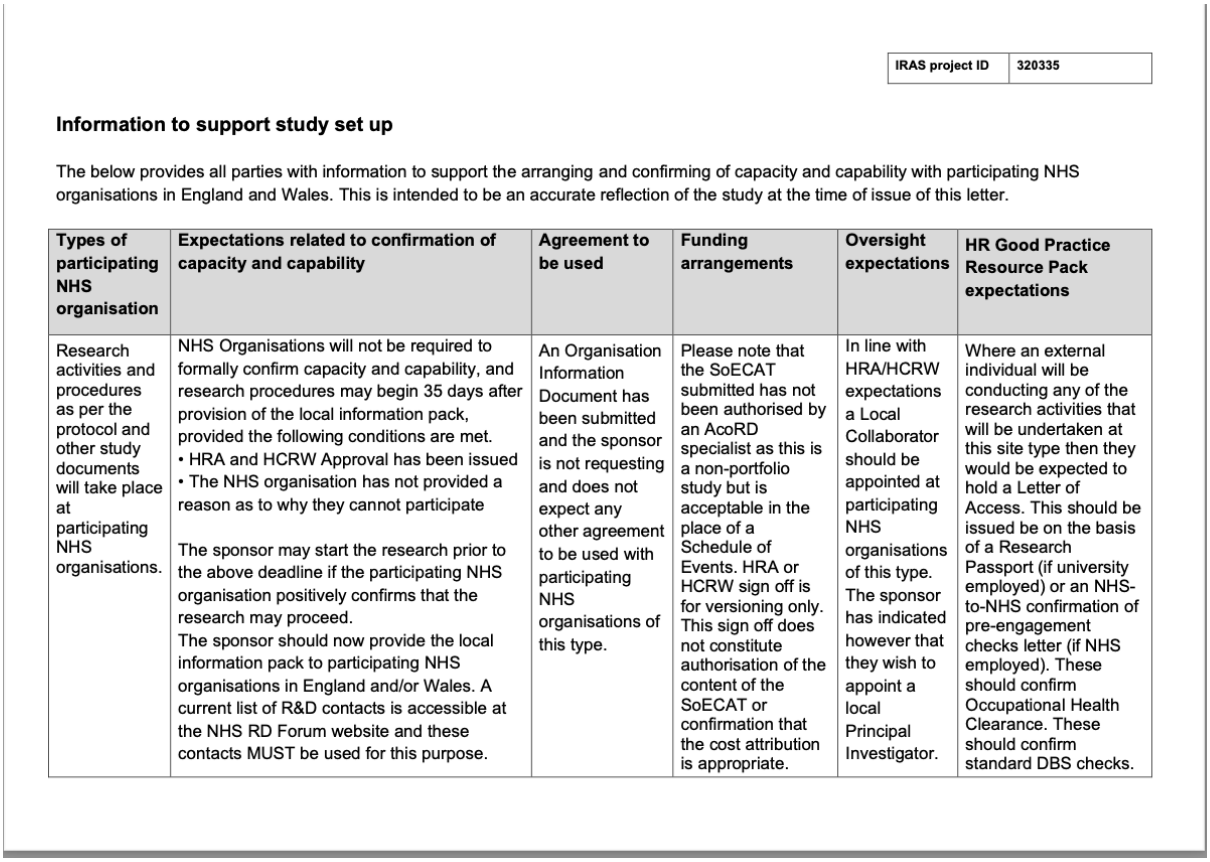
Email: approvals@hra.nhs.uk
Copy to: *Miss Tara Walsh*



List of Documents

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

Document	*Version*	*Date*
Cover Letter [Response to Queries]	N/A	05 July 2023
Interview schedules or topic guides for participants [Moderator Guide_320335_26.04.2023]	V.1.0	26 April 2023
IRAS Application Form [IRAS_Form_11052023]		11 May 2023
Letter from funder [Letter from Funder_320335-26.04.2023]	V.1.0	26 April 2023
Letter from sponsor [Sponsors Insurance Certificate]	V.1.0	01 August 2022
Letters of invitation to participant [Invitation Email]	V.1.0	18 May 2023
Organisation Information Document [Organisation Information Document_320335_v.1.0.]	V.1.0	26 April 2023
Other [Participant Debrief Sheet]	2.0	05 July 2023
Other [Study Poster]	V.1.0	18 May 2023
Participant consent form [Participant Consent Form]	2.0	05 July 2023
Participant information sheet (PIS) [Participant Information Sheet]	2.0	05 July 2023
Research protocol or project proposal [Research Protocol_320335_26.04.2023]	V.1.0	26 April 2023
Schedule of Events or SoECAT [SoECAT]		26 April 2023
Summary CV for Chief Investigator (CI) [Dr Francesca Brady CV [CI and student supervisor]]		26 April 2023
Summary CV for student [Tara Walsh CV [Student]]		26 April 2023

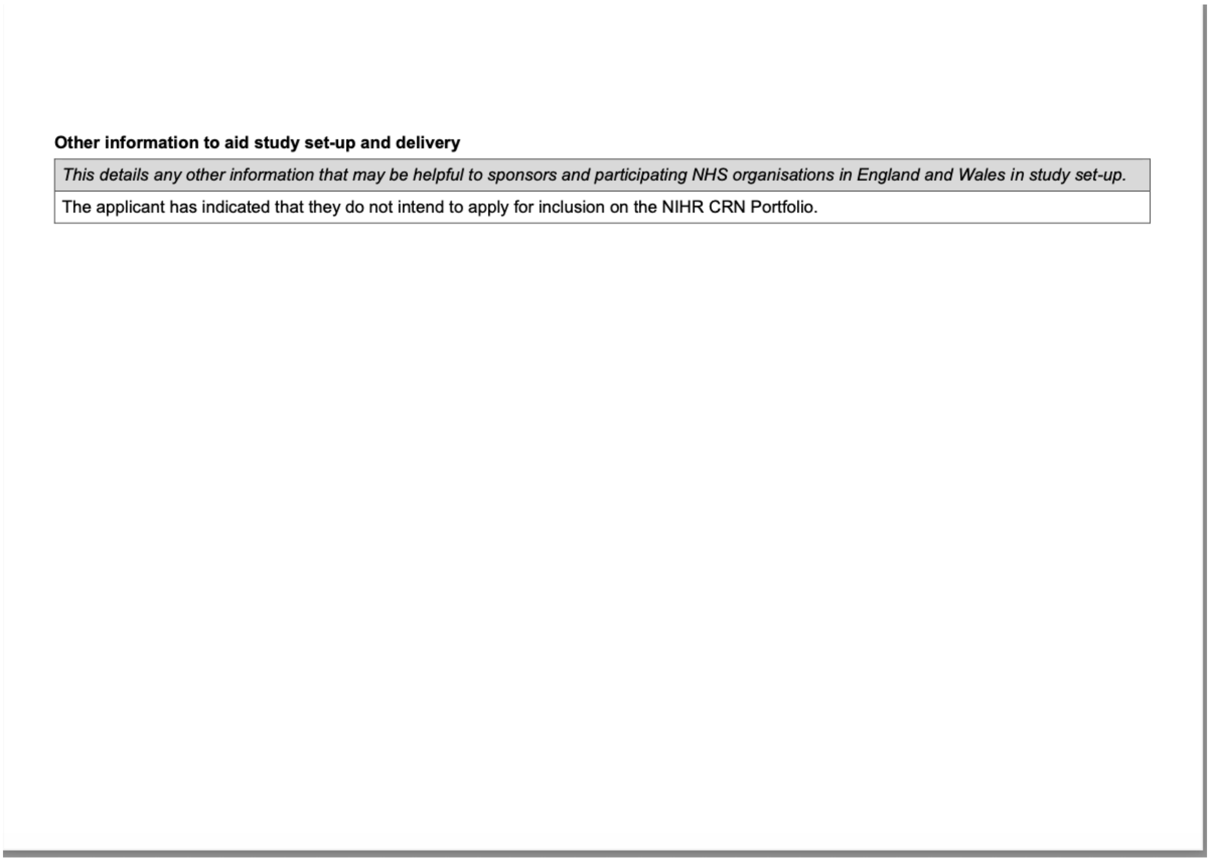


IRAS project ID	320335

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.

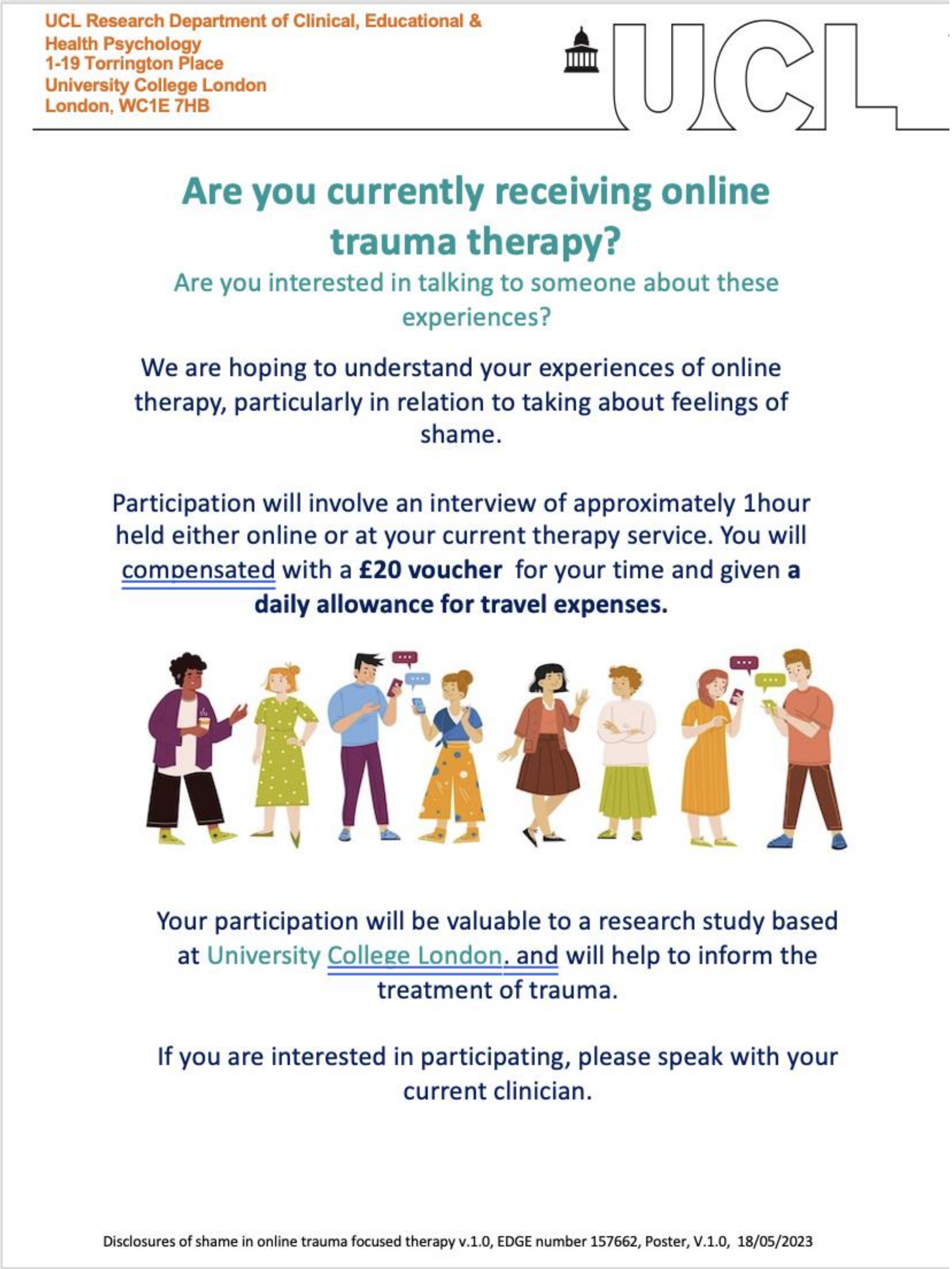
Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
Research activities and procedures as per the protocol and other study documents will take place at participating NHS organisations.	NHS Organisations will not be required to formally confirm capacity and capability, and research procedures may begin 35 days after provision of the local information pack, provided the following conditions are met. • HRA and HCRW Approval has been issued • The NHS organisation has not provided a reason as to why they cannot participate The sponsor may start the research prior to the above deadline if the participating NHS organisation positively confirms that the research may proceed. The sponsor should now provide the local information pack to participating NHS organisations in England and/or Wales. A current list of R&D contacts is accessible at the NHS RD Forum website and these contacts MUST be used for this purpose.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other agreement to be used with participating NHS organisations of this type.	Please note that the SoECAT submitted has not been authorised by an AcoRD specialist as this is a non-portfolio study but is acceptable in the place of a Schedule of Events. HRA or HCRW sign off is for versioning only. This sign off does not constitute authorisation of the content of the SoECAT or confirmation that the cost attribution is appropriate.	In line with HRA/HCRW expectations a Local Collaborator should be appointed at participating NHS organisations of this type. The sponsor has indicated however that they wish to appoint a local Principal Investigator.	Where an external individual will be conducting any of the research activities that will be undertaken at this site type then they would be expected to hold a Letter of Access. This should be issued be on the basis of a Research Passport (if university employed) or an NHS-to-NHS confirmation of pre-engagement checks letter (if NHS employed). These should confirm Occupational Health Clearance. These should confirm standard DBS checks.



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 do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix B



UCL Research Department of Clinical, Educational &
Health Psychology
1-19 Torrington Place
University College London
London, WC1E 7HB

Are you currently receiving online trauma therapy?

Are you interested in talking to someone about these experiences?

We are hoping to understand your experiences of online therapy, particularly in relation to taking about feelings of shame.

Participation will involve an interview of approximately 1hour held either online or at your current therapy service. You will compensated with a **£20 voucher** for your time and given **a daily allowance for travel expenses.**

Your participation will be valuable to a research study based at University College London. and will help to inform the treatment of trauma.

If you are interested in participating, please speak with your current clinician.

Disclosures of shame in online trauma focused therapy v.1.0, EDGE number 157662, Poster, V.1.0, 18/05/2023

Appendix C

CONSENT FORM

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study: Online therapy and disclosures of shame**:** An exploration into the experiences of clients presenting with PTSD.
Department: Department of Clinical, Educational and Health Psychology
Name and Contact Details of the Researcher(s): Tara Walsh
Name and Contact Details of the Principal Researcher: Dr Justine Bush (Justine.bush@candi.nhs.uk) and Dr Francesca Brady (f.brady@ucl.ac.uk)
Name and Contact Details of the UCL Data Protection Officer: Alexandra Potts data-protection@ucl.ac.uk

This study has been approved by the NHS Research Ethics Committee: Project ID number: 320335

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by **ticking/initialling each box below I am consenting to this element of the study**. I understand that it will be assumed that **unticked/initialled boxes means that I DO NOT consent to that part of the study**. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.

		Tick Box
1	I confirm that I have read and understood the Participant Information Sheet V.3.0 dated 04/04/2024 for the above study. I have had an opportunity to consider the information and what will be expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction and would like to take part in an individual interview.	
2	I understand that my personal information such as my name, age, mobile number, email address and/or postal address will be used for the purposes explained to me i.e. only to contact me about the study and will be deleted after my participation if I do not consent to further follow-up contact.	
3	I understand that confidentiality will be respected subject to legal constraints and professional guidelines. **I am aware that if there is any significant risk of harm to me or another person that this may need to be reported to my therapist (if applicable) who may then contact other relevant services, such as my GP.**	
4	I understand that my data gathered in this study will be stored anonymously and securely. It will not be possible to identify me in any publications and I understand that if the researchers would like to use a direct quote in a publication, they will use a pseudonym.	
5	I understand that my participation is voluntary and that I am free to withdraw up until April 2024 without giving a reason, without my care being affected. I understand after this time, as all data will be analysed and	

	compiled together, it would not be possible to withdraw.	
6	I understand that the information I have submitted will be anonymised and will be published as a report and may also be published in a journal. I understand that I can receive a copy of these if I consent to my contact details being retained for this purpose.	
7	**I consent to my interview being audio and video recorded as default of Microsoft teams however, having my camera on is optional. I understand that the recordings will be stored, using password-protected software and will be used for research purposes only. I understand that interviews will then be destroyed once transcription has taken place. I understand that my anonymised data will then be held for a minimum of 10years in accordance with UCL regulation.**	
8	I understand the potential risks of participating and the support that will be available to me should I become distressed during the course of the research. I am aware of who I should contact if I have concerns during/after the study.	
9	I voluntarily agree to take part in this study.	

If you wish to be contacted to provide feedback on our analysis of your interview please tick the box. Your contact details would be stored securely until this date. If you do not wish to be contacted, this will not impact your participation in this study. ▪ Yes, I would like to be contacted to provide feedback.	
If you wish to be contacted when this study is completed to hear about our findings please tick the box. Your contact details would be stored securely until this date. If you do not wish to be contacted this will not impact your participation in this study. ▪ Yes, I would like to be contacted to hear about the findings of this research	
If you wish to be contacted about participating in future research projects please tick the box. Your contact details would be stored securely for 2 years. If you do not wish to be contacted this will not impact your participation in this study. ▪ Yes, I would like to be contacted about future research and I am happy for my contact details to be stored for 2 years.	

Name of participant	Date	Signature
Researcher	Date	Signature

Appendix D

PARTICIPANT INFORMATION SHEET
NHS Research Ethics Committee Approval ID number: 320335

Title of Study: Online therapy and disclosures of shame: An exploration into the experiences of clients presenting with PTSD.

Department: Department of Clinical, Educational and Health Psychology
Researcher: Tara Walsh, Trainee Clinical Psychologist, tara.walsh.21@ucl.ac.uk
Principal: Researchers: Dr Francesca Brady, Clinical Psychologist, f.brady@ucl.ac.uk
Dr Justine Bush, Clinical Psychologist, Justine.bush@candi.nhs.uk

We would like to invite you to take part in this study. Before you decide whether you want to take part, it is important for you to understand what the study involves and why we are doing it. Please read the below information carefully, which will help you to make this decision. You can ask the research team if there is anything unclear or if you would like more information before making your decision. You will be given a copy of this information sheet to keep.

What is this study about?

This study is being carried out by researchers from University College London (UCL) in collaboration with Camden and Islington Mental Health Trust. In particular, with the services, Traumatic Stress Clinic (TSC) and IAPT community trauma clinic (CTC). We would like to speak with people who have developed post-traumatic stress following experiencing a traumatic events(s). In particular, we would like to hear from people who have experienced shame in relation to their trauma. We hope that this research study will help us to gain a better insight in the experiences of those receiving therapy in order to improve online therapy for those who have experienced trauma. **The London-Stanmore Research Ethics Committee has given a favourable opinion of the study.**

Why have I been invited to take part?

You have been invited to take part in this study because we understand that you have been receiving online therapy for your experience of trauma either at the TSC or C&I IAPT or have heard about this study through alternate means. **We hope that around 10-15 people will take part in this study.**

What does taking part involve?

If you are interested in participating, you will be invited to speak with the researcher who can answer any questions you may have about the research. If you then choose to participate, you will be asked to sign a consent form. The researcher will then arrange a date and time to meet with you online via Microsoft teams or in person, depending on your preference. You will be asked about your experiences of and discussions of shame in therapy. **Microsoft Teams interviews will be audio and video recorded, as default. However, you may choose to wish to switch your camera on or off for the duration of the interview. The meeting will be recorded for transcription purposes ONLY. After this the video will be permanently deleted.**

The interview will last approximately up to one hour and if you would like to do it using video call, we ask that you find a quiet, comfortable and private space to talk. If you would like the interview to be in person, we will arrange a confidential and safe space at your therapy service. As a thank you for taking the time to participate in the study, you will also be given a £20 Amazon/ Love to Shop voucher. **Should you meet the researcher in person at your local therapy service, you will be compensated for your travel expenses up to a daily maximum of £9.40.**

We would be offering everyone who took part in the study the opportunity to check the transcript of their interview prior to analysis stage. The findings from the analysis will be written up as a

part of a doctoral research programme. We will also be aiming to present the research at conferences and publish in a peer reviewed journal publication. Should you wish, a copy of these will be shared with you.

Do I have to take part?

No. Your participation is voluntary, and you are free to choose whether or not to take part. If you choose not to take part, this will not affect your therapy in anyway. You are also free to withdraw from the study at any point up until **April 2024.** You do not need to provide an explanation and this will not affect your trauma treatment in any way. **If you change your mind about taking part after the interview, you can contact us and you will be able to withdraw your data from the study.** Unfortunately, after **April 2024** as your data will be collated with others it will not be possible to identify your responses in order to withdraw you from the study.

What are the risks and benefits of taking part?

You may find that talking about your experiences might bring up some painful memories and emotions. We will take every step to make you feel comfortable and you can break or stop the interview at any point. You also do not have to answer any questions that make you feel uncomfortable. If after the interview you would like to speak with someone, you will be given the lead researcher's contact details and you can also contact your current therapist at the TSC or IAPT CTC. We will also provide you with information of additional services that you may find helpful.

You may find some positive outcomes by participating in the study. With this study, you will have an additional space to think and talk about your experiences which some people find helpful. We also hope that the information we learn from the study will be of interest to you and support you in making sense of your experiences. Importantly, we hope that this research improve the care provided to other people affected by traumatic experiences.

What will happen to the information I provide?

With your consent, the conversation between yourself and the researcher will be audio and video recorded (as default by Microsoft Teams) to capture all the important information that you share. However, you may choose to wish to switch your camera on or off for the duration of the interview. We will listen to the recording and transcribe what you and the researcher say in the interview. After this, the recording will be permanently deleted. No personal or identifiable information included the written transcript so it will not be possible to identify your responses.

All information will be stored securely on Data Safe Haven, a secure network which complies with NHS information governance. This information is only accessible by the researchers in this study. The transcripts of the interview will securely be stored until transcription has been completed. Following this the recordings will be permanently deleted.

The written transcripts will be analysed by the research team and will identify the main themes expressed by everyone who participated. The results of the study will be written up as a part of a doctoral thesis, which may also be published in a peer-reviewed scientific journal.

What other information would you collect?

We will ask you to provide some information about yourself, such as age, gender and ethnicity. This is to help provide some background information about the people who take part. This information will be anonymised so that it is not possible to identify any individuals.

Will my participation in this study be kept confidential?

All information we collected during the interview will be kept strictly confidential. Only the researchers directly involved in the project will be able to access the information you give. All data will be collected and stored in accordance with the UK Data Protection Act 2018 and General Data Protection Regulation (GDPR) 2018. As stated above, all identifiable information will be removed from transcripts to ensure anonymity.

If during the interview, we become worried about your safety or that of somebody else's, we may have to tell someone else in order to keep you safe. This person would likely be your current therapist. They then may also inform your GP or another health or social care professional. The kinds of things that would cause us concern would be if you had thoughts of harming yourself in anyway or if you told us that someone else was in immediate danger. We will always try to tell you before we share anything with another professional, however this may not always be possible.

How will we use information about you?

We will need to use information from you, from your medical records, for this research project.

This information will include your NHS number, name, contact details, date of birth. 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.

What are your choices about how your information is used?

You may choose to withdraw the data you provided until April 2024 when the data will be analysed without providing any reason, and this will not affect your therapeutic care. This will also not affect your incentive payment. Please notify the researcher (or either of the principal researchers) if you wish to withdraw from the study.

Where can you find out more about how your information is used?

You can find out more about how we use your information
www.hra.nhs.uk/information-about-patients/

- by asking one of the research team (contact details are at the top of this sheet)
- or by sending an email to data-protection@ucl.ac.uk

The data custodian for this study is the (Justine Bush, see contact details above)

What will happen to the results of the study?

We will write a report about what we found out during the study. This will cover information we gather from everyone we speak to, not just you. We may include direct quotations from interviews in the published report, but we will not include names of participants and we will ensure that any quotations we use cannot be linked or identified as coming from any specific individual. All participants will be offered the opportunity to receive a copy of the results via email. Please see consent form for more information.

What if something goes wrong?

Every care will be taken in the course of this study. However, if you wish to make a complaint regarding the research study or have any concerns about any aspect of the way you have been approached or treated by members of staff you may have experienced due to your participation in the research, you can raise this concerns with any member of the research team (details below). They are obliged to forward all complaints to the local ombudsman who will investigate the complaint.

If you would like to raise a concern about the therapy you received, you may raise this with your therapist and the services management team will investigate what has happened and try to put things right. Alternatively, you can email the NHS Trust (Camden and Islington NHS Foundation Trust) at feedback@candi.nhs.uk about making a formal complaint which will be investigated by a senior clinician from a team different to the team your complaint might be with.

If you remain unhappy and/or wish to raise an independent and/or formal complaint/concern, you can do this via London Independent Health Complaints Advocacy Service – POhWER - pohwer@pohwer.net , www.pohwer.net, 0300 456 2370.

Thank you reading this information sheet and for considering taking part in this study

Data Protection privacy notice	**If I have any questions, who can I ask?**
UCL’s Data Protection office can be contacted at data-protection@ucl.ac.uk. You can read UCL’s privacy notice at: https://www.ucl.ac.uk/legal-services/ privacy/participants-health-and-care-research-privacy-notice and details of your rights at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of- the-gdpr/individuals-rights/ Your personal data (name, contact details, gender, ethnicity) will be processed as described in this information sheet. **The legal basis for data processing is to “perform a task in the public interest”**	Tara Walsh Trainee Clinical Psychologist Email: tara.walsh.21@ucl.ac.uk Supervised by Dr Justine Bush Email: Justine.bush@candi.nhs.uk Dr Francesca Brady Email: f.brady@ucl.ac.uk *If you are unhappy about the study at any stage, please contact the researchers on the email address above. If you would like to complain further, you can email ethics@ucl.ac.uk.*

Appendix E

STAFF PARTICIPANT INFORMATION SHEET
NHS Research Ethics Committee Approval ID number: 320335

Title of Study: Online therapy and disclosures of shame: An exploration into the experiences of clients presenting with PTSD.

Department: Department of Clinical, Educational and Health Psychology
Researcher: Tara Walsh, Trainee Clinical Psychologist, tara.walsh.21@ucl.ac.uk
Principal: Researchers: Dr Francesca Brady, Clinical Psychologist, f.brady@ucl.ac.uk
Dr Justine Bush, Clinical Psychologist, Justine.bush@candi.nhs.uk

We would like to invite you to take part in this study. Before you decide whether you want to take part, it is important for you to understand what the study involves and why we are doing it. Please read the below information carefully, which will help you to make this decision. You can ask the research team if there is anything unclear or if you would like more information before making your decision. You will be given a copy of this information sheet to keep.

What is this study about?

This study is being carried out by researchers from University College London (UCL) in collaboration with Camden and Islington Mental Health Trust. In particular, with the services, Traumatic Stress Clinic (TSC) and IAPT community trauma clinic (CTC). We would like to speak with therapists who have been delivering online therapy to people who have developed post-traumatic stress following experiencing a traumatic event(s). In particular, we would like to hear from therapists who have supported people who have experienced shame in relation to their trauma. We hope that this research study will help us to gain a better insight in the experiences of those receiving therapy in order to improve online therapy for those who have experienced trauma. **The London-Stanmore Research Ethics Committee has given a favourable opinion of the study.**

Why have I been invited to take part?

You have been invited to take part in this study because we understand that you have been delivering online therapy to people for their experience of trauma either at the TSC or IAPT. **We hope that around 10-15 people will take part in this study.**

What does taking part involve?

If you are interested in participating, you will be invited to speak with the researcher who can answer any questions you may have about the research. If you then choose to participate, you will be asked to sign a consent form. The researcher will then arrange a date and time to meet with you online via Microsoft teams or in person, depending on your preference. You will be asked about your experiences of and discussions of shame in therapy. **Microsoft Teams interviews will be audio and video recorded, as default. However, you may choose to wish to switch your camera on or off for the duration of the interview. The meeting will be recorded for transcription purposes ONLY. After this the video will be permanently deleted.**

The interview will last approximately up to one hour and if you would like to do it using video call, we ask that you find a quiet, comfortable and private space to talk. If you would like the interview to be in person, we will arrange a confidential and safe space at your therapy service. As a thank you for taking the time to participate in the study, you will also be given a £20 Amazon/ Love to Shop voucher. **Should you meet the researcher in person at your local therapy service, you will be compensated for your travel expenses up to a daily maximum of £9.40.**

We would be offering everyone who took part in the study the opportunity to check the transcript of their interview prior to analysis stage. The findings from the analysis will be written up as a part of a doctoral research programme. We will also be aiming to present the research at conferences and publish in a peer reviewed journal publication. Should you wish, a copy of these will be shared with you.

Do I have to take part?

No. Your participation is voluntary, and you are free to choose whether or not to take part. If you choose not to take part, this will not affect your therapy in anyway. You are also free to withdraw from the study at any point up until **April 2024.** You do not need to provide an explanation and this will not affect your trauma treatment in any way. **If you change your mind about taking part after the interview, you can contact us and you will be able to withdraw your data from the study.** Unfortunately, after **April 2024** as your data will be collated with others it will not be possible to identify your responses in order to withdraw you from the study.

What are the risks and benefits of taking part?

You may find that talking about your experiences of delivering online trauma therapy might bring up some painful memories and emotions. We will take every step to make you feel comfortable and you can break or stop the interview at any point. You also do not have to answer any questions that make you feel uncomfortable. If after the interview you would like to speak with someone, you will be given the lead researcher’s contact details and you can also contact your current therapist at the TSC or IAPT CTC. We will also provide you with information of additional services that you may find helpful.

You may find some positive outcomes by participating in the study. With this study, you will have an additional space to think and talk about your clients experiences which some people find helpful. We also hope that the information we learn from the study will be of interest to you and support you in working with those who have experienced trauma. Importantly, we hope that this research improve the care provided to other people affected by traumatic experiences.

What will happen to the information I provide?

With your consent, the conversation between yourself and the researcher will be audio and video recorded (as default by Microsoft Teams) to capture all the important information that you share. However, you may choose to wish to switch your camera on or off for the duration of the interview. We will listen to the recording and transcribe what you and the researcher say in the interview. After this, the recording will be permanently deleted. No personal or identifiable information included the written transcript so it will not be possible to identify your responses.

All information will be stored securely on Data Safe Haven, a secure network which complies with NHS information governance. This information is only accessible by the researchers in this study. The transcripts of the interview will securely be stored until transcription has been completed. Following this the recordings will be permanently deleted.

The written transcripts will be analysed by the research team and will identify the main themes expressed by everyone who participated. The results of the study will be written up as a part of a doctoral thesis, which may also be published in a peer-reviewed scientific journal.

What other information would you collect?

We will ask you to provide some information about yourself, such as age, gender and ethnicity. This is to help provide some background information about the people who take part. This information will be anonymised so that it is not possible to identify any individuals.

Will my participation in this study be kept confidential?

All information we collected during the interview will be kept strictly confidential. Only the researchers directly involved in the project will be able to access the information you give. All data will be collected and stored in accordance with the UK Data Protection Act 2018 and General Data Protection Regulation (GDPR) 2018. As stated above, all identifiable information will be removed from transcripts to ensure anonymity.

If during the interview, we become worried about your safety or that of somebody else’s, we may have to tell someone else in order to keep you safe. This person would likely be your current therapist. They then may also inform your GP or another health or social care professional. The kinds of things that would cause us concern would be if you had thoughts of harming yourself in anyway or if you told us that someone else was in immediate danger. We will always try to tell you before we share anything with another professional, however this may not always be possible.

How will we use information about you?

We will need to use information from you for this research project. Name, contact details, date of birth. People will use this information to do the research as part of gathering initial demographic data and to contact you about the study. 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.

What are your choices about how your information is used?

You may choose to withdraw the data you provided until April 2024 when the data will be analysed without providing any reason, and this will not affect your therapeutic care. This will also not affect your incentive payment. Please notify the researcher (or either of the principal researchers) if you wish to withdraw from the study.

Where can you find out more about how your information is used?

You can find out more about how we use your information
www.hra.nhs.uk/information-about-patients/

- by asking one of the research team (contact details are at the top of this sheet)
- or by sending an email to data-protection@ucl.ac.uk

The data custodian for this study is the (Justine Bush, see contact details above)

What will happen to the results of the study?

We will write a report about what we found out during the study. This will cover information we gather from everyone we speak to, not just you. We may include direct quotations from interviews in the published report, but we will not include names of participants and we will ensure that any quotations we use cannot be linked or identified as coming from any specific individual. All participants will be offered the opportunity to receive a copy of the results via email. Please see consent form for more information.

What if something goes wrong?

Every care will be taken in the course of this study. However, if you wish to make a complaint regarding the research study or have any concerns about any aspect of the way you have been approached or treated by members of staff you may have experienced due to your participation in the research, you can raise this concerns with any member of the research team (details below). They are obliged to forward all complaints to the local ombudsman who will investigate the complaint.

If you would like to raise a concern about the therapy you received, you may raise this with your therapist and the services management team will investigate what has happened and try to put things right. Alternatively, you can email the NHS Trust (Camden and Islington NHS Foundation Trust) at feedback@candi.nhs.uk about making a formal complaint which will be investigated by a senior clinician from a team different to the team your complaint might be with.

If you remain unhappy and/or wish to raise an independent and/or formal complaint/concern, you can do this via London Independent Health Complaints Advocacy Service – POhWER - pohwer@pohwer.net , www.pohwer.net, 0300 456 2370.

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

Data Protection privacy notice

UCL’s Data Protection office can be contacted at data-protection@ucl.ac.uk. You can read UCL’s privacy notice at: https://www.ucl.ac.uk/legal-services/ privacy/participants-health-and-care-research-privacy-notice and details of your rights at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of- the-gdpr/individuals-rights/

Your personal data (name, contact details, gender, ethnicity) will be processed as described in this information sheet. **The legal basis for data processing is to “perform a task in the public interest”**

If I have any questions, who can I ask?

Tara Walsh Trainee Clinical Psychologist

Email: tara.walsh.21@ucl.ac.uk

Supervised by

Dr Justine Bush
Email: Justine.bush@candi.nhs.uk

Dr Francesca Brady
Email: f.brady@ucl.ac.uk

If you are unhappy about the study at any stage, please contact the researchers on the email address above. If you would like to complain further, you can email ethics@ucl.ac.uk.

Appendix F

Client Moderator Guide

Demographic Information can say prefer not to say for the following

- Age
- Gender
- Ethnicity
- Type of therapy
- Length of therapy –
- Prior therapy experience online or f2f

1. What was your experience of your current/recent remote therapy?
    a. If you had therapy before how did this experience compare to that?
        i. In person or remote
        ii. Did you feel connected/ far away from the therapist?
        iii. Fully remote or hybrid – explore differences

2. What was your experience of building a relationship with your therapist remotely?
    a. What was helpful/ unhelpful?
    b. How did this compare to previous experiences of building relationships with therapists, if any?

3. What was your experience of having a private/confidential space in remote therapy?
    a. What impacted this
        i. Physical space - i.e space you were in, medium of remote therapy, Internet issues, therapeutic relationship etc

4. It can be really difficult to talk about experiences of trauma. You do not need to provide any details about the trauma you experienced but would you be able to describe your experience of talking about these experiences?
    a. How were you supported to talk about this experience?
    b. What if anything got in the way of you being able to talk about your experiences?

Shame is a really common emotion that people often experience following a trauma. People who experience a trauma sometimes blame themselves for what happened to them. They may also think that there's something wrong or shameful about themselves. We're going to be thinking about shame and your experience of shame within the therapy you had in the next few questions.

5. What is your understanding of shame/ how would you define it?
    a. How much do you feel affected by feelings of shame?
    b. In what way? relationships, professional/work, personal contexts etc

6. Did you experience any feelings of shame in relation to your trauma?
    a. How did this impact your therapy experience?
    b. Were you able to discuss this with your therapist? What made it easier/harder to talk about feelings of shame in therapy?
        ii. Did your therapist’s identity or approach impact your ability to discuss your feelings of shame in therapy?
        iii. Did your own identity/background impact your ability to discuss your feelings of shame in therapy
    c. What impact did having therapy online (rather than in person) have on how you felt able talk about the events that made you feel ashamed?

7. What if any, was your experience of shame within your therapy session?
    a. What affected this?
    b. We’re you concerned about judgement of therapist?
    c. How did the therapist respond to your experiences of shame within the therapy room?
    d. Was this impacted about being online or not in the room together?

8. As you are nearing the end of your therapy journey, have your experiences/views of shame changed in relation to your trauma?

9. Is there anything else you’d like to tell me that I have not asked about?

Appendix G

Staff Moderator Guide

Demographic Information

- Age
- Gender
- Ethnicity
- Type of therapies offered
- Length of therapies offered
- Prior experience of delivering online or f2f

10. What was your experience of delivering remote therapy?
    i. Do you also offer in person therapy? How do you compare remote and in person therapy? Did you feel connected/ far away from the client?
    ii. Fully remote or hybrid – explore differences.

11. What was your experience of building a relationship with your client remotely?
    c. What was helpful/ unhelpful?
    d. How did this compare to previous experiences of building relationships with clients, if any?

12. What was your experience of having a private/confidential space in delivering remote therapy?
    a. What impacted this?
        i. Physical space - i.e. space you were in, medium of remote therapy, Internet issues, therapeutic relationship etc.

13. It can be really difficult for clients to talk about experiences of trauma. Would you be able to describe your experience of supporting clients to talk about these experiences?
    a. How were your client's supported to talk about their experience?
    b. What if anything got in the way of your client being able to talk about their experiences?

Shame is a really common emotion that people often experience following a trauma. People who experience a trauma sometimes blame themselves for what happened to them. They may also think that there's something wrong or shameful about themselves. We're going to be thinking about shame and your client's experience of shame within the therapy you had in the next few questions.

14. What is your understanding of shame/ how would you define it?
    a. How much did your client feel affected by feelings of shame?
    b. In what way? relationships, professional/work, personal contexts etc

15. Did your client experience any feelings of shame in relation to their trauma?

    a. How did this impact their therapy experience?
    b. What impact did having therapy online (rather than in person) have on how your client felt able talk about the events that made them feel ashamed?
    c. Were they able to discuss this with you? What made it easier/harder for them to talk about feelings of shame in therapy?
        ii. Did your identity or approach impact their ability to discuss their feelings of shame in therapy?
        iii. Did your client's own identity/background impact their ability to discuss their feelings of shame in therapy?

16. What if any, was your client's experience of shame within your therapy session?
    a. What affected this?
    b. Were they concerned about judgement from you as the therapist.
    c. How did you respond to your client's experiences of shame within the therapy room?
    d. Was this impacted about being online or not in the room together?

17. Nearing the end of your clients' therapy journey, did their experiences/views of shame changed in relation to their trauma?

18. Is there anything else you'd like to tell me that I have not asked about?

Appendix H

PARTICIPANT DEBRIEF SHEET
NHS Research Ethics Committee Approval ID number: 320335

Title of Study: Online therapy and disclosures of shame: An exploration into the experiences of clients presenting with PTSD.

Department:	Department of Clinical, Educational and Health Psychology
Researcher:	Tara Walsh, Trainee Clinical Psychologist, tara.walsh.21@ucl.ac.uk
Principal: Researchers:	Dr Francesca Brady, Clinical Psychologist, f.brady@ucl.ac.uk Dr Justine Bush, Clinical Psychologist, Justine.bush@candi.nhs.uk

Thank you for taking part in this study

Thank you for taking part in our study which explored your experiences of online trauma therapy, particularly exploring feelings of shame. There was no deception involved in the study.

What will happen to the results of the study?

We will write a report about what we found out during the study. This will cover information we gather from everyone we speak to, not just you. We may include direct quotations from interviews in the published report, but we will not include any names or identifying details of participants and we will ensure that any quotations will be anonymised.
All participants will be offered the opportunity to receive a copy of the results via email, as indicated by your preferences on the consent form. If you would like to change your preferences now or later, please speak to the researcher, who can amend this for you.

Right to withdraw

You may choose to withdraw the data you provided until February 2024 when the data will be analysed, without providing any reason, and this will not affect your therapeutic care. This will also not affect your incentive payment. Please notify the researcher (or either of the principal researchers) if you wish to withdraw from the study.

Additional support

We are aware that our discussions today may have brought up some difficult emotions. We would like to remind you that should you feel distressed, please speak to the researcher, if you feel able to.

In addition, during working hours you can contact the team that coordinates your mental health care on a long-term basis. If you are not sure who this is, speak to the researcher who can signpost you to the right team.
If you need urgent mental health support outside of that team's working hours, then you should contact the Crisis Single Point of access on Freephone 0800 917 3333. This number is available 24 hours a day, 7 days a week.

You can also please make contact with emergency services by telephone on 999 or by presenting to your local accident and emergency service.

Thank you once again for your valuable participation

Data Protection privacy notice	**If I have any questions, who can I ask?**
UCL’s Data Protection office can be contacted at data-protection@ucl.ac.uk. You can read UCL’s privacy notice at: https://www.ucl.ac.uk/legal-services/ privacy/participants-health-and-care-research-privacy-notice and details of your rights at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of- the-gdpr/individuals-rights/ Your personal data (name, contact details, gender, and ethnicity) will be processed as described in this information sheet. **The legal basis for data processing is to “perform a task in the public interest”**	Tara Walsh Trainee Clinical Psychologist Email: tara.walsh.21@ucl.ac.uk Supervised by Dr Justine Bush Email: Justine.bush@ucl.ac.uk Dr Francesca Brady Email: f.brady@ucl.ac.uk *If you are unhappy about the study at any stage, please contact the researchers on the email address above. If you would like to complain further, you can email ethics@ucl.ac.uk.*

Appendix I

Themes	**Example Codes**
Complexity of shame	
The Shame Identity	Longevity of shame, location of shame is internal, growing up with shame, shame as all encompassing
Secrecy and Silencing	Stigma of help seeking, suppression and revelation, fear of shame
Shame Liberation	Self-discovery, absence of shame, empowerment and assertiveness, shifting the blame and shame
Shame sensitive practice	
Healing from Negative Care Experiences	Misunderstood and mislabelled, lack of experience and knowledge is harmful, invalidation of experience
Building a Trusting Alliance	The compassionate lens, a language to describe experience, disclosure and
Bridging the Cultural Barrier Gap	Burden of mixed-race identity, lack of racial representation in therapy, therapist disclosure builds relationship
Rethinking the “therapy room”	
Breaking Physical Barriers to Care	Increased accessibility, the forgotten population, intimacy in remote connection
Therapeutic Safeness	Managing risk remotely, redefining what safety is, safety of own home, therapist anxieties
Renegotiating the Therapeutic Space	Experience and skill, managing confidentiality and boundaries, pre and post therapy processes