UNIVERSITY OF HULL

Exploring Clients' and Therapists' Experiences of Trauma-Focused Therapies

being a thesis submitted in partial fulfilment of the

requirements for the degree of

Doctor of Clinical Psychology

at the University of Hull

by

Annie Townshend

BSc (Hons) Psychology, University of York

May 2023

Acknowledgements

Firstly, I would like to thank the therapists who took part in this research; I am deeply grateful for the time you gave and the candour with which you spoke about your experiences. I really valued your enthusiasm for the research and hope, like you, that the sharing of your experiences will help to influence the future of the flash technique.

I would also like to extend my thanks to my supervisors, Dr Jo Beckett, Dr Emma Wolverson and Dr Anne Parry. Your passion for this research and consistent reassurance has been such a support to me over the last three years. Thank you for sharing your knowledge with me and for the patience with which you answered my many questions.

A big thank you to my friends for your support and encouragement throughout. To my fellow ClinPsyD trainees, I am so grateful for the sense of camaraderie I feel when I am around you, I feel lucky to have shared this experience with you. Particular thanks are given to my closest friend, Elle, for always knowing when to lighten the mood and for celebrating each success, big and small.

Finally, to my family, I do not have the words to express my gratitude to you. Your endless love and encouragement is the reason I am where I am today. Thank you for supporting me in everything I do and for always believing in me.

Overview

This portfolio thesis contains three parts. Part One is a systematic literature review and Part Two is an empirical paper. Together they provide a greater understanding of clients' and therapists' experiences of trauma-focused therapies. Part Three forms the appendices.

Part One: A systematic literature review of clients' experiences of trauma-focused cognitive behavioural therapy (TF-CBT). The review identified 11 papers and completed a narrative synthesis of the qualitative data pertaining to clients' descriptions of their experiences of TF-CBT. The synthesis constructed five themes. The review highlighted the range of emotions experienced by clients before, during and after TF-CBT. It demonstrated the importance gaining a deeper understanding of clients' experiences of TF-CBT using qualitative research and highlighted the implications of this understanding for clinical practice.

Part Two: An empirical paper exploring therapists' experiences of the flash technique (FT). Semi-structured interviews were completed with 15 participants; reflexive thematic analysis was used to develop and make sense of themes identified from the data. The study found that therapists perceived FT to be a useful tool to contain clients' trauma-related distress and empowered clients to proceed to trauma processing. The study highlighted increased positive affect experienced by therapists implementing FT and the subsequent implications for therapists' wellbeing.

Part Three: Appendices relating to the systematic literature and empirical paper, including a reflective account of the research and a statement of epistemology.

Total word count: 23,826 (including abstracts, tables, references and appendices)

Contents

List of Tables and Figures

Part One: Systematic Literature Review

Part Two: Empirical Paper

Part One: Systematic Literature Review

What do Clients say About Their Experiences of Trauma-Focused Cognitive Behavioural Therapy? A Review of the Qualitative Literature

Annie Townshend*, Dr Jo Beckett, Dr Emma Wolverson & Dr Anne Parry

Faculty of Health Sciences, School of Psychology and Social Work

Aire Building, University of Hull, Hull, United Kingdom, HU6 7RX

*Corresponding Author Email: A.Townshend-2020@hull.ac.uk

This paper is written in the format ready for submission to the journal

Journal of Trauma and Dissociation

Please see Appendix A for the Guideline for Authors

Word count: 9,774 (including tables and figures, excluding references)

Abstract

Background

Trauma-focused cognitive behavioural therapy (TF-CBT) is an effective treatment for trauma-related distress. However, within the literature, it is less clear what clients think about the intervention. This review aimed to explore clients' experiences of TF-CBT.

Data Sources

Qualitative studies containing accounts of clients' experiences of TF-CBT were identified through online database searches: Academic Search Premier, APA PsycInfo, APA PsycArticles, CINAHL Complete, and MEDLINE. A total of 880 studies were retrieved and screened for inclusion in this review; 11 studies met the inclusion criteria and proceeded to quality appraisal and data synthesis.

Data Synthesis

Narrative synthesis was used to synthesise data from the results sections of the 11 included studies.

Results

From the 11 studies, five themes were constructed including: 'feeling the fear and doing it anyway', 'experiencing distress during TF-CBT sessions', 'the importance of a supportive therapeutic relationship', 'the distress experienced during TF-CBT was worth it', 'transformative change as a result of TF-CBT'.

Conclusion

The reviewed findings indicated that participants' experiences of TF-CBT centred around the range of strong emotions experienced before, during and after TF-CBT. The review highlighted the need for clinicians to carefully consider the rationale for implementing TF-CBT on a case-by-case basis due to differences in participants' ability to tolerate the significant distress associated with TF-CBT.

Keywords: TF-CBT, clients, experiences, qualitative, systematic literature review

Introduction

Trauma-focused cognitive behavioural therapy (TF-CBT) is a psychological therapy recommended by the National Institute of Clinical Excellence (NICE) for the treatment of trauma-related distress in children, adolescents and adults, (NICE, 2018) which can develop in response to experiencing or witnessing a traumatic event which is perceived to be a threat to life or physical injury (American Psychological Association [APA], 2013). TF-CBT was developed by Cohen et al. (2006) to treat children experiencing trauma-related distress. It aims to provide children and their carers with the understanding, knowledge and skills to make sense of their traumatic experiences. The core components of TF-CBT include: psychoeducation and parenting, relaxation, affective expression and modulation, cognitive coping, trauma-narrative development and processing, in vivo exposure, and enhancing safety and future development (Cohen et al., 2012). TF-CBT has since evolved and been adapted to treat a range of populations experiencing trauma-related distress (Mavranezouli et al., 2020).

TF-CBT has been shown to be significantly more effective in treating symptoms of trauma-related distress than waitlist/usual care conditions and equally as effective as eye movement desensitisation and reprocessing (EMDR) and other pharmacological interventions in adults (Mavranezouli et al., 2020) and is marginally more effective than EMDR in children and adolescents (Lewey et al., 2018).

While TF-CBT has been shown to be effective for people experiencing trauma-related distress, clinicians have reported concerns about treatment acceptability (Becker et al., 2004; Ruzek et al., 2014; van Minnen et al., 2010). Becker et al. (2004) found that only 17% of 207 US-based licensed psychologists in clinical practice used imaginal exposure, an important component of TF-CBT, to treat post-

traumatic stress disorder (PTSD) with more than half of surveyed clinicians reporting concerns that clients would be more likely to drop out of treatment as a result of using imaginal exposure. Despite evidence linking change mechanisms in TF-CBT with the exposure components i.e. focusing on the traumatic memory (Deblinger et al., 2011), therapists were more likely to use psychoeducation about anxiety and coping during TF-CBT interventions (Allen & Johnson, 2012). Therapists have reported feeling reluctant to use imaginal exposure due to concerns around risk of re-traumatisation, defined by Kilpatrick and Best (1984) as an increase in suffering, causing clients to disengage from therapy (Becker et al., 2004; Ruzek et al., 2014; van Minnen et al., 2010). For some clients, the distress experienced during exposure-components of TF-CBT may lead to the formation of a new trauma memory which, combined with the perceived risk of re-traumatisation, conflicts with The British Psychological Society (BPS) Code of Ethics and Conduct (BPS, 2021) which states psychologists have a responsibility to avoid harm. This conflict highlights the importance of understanding clients' experiences of TF-CBT to improve the experience of therapy for both the client and the therapist. Supporting clinicians' concerns that clients may become re-traumatised as a result of TF-CBT, TF-CBT is associated with higher drop-out rates among adults compared with therapies that do not include exposure components (Bisson et al., 2013). If clients find TF-CBT so intolerable that they do not complete treatment, then TF-CBT is not an effective intervention for trauma-related distress.

Understanding how clients experience TF-CBT will provide valuable insights to inform how clinicians deliver the intervention and whether it is as distressing as clinicians fear. To date, research into client experience of TF-CBT is rarely grounded

in the perspectives of people accessing TF-CBT and instead is reported through clinicians' perception of clients' experiences, limiting the knowledge gained.

Neelakantan et al. (2019) reviewed the qualitative research investigating children and adolescents, aged 4-20 years old, and their caregivers' experiences of TF-CBT and concluded that experiences were generally positive. Researchers paid particular attention to exploring how challenges to engagement can be addressed as well as an emphasis on clients' perceptions of emotional and physical safety. Although NICE (2018) recommends TF-CBT for adults as well as children and adolescents, the review only included studies focusing on the experiences of children and adolescents and their caregivers. Moreover, Neelakantan et al.'s (2019) review aimed to explore experiences of TF-CBT but four of the eight studies implemented interventions which were not TF-CBT, for example, Pernebo and Almqvist's (2016) study exploring participants' experiences of trauma-focused psychotherapy based on trauma and psychodynamic theory, was included in the review. Additionally, Neelakantan et al.'s (2019) review only included studies published before September 2016. It is particularly important to review research that has been published more recently given the context of the COVID-19 pandemic which has led to adapted ways of working, for example delivering TF-CBT online, and has also led to an increase in the prevalence of trauma-related distress (Shevlin et al., 2021). Therefore, the current review builds on the review completed by Neelakantan et al. (2019) by completing an up-to-date search of the literature and by including the experiences of adults who have experienced TF-CBT as well as children. The aim of this literature review is to explore qualitative accounts provided by clients, defined as people who have received TF-CBT, about their experiences of TF-CBT. The review findings may help to identify ways to reduce therapists' avoidance of exposure-based components

given the important links with change mechanisms, and may also inform communication of what to expect during TF-CBT so clinicians and clients feel more prepared prior to commencing the intervention.

Research question: What do clients say about their experiences of TF-CBT?

Method

Search Strategy

A systematic literature search, up to and including December 2022, was conducted using five electronic databases: Academic Search Premier, APA PsycInfo, APA PsycArticles, CINAHL Complete, and MEDLINE to increase the likelihood of finding relevant literature. A date limiter, 2006-present, was applied to reflect the publication of the first literature outlining the TF-CBT procedure (Cohen et al., 2006). A language limiter was applied to only include papers written in English due to resource constraints on translation.

Search Terms

An initial scoping search helped to identify key search terms and synonyms, search terms were then reviewed with support from a University Academic Liaison Librarian. The following search terms were applied to article titles and abstracts:

TF-CBT OR trauma focused cognitive behavio* therapy

AND

Experience* OR perception* OR attitude* OR view* OR feeling* OR qualitative OR perspective*

Study Screening and Selection Strategy

All articles were screened by title and abstract to assess their relevance. If relevance could not be ascertained from the title and abstract, the full article was reviewed. Articles identified following initial screening were then reviewed with the inclusion criteria applied (see Table 1).

Table 1

Review Inclusion Criteria and Rationale

Inclusion criteria	**Rationale**
Interventions based on TF-CBT as outlined by Cohen et al. (2006); this included papers that solely focused on TF-CBT as well as those that compared TF-CBT to other treatment interventions where it was possible to extract data describing experiences related specifically to TF-CBT.	To ensure articles focused on TF-CBT as an intervention technique for clients experiencing trauma-related distress.
Qualitative and mixed-methods study designs, where it was possible to extract qualitative data.	As quantitative studies are often focused on gaining objective measurements of an identified phenomenon; whereas in-depth experiences can only be gained from qualitative data which was the focus of the review.
Studies that reported clients' experiences of TF-CBT as an intervention. Papers were	The review focused on clients' ideas about what it was like to experience

included that focused on clients' experiences of TF-CBT as a whole and/or clients' experiences of specific components of TF-CBT, for example, visits to the trauma site completed during TF-CBT.	TF-CBT as an intervention for trauma-related distress, therefore it was important to consider specific components which made up TF-CBT as well as TF-CBT as a whole.
Papers were included that interviewed a range of participants (e.g. clinicians and caregivers) where it was possible to extract sufficient data (sufficient was defined as at least two relevant quotes across two themes or at least four quotes within one theme) relating to clients' descriptions of their experiences of TF-CBT. Clients were defined as the individuals who received the TF-CBT intervention to treat trauma-related distress.	To ensure data analysis was driven by clients' experiences of TF-CBT rather than others' perceptions of clients' experiences which may not be a true reflection of clients' experiences of TF-CBT. Sufficient data was defined to ensure there was enough richness in the data to draw meaningful conclusions.
Primary research articles (i.e. not abstracts, literature reviews, meta-analyses, commentaries, letters, editorials, reports, conferences).	As empirical studies typically provide more detail pertaining to important contextual factors, i.e. nature of intervention delivered, and present primary findings in relation to a specified research question.
Any country of publication.	Although it is recognised that practise may vary between countries, no limits were set around country of

	publication due to this review taking an exploratory approach.
Studies included clients who had experienced any number of TF-CBT sessions.	Although NICE (2018) recommends 6-12 sessions of TF-CBT for children and adolescents and 8-12 sessions of TF-CBT for adults, this review set no limits to number of sessions due to the exploratory approach taken by this review.
Studies included clients who were of any age.	NICE (2018) recommends TF-CBT for both children and adults who experience trauma-related distress.
Date range: 2006-present.	The first literature outlining the TF-CBT procedure was published in 2006 (Cohen et al., 2006).
English language.	Due to resource constraints on translation.

Data Extraction and Quality Assessment

After article selection, key data were extracted from each article. This included: study aim(s) and relevant interview topics, sample characteristics, details of the TF-CBT intervention, methodological approach and key findings related to client experience (see Table 2).

Quality of the included studies was assessed using the Critical Appraisal Skills Programme (CASP, 2018) qualitative checklist which comprises 10 questions designed to critically assess the quality of qualitative studies (see Appendix B). The CASP was selected because it covers all relevant aspects of methodological quality contributing to an in-depth quality assessment and it is a commonly utilised tool in other literature reviews of qualitative studies within the field of health and social research (Dalton et al., 2017). Additionally, the checklist covers all relevant aspects of methodological quality contributing to an in-depth quality assessment. Each study was scored and assigned an overall quality rating score out of 10 (the sum of all 'yes' answers). Assessing rater reliability, a subset of papers (two of the highest, two of the middle and two of the lowest scores) were rated by a peer researcher, blind to the original ratings. The percentage level of agreement was 93%; discrepancies were discussed and a final decision was made by the first author. A summary table of the results of the quality assessment has been included in Appendix C. Due to the limited number of studies, studies were not excluded from the analysis based on their quality assessment score but the information gathered was taken into consideration during data analysis.

Data Analysis and Synthesis

Data was analysed using narrative synthesis (Popay et al., 2006), which is used to synthesise findings of included studies and understand how the data might be related. Narrative synthesis also encourages the exploration of whether a model or theory can be used to organise and explain the findings. Narrative synthesis was selected as the studies included in the review had high heterogeneity in relation to the sample characteristics as well as aspect of TF-CBT intervention focused on. Therefore, narrative synthesis was deemed an appropriate tool to combine the findings from the included studies, understand how study findings might be connected and use this perspective to provide greater insight

into the experiences of people who have accessed TF-CBT for experiences of trauma-related stress.

Popay et al.'s (2006) guidelines on conducting a narrative synthesis were consulted throughout the following data synthesis process:

- A detailed examination of the studies retrieved was completed to support methodological and conceptual critique of studies. Data relevant to the research question was extracted and compiled (see Table 2).
- From the extracted qualitative findings of each study, an initial thematic analysis was completed whereby similar data items, including quotes and themes, were grouped together. Particular attention was paid to direct quotations to ensure the meanings made were as close to the raw data as possible.
- A second iteration of the thematic analysis was completed to check for the generation of new themes from the extracted data. Themes generated during the first and second iteration of the analysis were compiled and organised to tell the story of the extracted data in a way that addressed the aims and question underpinning the review.

Results

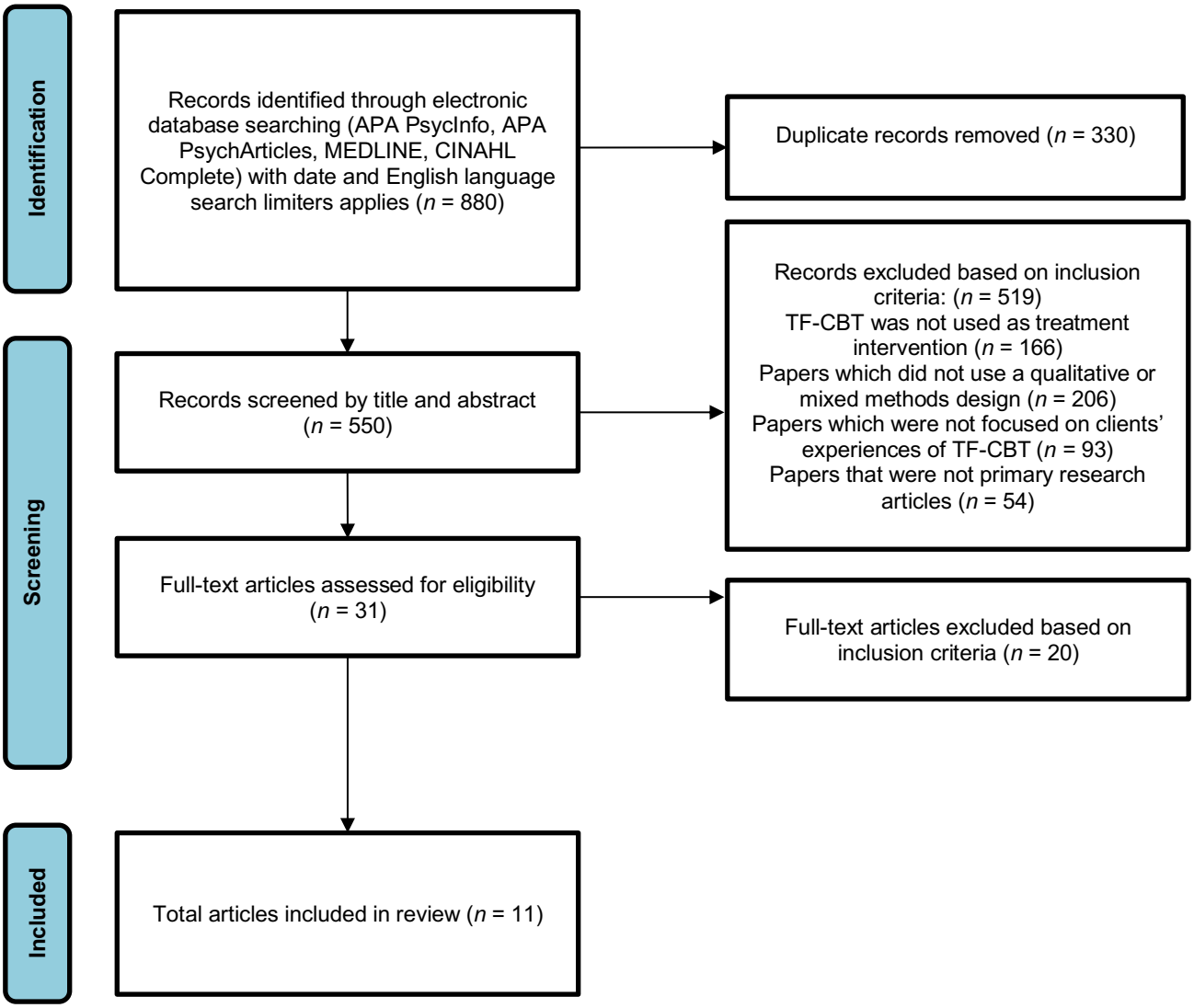
Identification of Relevant Studies

The search identified 880 articles, 550 of which were screened by their title and abstract following the removal of duplicates. Of these, 519 articles were excluded due to not meeting the inclusion criteria (Table 1). The remaining 31 articles were assessed for eligibility upon reading the full text. No additional articles were found during a citation search or a hand search of reference lists of included papers. The review obtained a final sample of 11 articles. The study selection process was informed by the Preferred

Reporting for Systematic Reviews and Metanalyses (PRISMA) 2020 statement (Moher et al., 2021; Figure 1).

Figure 1

PRISMA Flow Diagram Demonstrating a Summary of the Article Screening and Selection Process



Overview of Included Studies

Samples were mainly drawn from Western countries (UK, USA, Australia, Norway), with one study from South Africa (Kaminer et al., 2022) and one study from Zambia (Murray et al., 2014). Sample sizes varied from six (Kaminer et al., 2022) to 30 participants (Dittmann & Jensen, 2014). Age range varied widely, from 9.53-63 years.

The majority of studies focused mainly on participants' experience of TF-CBT as a whole although two studies focused on participants' experiences of a specific component of TF-CBT (Murray et al., 2016; Shearing et al., 2011). The TF-CBT intervention delivered to participants varied across studies, with four of the included studies following the procedure outlined in Cohen et al.'s (2006) original treatment manual (Dittman & Jensen, 2014; Eastwood et al., 2021; Murray et al., 2014; Okamura et al., 2020). Other studies had adapted the original TF-CBT procedure: for adults (Lowe & Murray, 2014; Vincent et al., 2013), as a parent-led intervention (Salloum et al., 2015), as part of a group intervention (Kroese et al., 2016), and as a shorter intervention (Kaminer et al., 2022). Two of the included studies focused on participants' experiences of specific components of TF-CBT (Murray et al., 2016; Shearing et al., 2011) rather than TF-CBT as a whole. Most studies included information about how many TF-CBT sessions participants had completed (Dittmann & Jensen, 2014; Eastwood et al., 2021; Kaminer et al., 2022; Kroese et al., 2016; Lowe & Murray, 2014; Salloum et al., 2015; Vincent et al., 2013), with number of sessions completed ranging from 2-19.

The main method of data collection was semi-structured interviews except Murray et al. (2016) who gathered qualitative data from questionnaires completed by participants. Studies mostly interviewed participants following completion of the TF-CBT intervention, Murray et al. (2016), Shearing et al. (2011) and Vincent et al. (2013) gathered data from participants while they were still engaged in the TF-CBT intervention. Two studies interviewed participants who had dropped out of treatment prematurely (Dittmann & Jensen, 2014; Eastwood et al., 2021). Analytic approaches included phenomenological (*n* = 5), grounded theory (*n* = 2), thematic (*n* = 2), 'iterative integrative' (*n* = 1) frequency coding (*n* = 1). The main characteristics of the included studies are summarised in Table 2 and are grouped according to age of participant.

Table 2

Study Characteristics and Key Findings

Author(s), date of publication, location	Study aim(s)	Sample characteristics	TF-CBT intervention	Methodological approach	Key findings extracted relating to clients' experiences of TF-CBT	Quality score
Child papers (studies investigating experiences of participants under 17 years old)						
1. Dittmann & Jensen (2014) Norway	To bridge knowledge gaps and enhance therapy methods by exploring traumatised children's experiences receiving TF-CBT	Interviews were conducted with 30 participants. Participants were aged 11-17 years old (mean 15 years), 23 females, 7 males. All participants had experienced at least one traumatic event (sexual abuse, domestic violence, violence from peers, life-threatening accidents, or the sudden death of a parent).	26 participants fully completed TF-CBT intervention, 4 participants dropped out prematurely (did not complete 6 sessions). Completed interventions ranged from 12-15 sessions. Therapists followed the TF-CBT treatment manual (Cohen et al., 2006). Caregiver involvement in the intervention was based on caregiver availability.	Qualitative Semi-structured interviews. Thematic analysis	Four themes: (1) Changing expectations (2) Talking to the therapist and sharing information (3) Working through the trauma narrative (4) Change and change processes	9
2. Kaminer et al. (2022) South Africa	To explore whether participants found the abbreviated TF-CBT model to be acceptable and tolerable. To assess	Interviews were conducted with 6 participants. Participants were aged 11-17 years old.	All participants fully completed the TF-CBT intervention. Completed interventions ranged from 8-9 sessions.	Mixed-methods Qualitative: semi-structured interviews completed with young people,	Three client themes: (1) Importance of the therapeutic alliance (2) Value of coping skills	8

	counsellor experiences of delivering the abbreviated TF-CBT intervention. To qualitatively explore participants' experiences of the abbreviated intervention.	All participants had experienced between 2 and 6 traumatic events (domestic violence, witnessing a murder, sexual assault and traumatic bereavement).	Therapists followed an abbreviated eight-session TF-CBT manual the TF-CBT treatment manual which comprised the same components from the original TF-CBT manual (Cohen et al., 2006) but with reduced time to complete each component. Caregiver involvement in the intervention was based on caregiver availability.	caregivers, and counsellors. Thematic analysis	(3) Trauma narrative process as challenging but beneficial	
3. Murray et al. (2014) Zambia	To examine Zambian counsellors, children and caregivers' perceptions of TF-CBT.	Interviews were conducted with 18 participants. Mean age of participants was 12.76 years old, 18 females. All participants had experienced at least one traumatic event (sexual abuse).	All participants were interviewed following intervention completion (number of sessions undefined). The therapist followed the TF-CBT treatment manual (Cohen et al., 2006). Caregiver involvement in the intervention was based on caregiver availability.	Mixed-methods Qualitative: semi-structured interviews. Grounded theory approach	Three themes: (1) The program helped (2) Challenges/dislikes (3) Recommendations to make the program better	7
4. Okamura et al. (2020)	To explore youth and caregivers'	Interviews were conducted with 8 participants.	All participants were interviewed following intervention completion	Mixed-methods	Five themes:	8

USA	perspectives of TF-CBT.	Participants were aged 11-19 years old (mean 14.38 years), 6 females, 2 males. All participants had experienced at least one traumatic event (witnessing a murder, sexual abuse).	(number of sessions undefined). The therapist followed the TF-CBT treatment manual (Cohen et al., 2006). Caregiver involvement in the intervention was based on caregiver availability.	Qualitative: semi-structured interviews. Iterative integrated approach including inductive and deductive reasoning to code data and generate themes.	(1) External motivation for initiating services (2) The importance of developing the therapeutic relationship (3) The focus of skill development (4) The significance of the trauma narrative (5) Perceived outcomes in both youth and caregiver following TF-CBT.	
5. Salloum et al. (2015) USA	To explore parents' and children's' perceptions of parent-led TF-CBT, specifically what they liked and disliked and what they found to be the most and least helpful about the parent-led, therapist-assisted treatment.	Interviews were conducted with 16 participants. Mean age of participants was 9.53 years old, 9 females, 7 males. All participants had experienced at least one traumatic event (sexual abuse, domestic violence, death of someone close).	All participants were interviewed following intervention completion. The intervention integrated the key components from the TF-CBT manual (Cohen et al., 2006) into a parent-led, therapist assisted program. The parent and child met with the therapist three times fortnightly and completed a parent-child workbook during 11 parent-child	Qualitative Semi-structured interviews completed with children and their caregivers. A theoretical codebook using the treatment components of the intervention was developed by the authors. Transcripts were coded using this codebook. Findings reported in a	11 themes: (1) Parent-child meetings (2) Workbook (3) Feeling identification (4) Relaxation (5) Trauma narrative (6) Exposures (7) Parent-led (8) Therapist sessions (9) Safety planning (10) Phone support (11) Psychoeducation	8

			meetings over the course of the six weeks. Caregiver involvement in the intervention was based on caregiver availability.	table in which each component was given a rating of liked/ disliked/ helpful/unhelpful by child and parent. Some quotes are also included.		
Adult papers (studies investigating experiences of participants over 17 years old)						
6. Eastwood et al. (2021) Australia	To understand how young people experience TF-CBT.	Interviews were conducted with 13 participants. Participants were aged 17-25 years old (mean 20.0 years), 9 females, 4 males. All participants had experienced at least one traumatic event (physical assault, sexual assault, uncomfortable sexual experience, assault with a weapon).	11 participants fully completed the TF-CBT intervention, 2 participants dropped out prematurely (did not complete 5 sessions). Completed interventions ranged from 9-19 sessions. The therapist followed the TF-CBT treatment manual (Cohen et al., 2006).	Qualitative Semi-structured interviews. Interpretative phenomenological analysis (IPA)	Four themes: (1) Experience of authentic care (2) Personal role in therapy and recovery (3) Talking about trauma is difficult but important (4) Transformative change	10
7. Kroese et al. (2016) UK	To study TF-CBT intervention for people with intellectual disabilities and complex PTSD.	Interviews were conducted with 12 participants. Participants were aged 21-46 years old (mean 33 years), 8 females, 4 males.	Participants were interviewed following the completion of TF-CBT which was delivered as a group intervention.	Mixed methods Qualitative: semi-structured interviews. IPA	Five themes: (1) Being listened to (2) It is nice to know you are not the only one (3) Being in a group can be stressful	9

		All participants had a diagnosis of an intellectual disability and had experienced at least one traumatic event.	The intervention was adapted from the TF-CBT manual (Cohen et al., 2006) and comprised a 12-week programme which included: development of an individual formulation; staying safe and stabilisation; neuropsychology of trauma; feelings and thoughts; understanding and managing emotions; improving relationships with others; depression and self-esteem; dissociation and different parts of ourselves; coping with triggers, memories, flashbacks and nightmares; self-harm and self-care; speaking up and moving on.		(4) The importance of feeling safe (5) Achieving and maintaining change	
8. Lowe & Murray (2014) UK	To examine clients' experiences of receiving a positive outcome following TF-CBT for PTSD.	Interviews were conducted with 9 participants. Participants were aged 30-63 years old (mean 53 years), 5 females, 4 males.	Participants completed between 6 and 15 TF-CBT sessions (mean 12 sessions). The intervention integrated the following components from the	Qualitative Semi-structured interviews. IPA	Five themes: (1) Living with symptoms before therapy (2) Feeling ready for therapy (3) Being involved	9

		All participants had experienced at least one traumatic event.	TF-CBT manual (Cohen et al., 2006): psychoeducation around PTSD; describing the trauma memory in detail; audio-recordings of narratives to practice imaginal exposure at home; cognitive restructuring to challenge and modify negative appraisals of traumatic event; relationship, problem-solving and anger management skills; relapse prevention and practicing coping strategies.		(4) Bringing about therapeutic change (5) Life after therapy	
9. Murray et al. (2016) UK	To ascertain whether participants found site visits helpful, to test whether the functions of the site visit predicted by cognitive theories of PTSD were endorsed, and to create a grounded theory model of how site visits are experienced.	Interviews were conducted with 25 adult participants. All participants had experienced at least one traumatic event.	Participants had completed a site visit according to the standardised protocol (Murray et al., 2015) as part of a TF-CBT intervention based on the TF-CBT treatment manual (Cohen et al., 2006).	Mixed-methods Qualitative: free-text written responses to questions as part of a questionnaire about the visit. Grounded theory	Model describes four main processes which occurred in a context of 'help and support': (1) Filling in the gaps (2) Different look and feel to the site (3) Negative experiences (4) Closure and moving on	8

10. Shearing et al. (2011) UK	To explore participants' experiences of undergoing reliving as part of CBT for PTSD in order to further clinicians' understanding of client experiences of reliving.	Interviews were conducted with 7 participants. Participants were aged 20-50 years old, 6 females, 1 male. All participants had experienced at least one traumatic event (physical assault, sexual assault, road traffic accident, natural disaster).	Participants had completed the reliving component of TF-CBT, based on the TF-CBT treatment manual (Cohen et al., 2006).	Qualitative Semi-structured interviews. IPA	Three themes: (1) Overcoming ambivalence (2) Painful but achievable (3) Positive change	9
11. Vincent et al. (2013) UK	To consider the acceptability of TF-CBT for asylum-seekers with PTSD by exploring their experiences of this treatment.	Interviews were conducted with 7 participants. Participants were aged 19-42 years old, 3 females, 4 males. All participants had experienced at least one traumatic event (physical assault, sexual assault, witnessing a murder, torture, war, imprisonment).	Participants had completed between 2 and 10 sessions of TF-CBT and at least 5 therapy sessions. The TF-CBT intervention involved focusing on traumatic events and their meaning using imaginal reliving (Ehlers & Clark, 2000) and/or adapted testimony (Grey & Young, 2008) as part of a TF-CBT intervention based on the TF-CBT treatment manual (Cohen et al., 2006).	Qualitative Semi-structured interviews. IPA	Six themes: (1) Importance of the therapeutic relationship (2) Experiences encouraging engagement in therapy (3) Staying where you are versus engaging in therapy (4) Experiences impeding engagement in therapy (5) Regaining life (6) Losing oneself	10

Quality of Included Studies

The methodological quality of included papers was assessed using the CASP, with an overall quality score assigned to each. Ten studies scored between 8-10 indicating 'very good quality', of which two studies scored the maximum rating 10/10 (Eastwood et al., 2021; Vincent et al., 2013), one study was rated 7/10 (Murray et al., 2014) due to lack of information.

Assessing overall quality, all 11 studies clearly stated the aims of the research, selected an appropriate research design to address their research aims, clearly stated the recruitment strategy which was deemed to be appropriate to the aims of the research and ensured the data was collected in a way that addressed the research issue. Clear evidence to support sufficiently rigorous data analysis was present in ten studies and all studies clearly stated their findings.

The most common reason for lower scores was inadequate reporting of the reflexive relationship between participants, the data and the researcher (Dittmann & Jensen, 2014; Kaminer et al., 2022; Kroese et al., 2016; Lowe & Murray, 2014; Murray et al., 2014; Murray et al., 2016; Okamura et al., 2020; Salloum et al., 2015). The three studies which did meet this criterion utilised IPA methodology (Eastwood et al., 2021; Shearing et al., 2011; Vincent et al., 2013). Three of the 11 studies provided no information to suggest ethical issues had been taken into consideration (Murray et al., 2014; Murray et al., 2016; Shearing et al., 2011).

Narrative Synthesis

From the 11 studies, five themes were constructed in relation to participants' experiences of TF-CBT, as displayed in Table 3. The following section provides a description of the five themes.

Table 3

Themes Derived from the Synthesis of Findings

Theme	Child papers featuring theme	Adult papers featuring theme
1. Feeling the fear and doing it anyway	Dittmann & Jensen, 2014; Kaminer et al., 2022; Murray et al., 2014.	Eastwood et al., 2021; Lowe & Murray, 2014; Murray et al., 2016; Shearing et al., 2011; Vincent et al., 2013.
2. Experiencing distress during TF-CBT sessions	Dittmann & Jensen, 2014; Kaminer et al., 2022.	Eastwood et al., 2021; Kroese et al., 2016; Lowe & Murray, 2014; Murray et al., 2016; Shearing et al., 2011; Vincent et al., 2013.
3. The importance of a supportive therapeutic relationship	Dittmann & Jensen, 2014; Kaminer et al., 2022; Murray et al., 2014.	Eastwood et al., 2021; Kroese et al., 2016; Lowe & Murray, 2014; Murray et al., 2016; Vincent et al., 2013.
4. The distress experienced during TF-CBT was worth it		Eastwood et al., 2021; Kroese et al., 2016; Lowe & Murray, 2014; Shearing et al., 2011; Vincent et al., 2013.
5. Transformative change as a result of TF-CBT	Dittmann & Jensen, 2014; Kaminer et al., 2022; Murray et al., 2014; Okamura et al., 2020; Salloum et al., 2015.	Eastwood et al., 2021; Kroese et al., 2016; Lowe & Murray, 2014; Murray et al., 2016; Shearing et al., 2011; Vincent et al., 2013.

Theme 1: Feeling the fear and doing it anyway

Participants' fear prior to engaging in TF-CBT was found across seven studies (Dittmann & Jensen, 2014; Eastwood et al., 2021; Kaminer et al., 2022; Murray et al., 2014; Murray et al., 2016; Shearing et al., 2011; Vincent et al., 2013). Participants reported that this anticipatory anxiety manifested in nightmares (Murray et al., 2016) and re-experiencing (Vincent et al., 213). Participants attributed their feelings of dread to not knowing what to expect from therapy (Dittmann & Jensen, 2014) and fear about thinking about the trauma memories (Shearing et al., 2011);

"I dreaded telling a strange lady what I had experienced." (Participant age: 15 years old; Dittmann & Jensen, 2014; theme: changing expectations; page 1225)

"Before I went there, I had nightmares of how would I feel." (Murray et al., 2016; theme: negative experiences; page 425)

Participants commonly experienced an internal conflict between hope for change and fear about what TF-CBT might involve (Shearing et al., 2011; Vincent et al., 2013) which created feelings of discomfort and confusion;

"Someone is forcing you to talk about them [sic: the traumas] and you, you are trying to forget them […] you are forced to remember, so you feel discouraged and you feel happy, no happy. You feel angry at the time." (Participant age: 27 years old; Vincent et al., 2013; theme: staying where you are versus engaging in therapy; page 584)

Desperation for change was commonly reported by adult participants which may account for the fact that participants engaged in therapy despite their intense feelings of fear about TF-CBT. There was a sense across the studies that participants had tried everything to improve how they were feeling with little success which left them with TF-CBT as the last remaining opportunity for positive change. This also suggests participants maintained

hope that TF-CBT could be the thing to bring about positive change (Lowe & Murray, 2014; Shearing et al., 2011; Vincent et al., 2013);

"I was desperate for help, yes I was I admit that." (Participant age: 63 years old; Lowe & Murray, 2014; theme: feeling ready for therapy; page 226)

"I was really getting at the end of my rope. I was, I was tired of, sort of, like fighting to be alive […] I was really, really close to just ending everything." (Participant age: 22 years old; Vincent et al., 2013; theme: experiences encouraging engagement in therapy; page 585)

Participants in studies exploring children's experiences did not express feeling desperate for change as a motivator for engaging in TF-CBT.

Theme 2: Experiencing distress during TF-CBT sessions

Studies reported that the majority of participants described experiencing heightened levels of distress during TF-CBT sessions, particularly when focusing on the trauma memory (Dittmann & Jensen, 2014; Eastwood et al., 2021; Kaminer et al., 2022; Kroese et al., 2016; Lowe & Murray, 2014; Shearing et al., 2011);

"When we had to go in detail about the situations. Yeah it just felt like I wasn't in the room. Felt like I wasn't in the room. I was actually back when it was, all the stuff [the trauma] was happening. So I was like actually, I was scared and I'd leave, like obviously we'd stop because [the therapist] could see that I was not in the room." (Eastwood et al., 2021; theme: talking about trauma is difficult but important; page 743)

"I felt that fear and panic that I was going to die." (Shearing et al., 2011; theme: painful but achievable; page 464)

In three studies participants also described the negative impacts of TF-CBT across other areas of their lives including; a temporary increase in flashbacks and nightmares (Eastwood et al., 2021; Murray et al., 2016; Shearing et al., 2011), feelings of low mood and isolation resulting in a decline in academic performance (Eastwood et al., 2021), and relapse into drug misuse (Eastwood et al., 2021);

"I was very dark and depressed… like just constantly thinking about it and bringing little things up that you kind of like suppress and just not think about it. I was very negative." (Eastwood et al., 2021; theme: talking about trauma is difficult but important; page 743)

Some participants reported that TF-CBT was so distressing it impacted their ability to attend sessions (Eastwood et al., 2021; Vincent et al., 2013) and six participants dropped out of TF-CBT as they reported feeling worse after talking about the trauma memory during TF-CBT sessions (Dittmann & Jensen, 2014; Eastwood et al., 2021);

"I just didn't want to talk. I just wanted to stay home. I just wanted to be with my friends and just like distract myself instead of coming and ah talking about it and stuff." (Eastwood et al., 2021; theme: talking about the trauma is difficult but important; page 743)

"Up 'til now I don't know if it's helpful hundred percent or not because I do sometime cancel the appointment with her [sic: the therapist]. Just I had a strongly feeling to, to stop come here." (Participant age: 31; Vincent et al., 2013; theme: experiences impeding engagement in therapy; page 586)

Theme 3: The importance of a supportive therapeutic relationship

Trust that their therapist would keep them safe during the intervention was reported by participants to be instrumental in helping them to remain engaged in TF-CBT and tolerate

their feelings of distress (Dittmann & Jensen, 2014; Eastwood et al., 2021; Kaminer et al., 2022; Lowe & Murray, 2014; Murray et al., 2014);

"She [sic: the therapist] showed me it's a safe space and that I can trust her and what we will share will stay between us." (Kaminer et al., 2022; theme: importance of the therapeutic alliance; page 284)

"She [sic: the therapist) said that if it was difficult we could stop and do some breathing exercises and that helped very much." (Participant age: 15 years old; Dittmann & Jensen, 2014; theme: working through the trauma narrative; page 1226)

Also identified as key to the development of the therapeutic relationship was participants' perceptions that the therapist authentically cared for them (Eastwood et al., 2021; Kroese et al., 2016; Murray et al., 2016; Vincent et al., 2013). This was often conveyed through apparent surprise by participants that their therapist took them seriously and wanted to understand their experiences;

"So I just felt like I was… I wasn't just like a number in a study. I was a person that she [sic: the therapist] actually wanted to talk to. I think that made a huge difference." (Eastwood et al., 2021; theme: experience of authentic care; page 741)

"It made my heart warm and fuzzy. Made me feel like I was an actual person and that I was cared for." (Eastwood et al., 2021; theme: experience of authentic care; page 741)

Participants reported both verbal and non-verbal signs that their therapist authentically cared, for example, Eastwood et al. (2021) reported that some participants commented that their therapist remembered conversations from previous therapy sessions. Vincent et al. (2013) also reported that participants had identified the therapist's authentic care through their empathy, listening and practical help. However, the study completed by

Vincent et al. (2013) sampled participants who had received CBT-based psychoeducation and anxiety management sessions prior to commencing TF-CBT sessions, in fact the median number of sessions of TF-CBT completed by participants was three. As such, it was unclear in the study write-up whether the importance of the therapeutic relationship was specific to TF-CBT or therapy in general, particularly as the paper did not make it clear whether the two approaches were delivered by the same therapist.

Participants valued a collaborative approach to TF-CBT, for example, being encouraged to make decisions about the pace and direction of therapy (Eastwood et al., 2021; Lowe & Murray, 2014);

"It was taken at my pace. You know, my therapist suggested things what sort of like… instead of saying do this do that, she made suggestions and I sort of come out with suggestions and then she said, 'Oh yeah, try that.'" (Participant age: 56 years old; Lowe & Murray, 2014; theme: being involved; page 227)

Murray et al. (2014) also reported that four children valued being involved in decisions about therapy, however no supporting quotes were provided to evidence the researchers' claim.

Further exemplifying the importance of trust and collaboration between client and therapist during TF-CBT sessions, Dittmann and Jensen (2014) interviewed four participants who had dropped out of TF-CBT prematurely who stated that they did not feel listened to by their therapist;

"It was the fact that I had to drag up the things that had happened and that I didn't have time to think about it and that I felt pressured to talk about it when I didn't feel ready. I wished we could have done it another time when I was more ready and that I could have decided when, but I felt that I couldn't… that I had to say it right away. And when I said 'no'

many times and that I couldn't do it, she [sic: the therapist] didn't listen to me so at the end I had to say it to her. That was difficult for me." (Participant age: 17 years old Dittmann & Jensen, 2014; theme: working through the trauma narrative; page 1226)

Theme 4: The distress experienced during TF-CBT was worth it

Experiencing the benefits of TF-CBT helped participants to persevere with sessions in spite of the associated emotional distress (Eastwood et al., 2021; Kroese et al., 2016; Lowe & Murray, 2014; Shearing et al., 2011; Vincent et al., 2013);

"It's harder at the beginning then towards the end you can see some light at the end of the tunnel. I've been in a lot of places before where I felt there weren't no light at the end of the tunnel" (Kroese et al., 2016; theme: achieving and maintaining change; page 305)

"I feel like after we had talked about the trauma […] it's like I crossed a bridge. It was a very shaky bridge that I didn't want to cross, but once I crossed it, it kind of just… like, the grass was greener on that end, I just had to kind of, continue walking." (Eastwood et al., 2021; theme: talking about trauma is difficult but important; page 744)

Many participants perceived the emotional distress they experienced during TF-CBT was made worth it by the benefits gained, and in fact the pain was a necessary part of the journey. Eastwood et al. (2021) surmised participants held the belief that negative affect experienced during TF-CBT was evidence that therapy was working;

"There was some really shit times, but you know, you got to go through this shit to be able to feel better." (Eastwood et al., 2021; theme: transformative change; page 745)

"I knew as much as it did suck, I needed, I needed it to suck for me to get over it." (Eastwood et al., 2021; theme: talking about the trauma narrative is difficult but important; page 743)

This theme was created from data presented by adult papers; quotes presented in the child papers did not link the distress experienced during TF-CBT with perceived benefits.

Theme 5: Transformative change as a result of TF-CBT

Participants reported that the skills they had learned not only helped them to cope with their emotional distress during TF-CBT sessions but they also felt more equipped to cope with distress in the future (Eastwood et al., 2021; Kaminer et al., 2022; Kroese et al., 2016; Lowe & Murray, 2014; Okamura et al., 2020; Salloum et al., 2015). Relaxation techniques were described as particularly helpful (Dittmann & Jensen, 2014; Eastwood et al., 2021; Kaminer et al., 2022; Kroese et al., 2016; Lowe & Murray, 2014; Okamura et al., 2020; Salloum et al., 2015), however some participants reported finding relaxation unhelpful during TF-CBT sessions (Kroese et al., 2016);

"The breathing… it helped calm me down." (Participant age: 12 years old; Salloum et al., 2015; theme: relaxation; page 19)

"In my sessions I was introduced to the idea of mindfulness and that was a concept I have never sort of come across before. And going away and learning a little bit more about that and actually trying to use some of them techniques to sort of, help with perhaps anger issues and things like that… It's something that I can take away and continue to use and I do use in other situations." (Participant age: 57 years old; Lowe & Murray, 2014; theme: life after therapy; page 228)

“I know a lot of the people like the relaxation at the end but I didn’t like it very much because I don’t find it very easy to relax so when they were sat there with their eyes closed I was thinking, “this is weird”. (laughs) I can’t deal with that very well, but yeah.” (Kroese et al., 2016; theme: being in a group can be stressful; page 304)

Participants identified that TF-CBT gave them new insights into the trauma memory which contributed to feelings of closure allowing them to move on from the trauma (Eastwood et al., 2021; Lowe & Murray, 2014; Murray et al., 2016; Okamura et al., 2020; Shearing et al., 2011). Changes to the relationship with the trauma memory included a sense of increased distance between the participant and the trauma memory, decreased emotional distress associated with the trauma memory, and an increased sense of freedom associated with talking about the trauma memory;

“It was the final piece of the puzzle, and delivered so much reassurance, closure and release from the trauma.” (Murray et al., 2016; theme: closure and moving forward; page 425)

“I just don’t feel as scared of the memory if that makes sense?” (Shearing et al., 2011; theme: positive change; page 465)

Several studies reported that participants had experienced a transformative change in their relationship with the self (Eastwood et al., 2021; Lowe & Murray, 2014; Murray et al., 2014; Shearing et al., 2011; Vincent et al., 2013). Often participants described a shift in blame associated with the trauma which they had previously ascribed to themselves but that this had changed following TF-CBT;

“When I was raped I used to cry when I think about it. I would blame myself that it is because of me that's why I was raped. But due to the program and the counselor I should

not be blaming myself about what happened to me because it was not my fault." (Murray et al., 2014; theme: the program helped; page 910)

"…it was a terrible injustice that was done to me, umm. And that, you know, I have every right to be angry about it, and upset about it." (Shearing et al., 2011; theme: positive change; page 465)

Vincent et al. (2013) constructed the theme, *regaining identity*, to encapsulate changes to participants' self-to-self relating. However, it is important to note that the mean number of sessions of TF-CBT received by participants in this study was three.

Attribution of positive change differed across studies; three participants attributed improvements in their relationship with the self to outside factors, for example, their parents received help or they had connected with friends (Dittmann & Jensen, 2014) whereas participants in other studies attributed relational improvements to TF-CBT (Eastwood et al., 2021; Kroese et al., 2016; Lowe & Murray, 2014; Murray et al., 2014; Okamura et al., 2020);

"It brought my family relationship a little better with me because I broke their trust at one point… they didn't trust me… because I was stealing from them and I was doing… things that weren't appropriate so they just didn't trust me. So, it brought my family closer to me. I basically just like the trauma narrative part, writing that out." (Okamura et al., 2020; theme: the significance of the trauma narrative; page 1718)

Other positive impacts of TF-CBT reported by participants included improved sleep with less disturbance and fewer nightmares (Dittmann & Jensen, 2014; Lowe & Murray, 2014; Shearing et al., 2011);

"I think I've got a lot more energy, and I'm sleeping better. That kind of helps to make everything seem a lot more manageable." (Shearing et al., 2011; theme: positive change; page 465)

"But I am sleeping much better, I'm eating. Certainly my sleep patterns have changed, although I've had a couple of nights where it is not quite right. But I am not having the nightmares and not waking up and then not being able to go back to sleep… I can go back to sleep. I don't have this constant feeling of impending doom anymore." (Participant age: 63 years old; Lowe & Murray, 2014; theme: life after therapy; page 228)

However, Lowe and Murray (2014) specifically sampled participants who reported significant symptom reduction following TF-CBT. As such, less weight can be ascribed to conclusions about the benefits of TF-CBT due to the lack of balance that would be gained if they had also interviewed participants who did not experience such positive effects of TF-CBT.

Another perceived benefit of TF-CBT was participants' increased hope for the future (Dittmann & Jensen, 2014; Eastwood et al., 2021; Kroese et al., 2016; Lowe & Murray, 2014; Okamura et al., 2020; Vincent et al., 2013);

"I used to think negatively… that life sucks… that there wasn't any hope for me and that I would turn out to be a bad person… but after starting therapy I started to think that things change and it's only me that controls the possibilities and that I should start doing my best and if I get… when I get the chance I shouldn't lose it." (Participant age: 14 years old; Dittmann & Jensen, 2014; theme: change and change processes; page 1227)

"So I think I've done well to get where I've got to today… It enabled me to focus on other things, other points of my life… I went to MENCAP and learnt how to be a carer." (Participant age: 57 years old; Lowe & Murray, 2014; theme: life after therapy; page 228)

In particular, three participants across two studies described a dramatic shift from plans to commit suicide (Eastwood et al., 2021; Vincent et al., 2013);

"Meeting with [sic: the therapist] it was all for me, you know, to help me to have a new life 'cause otherwise if I hadn't met, if I hadn't met him, I wouldn't have carried, I wouldn't have carried on my life really." (Participant age: 29 years old; Vincent et al., 2013; Theme: regaining life; page 588)

Discussion

Overview of Findings

This review aimed to collate and synthesise clients' experiences of TF-CBT as a NICE (2018) recommended intervention for adults and children experiencing trauma-related distress.

The current review aimed to provide a more valid synthesis of clients' experiences of TF-CBT given the significant heterogeneity in interventions outlined by papers included in Neelakantan et al.'s (2019) review. Three papers included in Neelakantan et al.'s (2019) review met the inclusion criteria of the current review, the other five papers were excluded as the interventions described were not based on TF-CBT as outlined by Cohen et al. (2006). Additionally, the current review aimed to provide a more up to date review of the literature accounting for the context of the COVID-19 pandemic. However, only two papers included in this review were published after the start of the COVID-19 pandemic, neither of which mentioned adaptations made to the delivery of TF-CBT. Additionally, neither paper indicated that trauma events experienced by participants were explicitly linked to COVID-19 although Shevlin et al. (2020) suggest this link may be more implicit, for example, increased risk of domestic violence during COVID-19 lockdowns. This may suggest

COVID-19 has had a limited impact on clients' experiences of TF-CBT although future research could explore this further.

The finding that adults also experienced anxiety prior to TF-CBT sessions builds on Neelakantan et al.'s (2019) review which indicated children commonly reported distress prior to commencing TF-CBT. Across the studies included in the current review, participants commonly linked feelings of anticipatory anxiety to exposure components of TF-CBT, such as talking about the trauma narrative. Becker et al.'s (2004) finding that clinicians avoid implementing exposure components of TF-CBT may indicate clinicians' countertransference, defined by Freud (1910) as the process whereby a clinician's emotional response to their client influences their interaction with the client, in response to clients' feelings of anxiety. This may also suggest that neither clinicians nor clients feel adequately prepared to engage in exposure components of TF-CBT.

The current review highlighted how frequently participants linked distress experienced during sessions with exposure components of TF-CBT. This seemingly confirms the validity of clinicians' concerns outlined by Becker et al. (2004), Ruzek et al. (2014), and van Minnen et al. (2010) that clients may experience distress during TF-CBT, specifically in relation to exposure, which can lead to them disengaging from therapy as was found across adult and child papers in the current review. This has implications for clinicians who must decide whether to follow NICE guidance (2018) and deliver TF-CBT given their ethical responsibility to do no harm (BPS, 2021). On the other hand, some adult participants suggested that the benefits gained were worth the distress experienced during TF-CBT, which might reassure clinicians. However, while most findings in this review were consistent across both adult and child papers, only adult participants reported that distress experienced during TF-CBT was worth the positive outcomes. This may be accounted for by children's motivations to engage in TF-CBT as they did not express the same

desperation for change as adult participants prior to commencing TF-CBT. Moreover, the level of cognitive functioning of younger children in particular may limit their understanding that TF-CBT could effect positive change.

Positive outcomes associated with TF-CBT were described by all papers included in the current review complimenting quantitative data gathered from studies evaluating effectiveness of TF-CBT (see Bisson et al., 2013 for a review). The rich qualitative data synthesised in the current review highlighted the multifaceted benefits of TF-CBT which ranged from improvements in sleep to more profound impacts on hope for the future. Adult and child participants emphasised the importance of a collaborative therapeutic relationship in building trust and feeling authentically cared for. This aligns with findings by Ormhaug et al. (2014) who reported that, in children and adolescents, higher ratings of therapeutic alliance were more strongly associated with positive outcomes following TF-CBT.

Limitations of the Review

Despite previous research indicating higher drop-out rates associated with TF-CBT than other psychological therapies (Bisson et al., 2013), only two of the 11 papers included in the review collected qualitative data from participants who disengaged from TF-CBT (Dittmann & Jensen, 2014; Eastwood et al., 2021). Consequently, the results of this review are likely to be skewed towards positive experiences of TF-CBT as the participants included in the review were still engaged in or had completed the intervention at the time of data collection.

Due to the exploratory nature of this review, studies were not excluded based on the number of TF-CBT sessions completed by participants. As such, data from participants who were still engaged in the intervention and had received as few as two TF-CBT sessions at the time of data collection (Vincent et al., 2013) were included in the synthesis.

The experiences of these participants may differ from those who had completed at least 6-12 TF-CBT sessions as recommended by NICE (2018). For example, participants who had not yet completed the recommended number of TF-CBT sessions at the time of data collection may not share the view held by other participants that the positive changes were worth the distress experienced during TF-CBT. Furthermore, their data was unlikely to be included in the theme: *transformative change as a result of TF-CBT*, and therefore this theme may only represent the views of a small number of participants who had completed enough of the intervention to be able to comment on its overall impact.

The inclusion of studies exploring children's experiences and those that explored adults' experiences allowed for the comparison of similarities and differences in findings across the two populations. However, it is noteworthy that although NICE guidance (2018) recommends TF-CBT for all people experiencing trauma-related distress, the approach differs quite significantly between adults and children. For example, three of the six papers exploring children's experiences followed the original TF-CBT protocol (Cohen et al., 2006) which involved caregivers in the intervention. There was also heterogeneity in the TF-CBT intervention across the adult papers reviewed. Therefore, consideration should be given to whether participants' experiences of TF-CBT can be compared if they received significantly different interventions. Reviewing child and adult studies separately may give greater scope for more in-depth analysis.

Implications for Practice and Research

To address the significant distress experienced by participants during exposure components of TF-CBT, clinicians should invest more time in the 'psychoeducation and parenting', 'relaxation', 'affective expression and modulation', and 'cognitive coping' components of TF-CBT. This may enable clients to feel more resourced and empowered which could help to mitigate distress experienced during the intervention. This might also

increase clinicians' confidence in their clients' ability to tolerate distress, addressing concerns expressed by clinicians about re-traumatisation during trauma-focused therapy (Ruzek et al., 2010). However, clinicians should consider using alternative trauma-focused therapies which do not require exposure to the trauma memory with clients who are less likely to be able to tolerate high levels of distress to avoid the risk of re-traumatisation.

Participants in this review valued therapists' authentic and collaborative approach during TF-CBT, therefore, clinicians should be open about the likelihood that clients will experience distress. Managing participants' expectations in this way could mitigate participants' distress as it gives them the opportunity to decide if they feel resourced enough to engage in a potentially destabilising intervention.

This review synthesised data from participants who had experienced as few as two TF-CBT sessions with those who had experienced up to 19 sessions. To increase the validity of research published in this area, future studies should include a minimum number of TF-CBT sessions in their inclusion criteria.

This review highlights the significance placed by participants on the outcome of TF-CBT when describing their experiences. However, due to the limited number of participants included in this review who had completed the recommended number of TF-CBT sessions (NICE, 2018), this finding may not represent the views of other participants in this review who were part way through the intervention. Therefore, future research should focus on collecting data from clients who have completed the number of TF-CBT sessions recommended by NICE (2018). This increased pool of participants may help to shed light on clients' experiences of TF-CBT as a full intervention.

Only two of the 11 studies reviewed collected data from clients who had disengaged from TF-CBT sessions, highlighting a significant gap in the literature. Future research should

explore the experiences of clients who have dropped out of TF-CBT in order to further understand why some clients are better able to tolerate TF-CBT than others.

Conclusion

Overall, this review demonstrated the importance of trying to deepen the understanding of clients' experiences of TF-CBT using qualitative research. The evidence within the included studies highlighted how clients' experiences of TF-CBT centred around the range of strong emotional responses experienced before, during and after TF-CBT. This review highlights the need for clinicians to carefully consider the rationale for implementing TF-CBT with clients due to differences in participants' ability to tolerate the significant distress associated with TF-CBT. Clinicians should consider using alternative trauma-focused therapies which do not require exposure to the trauma memory with clients who are less equipped to tolerate high levels of distress. However, for some clients, the rationale for using TF-CBT is strengthened by participants' experiences of positive transformative change discussed in this review.

References

Allen, B., & Johnson, J. C. (2012). Utilization and implementation of trauma-focused cognitive–behavioral therapy for the treatment of maltreated children. *Child Maltreatment*, *17*(1), 80-85.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: Author.

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

Bisson, J. I., Roberts, N. P., Andrew, M., Cooper, R., & Lewis, C. (2013). Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults. *Cochrane Database of Systematic Reviews*, (12).

British Psychological Society (BPS). (2021). *Code of ethics and conduct.* https://explore.bps.org.uk/binary/bpsworks/bf9d9fead1dfec7c/3acfadeebe810a324dde720ea7b34b6e87a80cad1de5471be0810935dac0415b/inf94_2021.pdf

Critical Appraisal Skills Programme (2018). CASP systematic review checklist. https://casp-uk.b-cdn.net/wp-content/uploads/2018/03/CASP-Qualitative-Checklist-2018_fillable_form.pdf

Cohen, J. A., Mannarino, A. P., & Deblinder, E. (Eds.). (2006). *Treating trauma and traumatic grief in children and adolescents.* Guilford Press.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (Eds.). (2012). *Trauma-focused CBT for children and adolescents: Treatment applications*. Guilford Press.

Dalton, J., Booth, A., Noyes, J., & Sowden, A. J. (2017). Potential value of systematic reviews of qualitative evidence in informing user-centered health and social care: Findings from a descriptive overview. *Journal of Clinical Epidemiology*, *88*, 37-46.

Deblinger, E., Mannarino, A. P., Cohen, J. A., Runyon, M. K., & Steer, R. A. (2011). Trauma-focused cognitive behavioral therapy for children: Impact of the trauma narrative and treatment length. *Depression and Anxiety*, *28*(1), 67-75.

Dittmann, I., & Jensen, T. K. (2014). Giving a voice to traumatized youth—Experiences with trauma-focused cognitive behavioral therapy. *Child Abuse & Neglect*, *38*(7), 1221-1230.

Eastwood, O., Peters, W., Cohen, J., Murray, L., Rice, S., Alvarez-Jimenez, M., & Bendall, S. (2021). “Like a huge weight lifted off my shoulders”: Exploring young peoples’ experiences of treatment in a pilot trial of trauma-focused cognitive behavioral therapy. *Psychotherapy Research*, *31*(6), 737-751.

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

Freud, S. (1910). *The future prospects of psycho-analytic therapy*. The standard edition of the complete psychological works of Sigmund Freud. Hogarth Press.

Grey, N., & Young, K. (2008). Cognitive behaviour therapy with refugees and asylum seekers experiencing traumatic stress symptoms. *Behavioural and Cognitive Psychotherapy*, *36*(1), 3-19.

Kaminer, D., Letsatsi, T., Stewart, S., Skavenski, S., & Simmons, C. (2022). Client and counsellor experiences of abbreviated trauma-focused cognitive behavioural

therapy for South African adolescents. *South African Journal of Psychology*, *52*(3), 277–289.

Kilpatrick, D. G., & Best, C. L. (1984). Some cautionary remarks on treating sexual assault victims with implosion. *Behavior Therapy, 15*(4), 421–423.

Kroese, B. S., Willott, S., Taylor, F., Smith, P., Graham, R., Rutter, T., Stott, A., & Willner, P. (2016). Trauma-focussed cognitive-behaviour therapy for people with mild intellectual disabilities: Outcomes of a pilot study. *Advances in Mental Health and Intellectual Disabilities, 10*(5), 299-310.

Lewey, J. H., Smith, C. L., Burcham, B., Saunders, N. L., Elfallal, D., & O'Toole, S. K. (2018). Comparing the effectiveness of EMDR and TF-CBT for children and adolescents: A meta-analysis. *Journal of Child & Adolescent Trauma*, *11*(4), 457-472.

Lowe, C., & Murray, C. (2014). Adult service-users' experiences of trauma-focused cognitive behavioural therapy. *Journal of Contemporary Psychotherapy*, *44*(4), 223-231.

Mavranezouli, I., Megnin-Viggars, O., Daly, C., Dias, S., Welton, N. J., Stockton, S., Bhutani, G., Grey, N., Leach, J., El-Leithy, S., Greenberg, N., Katona, C., & Pilling, S. (2020). Psychological treatments for post-traumatic stress disorder in adults: A network meta-analysis. *Psychological Medicine*, *50*(4), 542-555.

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & The PRISMA Group. (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLoS Med, 6*(7), 1-6.

Murray, H., Merritt, C., & Grey, N. (2016). Clients' experiences of returning to the trauma site during PTSD treatment: An exploratory study. *Behavioural and Cognitive Psychotherapy*, *44*(4), 420-430.

Murray, H., Merritt, C., & Grey, N. (2015). Returning to the scene of the trauma in PTSD treatment–why, how and when? *The Cognitive Behaviour Therapist*, *8*, 1-12.

Murray, L. K., Skavenski, S., Michalopoulos, L. M., Bolton, P. A., Bass, J. K., Familiar, I., Imasiku, M., & Cohen, J. (2014). Counselor and client perspectives of trauma-focused cognitive behavioral therapy for children in Zambia: A qualitative study. *Journal of Clinical Child & Adolescent Psychology*, *43*(6), 902-914.

Neelakantan, L., Hetrick, S., & Michelson, D. (2019). Users' experiences of trauma-focused cognitive behavioural therapy for children and adolescents: A systematic review and metasynthesis of qualitative research. *European Child & Adolescent Psychiatry*, *28*(7), 877-897.

National Institute for Health and Care Excellence. (2018). *Psychological interventions for the prevention and treatment of PTSD in adults; Treatment for adults (NICE Guideline NG116].* https://www.nice.org.uk/guidance/ng116/chapter/Recommendations#assessment-and-coordination-of-care

Okamura, K. H., Skriner, L. C., Becker-Haimes, E. M., Adams, D. R., Becker, S., Kratz, H. E., Jackson, K., Berkowitz, S., Zinny, A., Cliggitt, L., & Beidas, R. S. (2020). Perceptions of evidence-based treatment among youth and caregivers receiving trauma focused-cognitive behavioral therapy. *Journal of Child and Family Studies*, *29*(6), 1712-1722.

Ormhaug, S. M., Jensen, T. K., Wentzel-Larsen, T., & Shirk, S. R. (2014). The therapeutic alliance in treatment of traumatized youths: Relation to outcome in a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, *82*(1), 52-64.

Pernebo, K., & Almqvist, K. (2016). Young children's experiences of participating in group treatment for children exposed to intimate partner violence: A qualitative study. *Clinical Child Psychology and Psychiatry*, *21*(1), 119-132.

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Britten, N., Roan, K., & Duffy, S. (2006). Guidance on the conduct of narrative synthesis in systematic reviews. *A Product from the ESRC Methods Programme Version 1,* 92.

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

Salloum, A., Dorsey, C. S., Swaidan, V. R., & Storch, E. A. (2015). Parents' and children's perception of parent-led Trauma-Focused Cognitive Behavioral Therapy. *Child Abuse & Neglect*, *40*, 12-23.

Shearing, V., Lee, D., & Clohessy, S. (2011). How do clients experience reliving as part of trauma-focused cognitive behavioural therapy for posttraumatic stress disorder? *Psychology and Psychotherapy: Theory, Research and Practice*, *84*(4), 458-475.

Shevlin, M., Butter, S., McBride, O., Murphy, J., Gibson-Miller, J., Hartman, T. K., Levita, L., Mason, L., Martinez, A. P., McKay, R., Stocks, T. V. A., Bennett, K., Hyland, P., & Bentall, R. P. (2021). Refuting the myth of a 'tsunami' of mental ill-health in

populations affected by COVID-19: Evidence that response to the pandemic is heterogeneous, not homogeneous. *Psychological Medicine*, *53*, 429-437.

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

Vincent, F., Jenkins, H., Larkin, M., & Clohessy, S. (2013). Asylum-seekers' experiences of trauma-focused cognitive behaviour therapy for post-traumatic stress disorder: A qualitative study. *Behavioural and Cognitive Psychotherapy*, *41*(5), 579-593.

Part Two: Empirical Paper

What are Therapists' Experiences of the Flash Technique?

Annie Townshend*, Dr Jo Beckett, Dr Emma Wolverson & Dr Anne Parry

Faculty of Health Sciences, School of Psychology and Social Work

Aire Building, University of Hull, Hull, United Kingdom, HU6 7RX

*Corresponding Author Email: A.Townshend-2020@hull.ac.uk

This paper is written in the format ready for submission to the journal

Journal of EMDR Practice and Research

Please see Appendix D for the Guideline for Authors

Word Count: 8,052 (including tables, excluding references)

Abstract

The flash technique (FT) is a trauma-focused therapeutic technique developed by Manfield et al. (2017) to increase the accessibility of trauma-focused therapy, specifically eye-movement reprocessing and desensitisation (EMDR), for clients experiencing heightened levels of trauma-related distress. Previous research has highlighted the negative impact of working with highly distressed clients on therapists' wellbeing, therefore this study focused on therapists' experiences using FT with clients experiencing trauma-related distress. Given the valuable clinical implications of previous qualitative research exploring clinician experiences of EMDR, this study adopted a qualitative design. Semi-structured interviews were carried out with 15 therapists who had used FT. Reflexive thematic analysis was used to develop and make sense of themes identified from the data. The analysis generated four themes: "It's one of those techniques that actually could make a significant difference to people's lives and the therapy process"; "This could be really exciting but how on earth is this going to work?"; "I don't know where I would have gone if I didn't have [the] flash [technique]"; "The secret very much is in the PEF [positive engaging focus]". This study found that therapists perceive FT to be a useful tool to contain clients' trauma-related distress and empowered clients to proceed to trauma processing. The positive affect experienced by participants during FT highlighted significant positive implications for the wellbeing of therapists who deliver trauma-focused therapies.

Keywords: flash technique (FT), eye movement desensitisation and reprocessing (EMDR), therapists, subjective experience, qualitative

Introduction

Current Trauma-Focused Therapies

Current National Institute of Clinical Excellence (NICE) guidelines recommend trauma-focused cognitive behavioural therapy (TF-CBT) or eye movement desensitisation and reprocessing (EMDR) as interventions for adults experiencing trauma-related distress (NICE, 2018). Bisson et al.'s (2013) systematic literature review of 70 randomised-controlled trials (RCTs) found TF-CBT and EMDR were more effective than waitlist control conditions at reducing trauma-related distress, however the measure relied on the clinician's interpretation of the client's change in emotional distress rather than clients' descriptions of their own experiences. Additionally, the exclusion of qualitative studies in this review further limits the utility of the results due to the possible omission of information regarding client experience of therapy which may help understand why, for example, drop-out rates were high in many studies.

Trauma-focused therapies, including both TF-CBT and EMDR, require exposure to the trauma memory which often renders them inaccessible to clients experiencing severe trauma-related distress, evidenced by high dropout and nonresponse rates (Schottenbauer et al., 2008). This may be due to the increase in distress experienced by some participants following trauma-focused therapies which involved elements of exposure (Feeny et al., 2002). This risk of re-traumatisation, defined by Kilpatrick and Best (1984) as an increase in suffering, conflicts with The British Psychological Society (BPS) Code of Ethics and Conduct (BPS, 2021) which states therapists have a responsibility to avoid harm. The implications of this include considering whether current trauma-focused therapies are ethical, at least in the presence of severe emotional distress, and whether there are other techniques that do not incur the same risk of re-traumatisation.

The Flash Technique

The flash technique (FT) was developed by Manfield et al. (2017) to increase the accessibility of trauma-focused therapies for clients who experience severe trauma-related distress. FT is used during the preparation phase of EMDR to quickly reduce the emotional disturbance of a traumatic memory while helping clients to stay within their window of tolerance (Siegel, 1999) so that EMDR can proceed (Manfield et al., 2017).

FT procedure has evolved since it was first developed by Manfield et al. in 2017. Current training indicates clients first establish a baseline of distress associated with the trauma memory using the Subjective Units of Distress Scale (SUDS; Wolpe, 1968, as adapted by Shapiro, 2018). The therapist and client then begin bilateral stimulation (BLS) for example, leg taps, and the therapist actively engages the client in conversation about their positive engaging focus (PEF). Examples of PEFs include: a memory of a holiday, the client's pet, or a piece of music. During the discussion of the PEF the client is asked to blink rapidly at regular intervals when the therapist says the word "flash". The client is periodically asked to lightly check in with the trauma memory, for example, "if you were to think about the memory, do you notice any change?" This 'checking in' should not last more than a few seconds before the client and therapist return to the PEF and continue BLS. This procedure is repeated until the client can think about the trauma memory with minimal distress. Once the SUDS rating of the trauma memory has sufficiently reduced, Manfield et al. (2017) suggest the therapist should proceed to the processing phase of EMDR.

Siegel et al.'s (2017) study investigating neural activity in relation to exposure to phobic stimuli is influential in understanding possible conceptual underpinnings of FT. Siegel et al. (2017) presented participants with arachnophobia small images of phobic stimuli, spiders, hidden within a large image designed to minimise conscious awareness of the phobic stimuli. Very brief exposure to masked images of spiders activated regions of the ventral

prefrontal cortex (vPFC), which supports fear processing by regulating the amygdala, in phobic participants without causing them to consciously experience fear. Whereas clearly visible exposure to images of spiders deactivated the vPFC allowing the amygdala to become dysregulated which corresponded with participants' increased fear ratings. Researchers concluded that limiting awareness of exposure to phobic stimuli through visual masking paradoxically facilitated participants' processing, while simultaneously minimising their experience of fear. This study has been proposed by Wong (2021) to explain why FT is effective in facilitating memory reconsolidation as distress is minimised during the procedure. Because participants are not encouraged to relive the trauma memory during FT procedure, vPFC regions may remain activated allowing the memory to be processed without the associated distress. However, this generalisation of findings is limited because FT procedure cannot recreate the same level of control of exposure to the feared stimuli as was created in Siegal et al.'s (2017) study. The level of exposure is important because the study has demonstrated that vPFC regions are only activated when participants are minimally exposed to the stimuli, supporting fear processing, compared to deactivation of these neural circuits when participants are fully exposed, inhibiting fear processing. During FT the therapist must try to ensure the client is only minimally exposed to the trauma memory, however it is not possible to be certain the client will not become fully exposed to the trauma memory.

Wong (2021) proposed a model to explain the function of the components of FT in containing distress associated with the trauma memory. He suggests when clients engage in trauma therapy, the trauma memory is the most salient item in working memory. The PEF encourages the client to consciously focus on a positive memory and pay less attention to the trauma memory, assigning it a lower priority item in working memory. A non-purposeful interruption to the PEF occurs when the client is encouraged to blink rapidly and consequently attention switches from the PEF to the trauma memory causing it

to become the most salient item in the working memory for a short time. This is not enough time for the amygdala to become overactivated and instead it remains regulated by the vPFC allowing clients to remain within their window of tolerance (Siegel, 1999). According to the adaptive processing model (AIP; Shapiro, 2007), activation of the amygdala reduces the capacity of the information processing system, as such, new information is not stored with appropriate affect and is instead stored in its excitatory, state-specific form. Ecker et al. (2012) suggest the only way to unlock, revise and relock these memories is through memory reconsolidation. Once the memory is unlocked without the presence of strong emotion, the brain's information processing system can resume processing and functionally integrate the memory. Wong (2021) suggests this juxtaposition between the traumatic memory and the amygdala, which has been activated but remains regulated by the vPFC, may be enough to violate the memory expectation (otherwise known as a prediction error) and consequently meet memory reconsolidation requirements (Ecker et al., 2012).The repetition of this brief access to the trauma memory may strengthen the connection between the vPFC and the amygdala while at the same time, allowing memory reconsolidation to occur. Although EMDR and FT are both based on assumptions made by the AIP model, during EMDR there is a higher chance that the vPFC will not be able to regulate the activation of the amygdala as the trauma memory is the most salient item in the working memory which may strengthen the connection between the trauma memory and increased activation of the amygdala.

The first literature about FT was published by Manfield et al. (2017) who described four case examples, each of whom reported significant trauma-related distress which was perceived by the therapist to make trauma processing using EMDR inaccessible. Following FT, trauma-related distress significantly reduced in all four cases, enabling the progression to trauma processing with EMDR; these positive outcomes were maintained through follow-up.

Further evidence has since been published supporting the use of FT with clients who experience high levels trauma-related distress. The usefulness of FT delivered as a group intervention via a webinar to 175 healthcare workers who had distressing memories related to treating COVID-19 patients was investigated by Manfield et al. (2021). There was no interaction between the participant and the presenters of the webinar, as such, participants were instructed to think about their PEF while following the BLS and blinking when prompted instead of engaging in a conversation about their PEF with the therapist. Results revealed that all participants experienced a decrease in SUDS level associated with the trauma memory and no participants reported adverse outcomes contributing to evidence that FT is not only effective but is possibly less likely to be experienced as re-traumatising when compared with other trauma-focused therapies. However, the researchers involved in these successful cases are the same researchers who developed FT; this conflict of interest may invalidate reported positive outcomes. Further supporting FT, a case study by Shebini (2019) reported success containing trauma-related distress with a client with dissociative identity disorder. Additionally, Shebini (2019) reported that, for this client, FT sessions focused on one trauma memory ranged between five to 45 minutes, compared with EMDR sessions which lasted between 60-90 minutes, suggesting FT may also reduce distress more efficiently than other trauma-focused therapy techniques such as stabilisation in EMDR.

Research Gap and Clinical Implications

There is minimal research into FT due to the recency of its development and much of the published research has been conducted by the original authors of FT. Further studies, conducted independent of the original authors, would strengthen the existing evidence base and generate momentum for FT to become more widely accessible to clients who are unable to engage with other trauma-focused therapies.

Struik (2019) reported that clinicians lack confidence in the utility of EMDR and an exploratory study investigating clinicians' experiences implementing EMDR with clients found that 40% of clinicians find it difficult to integrate EMDR into their clinical practice (Dunne & Farrell, 2011). Therapist allegiance occurs when a therapist has faith in the efficacy of a particular therapeutic approach causing them to implement the technique with higher levels of confidence and skill (Wampold, 2001). Research suggests that therapist allegiance is a significant determining factor in therapeutic outcomes (Sprenkle & Blow, 2004; Wampold, 2001) highlighting the importance of understanding clinicians' attitudes towards therapeutic techniques. Given the similarities between EMDR and FT, it is possible that therapists also lack confidence in the utility of FT as well as confidence in their knowledge and skill integrating FT into clinical practice. Therefore, gathering data pertaining to therapists' experiences of FT may have implications for FT training and support for therapists, for example, through supervisory groups, to facilitate positive therapeutic outcomes.

Although it is important to understand the efficacy of trauma-focused therapy techniques, it is also important to consider the voices of those who deliver such therapies. The distress experienced by clients during exposure components of current NICE-recommended trauma-focused therapies (NICE, 2018) can be distressing for the therapist (Devilly et al., 2009). This can cause therapists to experience secondary traumatic stress, defined by Figley et al. (1995) as the consequence of being emotionally impacted by another's experience of trauma, which can have negative implications for therapists' wellbeing (McCormack et al., 2018) and consequently their clinical practice (Rupert et al., 2015). However, as FT does not require the client to become exposed to the trauma memory, clients and therapists are less likely to experience distress during FT sessions which may therefore have implications for therapists' wellbeing and the care clients receive.

Therapists are likely to have experiences implementing FT with a variety of different clients and therefore may be able to provide valuable insights into whether FT is more successful with some clients than others and the meaning they have assigned to this. Understanding how therapists have integrated FT into their clinical practice may also shed light on key facilitators and barriers to successful implementation of FT. Additionally, as previous FT research has been solely conducted in the US, this study will be the first to gain the perspectives of UK-based participants.

Aims and Research Question

The current research will contribute to the growing evidence base surrounding FT as an accessible trauma-focused therapeutic technique that aims to contain clients' distress enough to proceed with trauma processing. The aim of this research is to explore the experiences of therapists who have used FT with clients.

To explore this, the following research question has been developed: What are therapists' experiences of the flash technique?

Method

Design

A qualitative design, using semi-structured interviews with therapists, was used to answer to answer the research question as this allowed an in-depth exploration of the experiences of therapists using FT. Focus groups were considered, however participants may have been more likely to conform to stronger narratives held by the group which could limit the texture and richness of the experiences shared. Additionally, therapists may not be used to sharing their experiences in group settings as clinical supervision and client work is most commonly undertaken one-to-one. It was therefore hypothesised that sharing experiences in a group-setting may feel exposing, again leading to greater conformity to more dominant

narratives shared. As such, individual interviews were selected to encourage rich, detailed accounts of therapists' experiences contributing to greater diversity across the data. Interview data was transcribed and analysed using reflexive thematic analysis (Braun & Clarke, 2021).

Researcher Position

The primary researcher was a 25-year-old, White British, female trainee clinical psychologist. Although the researcher understood the value of trauma-focused interventions and had worked with people who had experienced trauma, the researcher was not trained in EMDR or FT. To better understand the process of FT, the researcher observed therapy sessions in which FT was used and observed an FT training session. To aid the process of reporting the research, a reflective diary was utilised throughout the research process to note down personal reflections around decision-making, participant interviews, and data analysis. Throughout the research process, the primary researcher attended regular research supervision with three qualified and research experienced clinical psychologists (two of whom are trained in EMDR and FT) and attended a reflective practice group with other trainee psychologists. (See Appendix E and F for a full discussion of epistemology and reflective statement).

Sampling

Purposive sampling was used to recruit therapists (n = 15). Braun and Clarke (2019) recommend a sample size of 10-20 participants for thematic analysis within doctoral research. Data collection was terminated after 15 interviews as the data gathered was sufficiently rich and the later interviews consistently revealed no new information. The study inclusion criteria and accompanying rationales are outlined in Table 1.

Table 1

Study Inclusion Criteria and Rationale

Inclusion criteria	Rationale
Participants must have completed EMDR and FT training.	As FT is recommended to be used during preparatory phases of EMDR. Proof of training was gained via self-report at interview.
Participants must have used FT with clients to process trauma memories.	As FT was developed to enable clients to process distress associated with trauma memories and as the study aimed to explore therapists' experiences.
Participants must be able to complete the interview in English.	Due to resource constraints on translation.

There were no exclusion criteria. Supervisors used professional contacts and distribution lists to advertise the study to fellow EMDR practitioners, for example, via the EMDR UK & Ireland's JISCMail mailing group. The study was also distributed among members of a FT supervisory group in the North of England and was advertised on a Facebook group for EMDR practitioners.

Recruitment took place from September to December 2022. Nine therapists expressed interest in participation and then did not participate, no reasons were given for not participating. 15 therapists provided written consent to participate in the study and for anonymised quotes to be published.

Procedure

Each participant took part in one semi-structured audio-recorded interview completed by the first author. Interviews were completed face-to-face (*n* = 3) or via videocall (*n* = 12) according to participant preference. An encrypted laptop was used to audio-record the interviews which lasted between 26 minutes 16 seconds and 56 minutes 13 seconds, average interview time was 43 minutes 46 seconds. The interview schedule (see Appendix G) was guided by the research aims, research question, methodology, and collaboratively developed with the study supervisors, two of whom met the study inclusion criteria. The schedule included five open-ended questions (with prompts) designed to facilitate discussions around: (a) FT training; (b) clinical experience of FT; (c) challenges and facilitators to using FT; (d) how FT compares to other trauma-focused therapies. Participants were emailed a debriefing sheet after the interview (see Appendix H). This schedule was adapted with the research supervisors following completion of the first five interviews according to participants' comments and areas of discussion raised during the interview. Adaptations were made to delve deeper into therapists' own experiences and obtain further examples of therapists' thoughts, feelings and motivations around FT. The interviewer also noted down reflections after each interview in line with guidance on reflexive thematic analysis (Braun & Clarke, 2021).

Ethical Considerations

Ethical approval was granted by the Faculty of Health Sciences Ethics Committee (University of Hull; see Appendix I). The study also gained appropriate approvals from Health Research Authority for staff studies within the NHS as well as approval from two local NHS Trust Research and Development offices (see Appendix J). The recruitment materials and participant information sheet (see Appendix K) were reviewed by a therapist who met the inclusion criteria for the study, who confirmed the information was relevant and understandable. Informed consent was gained from participants following written and

verbal explanation of the research aims, procedure and participants' right to withdraw (see Appendix L for consent form). Due to questions raised by Allen and Wiles (2015) about how researchers can influence the content and process of research through assigning pseudonyms to participants, the decision was made to invite participants to select their own pseudonym to respectfully facilitate participants' ownership and input into the study. This pseudonym was used to anonymise data for storage and project write-up. During informed consent, participants were made aware of the procedure if they disclosed potential malpractice or safeguarding issues.

Data Analysis

Reflexive thematic analysis (Braun & Clarke, 2021) informed by a constructivist epistemology (Ültanir, 2012) was used to analyse the data. Such analysis complimented the explorative and inductive intent of the research, providing the opportunity to generate unanticipated insights (Nowell et al., 2017) which was important to the current research due to its exploratory nature. An interpretative phenomenological analysis (IPA) methodology was considered however the aims of the current study were more focused on exploring patterned meaning across participants which is better suited to reflexive thematic analysis than IPA which is more ideographically focused (Smith et al., 2009). The researcher actively produced themes from codes identified within the data which aimed to capture the essence of meaning co-created during data collection (Braun & Clarke, 2021), rather than attempting to fit the data within an existing frame or in the researcher's analytic preconceptions. Braun and Clarke's (2021) six phases of thematic analysis were followed (see Table 2 for the application of the six phases). Coding and theme development were discussed during supervision to enhance reflexivity and interpretative depth. The themes were reviewed and discussed in supervision. Braun and Clarke's (2021) tool for evaluating thematic analysis facilitated quality assurance (see Appendix M).

Table 2

The Procedure Applying Braun and Clarke's (2021) Six Phases of Reflexive Thematic Analysis.

Phase	Procedure
1. Familiarisation with the data	Audio recordings were transcribed. The transcripts were read and re-read. Initial reflections were noted.
2. Generate initial codes	Initial codes were generated through systematic line-by-line engagement with the data to capture aspects relevant to the research question.
3. Generate initial themes	Initial themes were generated by grouping concepts that underpinned similar codes. Each theme had a central organising concept which was distinct from the other themes and captured a meaningful aspect of the data in relation to the research question.
4. Develop and review themes	Initial theme viability was reviewed with research supervisors to explore scope for better pattern development in relation to the research question. Themes were revised accordingly.
5. Refine, define and name themes	The specificity of each theme was identified. Informative names for themes were assigned.
6. Write up	The themes were written to tell a story about the data including original supportive data that has been appropriately referenced.

Results

When analysing the data exploring therapists' experiences of FT, four themes were generated: (1) "It's one of those techniques that actually could make a significant difference to people's lives and the therapy process"; (2) "This could be really exciting but how on earth is this going to work?"; (3) "I don't know where I would have gone if I didn't have [the] flash [technique]"; (4) "The secret very much is in the PEF". Each theme is illustrated with supportive data extracts. See Appendix N for a worked example of the initial code generation and theme generation phases of data analysis.

Theme 1: *"It's one of those techniques that actually could make a significant difference to people's lives and the therapy process"*

Participants reported that clients who experience heightened levels of trauma-related distress are often unable to engage with current NICE-recommended trauma processing techniques. This was attributed to the requirement for clients to focus on the trauma memory which can cause them to become distressed, dissociate or disengage:

> *"A large amount of my work is supporting people with complex trauma so these are um often people that experience very intense emotions, often lots of fear um and what that can mean therapeutically is it's a massive ask for people to just get stuck in with processing some very traumatic memories that come with somatic sensations." (Sally)*

Participants expressed feeling conflicted between a desire to help their clients process trauma memories and their responsibility as therapists to avoid harm which left them feeling ill-equipped to regulate clients' high levels of distress:

"There's a certain level of sadness *for myself to see somebody in such* ***high*** *distress and I think it's inappropriate to leave them in it. With- even with EMDR where we're taught, you know, get out of the process, let it do its thing, it'll do its thing. I think, ah it's not fair that they're sitting with this." (Tom)*

To address this, participants sought out what they hoped might be less-distressing trauma-focused therapy techniques:

"I was looking for different techniques, both that make me feel a bit more confident in what I was doing and to, I guess I was hoping I could find something that would help to reduce any distress that anybody that I was working with might experience." (Sophie)

Following FT training, participants felt hopeful about the potential of FT to address clients' distress during trauma therapy:

"That's what really drew me to it; that the client didn't even have to sort of talk about ***anything*** *to do with the trauma you know, we actively encourage them not to um and that's what- that's when I thought, this could work you know, this could really work with my clients." (Tom)*

"Rather than having to almost push through the distress it was almost like you could approach it more gently so I was excited, yes." (Margaret)

Theme 2: *"This could be really exciting but how on earth is this going to work?"*

All participants recalled feelings of apprehension prior to implementing FT in their clinical practice. Some participants reported feeling sceptical about the efficacy of FT during training; for Jack, Louise and Geri this scepticism first arose when the trainers stated that FT was *always* effective at reducing clients' distress. The perceived simplicity and reduced

visibility of psychological processes of FT also contributed to participants' feelings of scepticism. Some participants identified they had experienced similar feelings of scepticism prior to implementing EMDR in clinical practice:

"There was this real um notion though that it would work for 100% of people which I'm not sure about, […] I do always get a little bit um questioning when someone says that they can help everybody." (Jack)

"I felt very sceptical, um it was kind of presented, (laughing) as so much is within EMDR, as a kind of magical technique that makes everything you know, acceptable to people." (Sally)

The limited evidence base around FT also contributed to participants' apprehensions about implementing FT and the evolving understanding about how FT might work:

"Um the evidence base like, is this too magical to be true kind of thing (laughing) um it's quite unbelievable when you see um flash work really so a little bit like, am I just doing something that's really magical and off track of NHS evidence-based treatment?" (Sarah)

"…it was really weird in the sense that first of all I thought 'this is… this is just gunna be really weird' and thinking- I think as a psychologist, more as a psychologist there's often that sort of 'oh am I really going to do this? Is it going to cause any harm? How do I get it right? How do you- you know what's the guidance on this?" (Sam)

Despite feeling apprehensive about the lack of evidence supporting FT, participants reported that their desire to relieve their clients' distress ultimately tipped the scales in favour of them implementing FT. Many participants recalled that conversations with other therapists enabled them to feel more confident using the technique:

"I guess er a combination of, 'this could be really exciting but how on earth is this going to work?' really. Um a real sense of both which is which is quite- quite unusual because it does feel quite new and without the full background but it doesn't seem to do any harm, it's not exposing people to their trauma" (Sarah)

"People who I trusted and people who I respected were you know speaking the benefits of it and I was quite keen to- to learn more about it as a different approach to ***hopefully*** *help the people I work with" (Mike)*

Theme 3: "I don't know where I would have gone if I didn't have [the] flash [technique]"

All participants reported significant positive effects associated with FT. Participants highlighted the efficacy of FT in reducing clients' distress even in cases of significant trauma memories. Therefore, participants reported using FT with clients who experienced the most significant distress and for whom current trauma-focused therapy techniques would likely be inaccessible:

"I use it quite a lot with clients who are experiencing kind of a high level of distress um and I can see that it's going to be quite difficult to- to kind of start doing processing until they're in their window of tolerance." (Jane)

Many participants also described feeling more confident working with distressed clients because, in their experience, FT did not cause harm and it effectively reduced trauma-related distress:

"It feels safer you know I don't feel as kind of anxious, I don't feel as- like I'm doing harm to people. I don't ***really*** *feel like I'm doing harm to people with EMDR but I guess there's a niggling worry, I suppose, that somebody's going to be stuck in a high level of distress and*

I don't really have that with flash because my experience is more- it's hardly even going anywhere near the memory um so yeah I feel safer." (Mike)

"It gives me a sense of confidence going into EMDR and other sessions, knowing that if things get too distressing I've got something that will quite easily bring it down as long as we can catch that positive engaging focus, […] so yeah it's a confidence booster as a therapist." (Tom)

Participants hypothesised that after FT clients felt more resourced and empowered which enabled them to progress to trauma-processing therapies such as EMDR. This was reinforced by positive feedback from clients following FT which encouraged participants to continue using the technique:

"It gives them [sic: clients] that sense of mastery so I think… from that I think it gave her confidence, it helped her look at the memories which again like I say session 5 she could look at that really big memory during EMDR." (Mandy)

"It's something I've found with that client and other people really just clicks for people, they like being able to draw on something positive, it makes them feel more confident, it makes them feel more skilled and resourced and I think that's a really good foundation for doing difficult work." (Sally)

Some participants even wondered whether their clients would have been able to engage with trauma processing had they not used FT:

"I've got some clients that I honestly think… I- I just don't know if they'd have been able to do therapy had I not done like flash then EMDR with them because they're just- they were just so avoidant of… the trauma that they just couldn't talk about it. But then by doing like flash and then EMDR it processed it so they could then start to talk about it." (Louise)

"So that's when my scepticism got addressed because actually clients said it was massively helpful and they worked on memories they were certain they wouldn't have been able to tolerate. So that for me is kind of proof in the pudding stuff." (Sally)

Christine hypothesised FT may reduce the time taken to process the trauma memories in subsequent sessions:

"I found that I was probably getting to um EMDR processing a bit more quickly with people who were more complex and arguably their time in EMDR processing was expedited because of the stuff they had contained in flash." (Christine)

However, five participants recalled occasions when the positive effects of FT were not maintained between therapy sessions and subsequently queried whether this was because they had not implemented FT correctly. Two of these participants reported that the initial positive effects of FT were not maintained with any of their clients and had therefore stopped using FT in their clinical practice:

"So the person's SUDS during the actual process of that session went from um 7 or 8 at the start to 0, but um when we revisited the following week the SUDS had gone back up. So it was clear that whatever was happening was effective in the moment but it hadn't followed the um mechanism to reduce that strength of that memory." (Jack)

"If I was thinking about it from purely an emotional, instant reaction point of view, I would probably think that it's something about me, that I'm doing it wrong or yeah (laughing) not as good- as good a therapist as them [sic: other therapists]." (Geri)

Theme 4: "The secret very much is in the PEF"

All participants discussed the PEF, identifying it as the key difference between FT and other trauma-focused therapy techniques for both therapists and clients. Participants perceived that the PEF facilitated the containment of clients' distress and therefore FT was most successful when the PEF was strong, engaging and meaningful. Additionally, participants noticed that FT was less successful at containing clients' distress if their chosen PEF had any negative associations, such as links to the trauma memory:

"I really think you've got to have a positive engaging focus that fits with that person. Um… it's really got to, it- it's that- that phrase I use: 'this has got to make you smile, not just on your cheeks but from the inside out, what does that for you in that way?'" (Mandy)

"I really opened her [sic: the client] up to- to talking about something she was really passionate about and you know you could see the change in her face and her body language and that. It then just gave me hope that we could work with the trauma so um so yeah. I think it's a bit like magic, it disarms people, it gets past the kind of defences and the fear and so that they start to, yeah kind of um relax a bit I suppose." (Jane)

Participants were keen to discuss their experiences experimenting with the PEF to ensure it was as meaningful and engaging for their clients as possible. Seven participants described using music as the PEF which encouraged clients to become fully immersed in the positive emotion:

"I also felt flash was quite individual and quite sort of uh- you invite the person to choose um what's their so called positive engaging focus; you can talk about anything they want, from their dog to their holiday to bring in the music. So in fact, a few times when we've done it, people have decided they're going to bring music so I had a room full of music which I thought was fantastic." (Caroline)

Even when the effects of FT were not maintained, all participants perceived their clients experienced the process of the PEF positively. Participants shared ideas about the PEF not simply being a means to an end by occupying the working memory, but that the process of the PEF was therapeutic in itself as it encouraged clients to simultaneously experience positive and negative emotions:

"I think she [sic: the client] felt quite good about it um because she was thinking about her positive focus and I think it was quite a strong positive focus and because we were talking about it together and I was asking her questions about it, I think that was quite nice." (Geri)

"I think it's- for some clients it gives a bit of a surprise, it does. That sense of 'oh I can have two things at once' that sense that actually 'I can have this thought here and it's not as distressing as I think it's going to be." (Jim)

Participants felt FT strengthened their therapeutic relationship with the client which may have been due to a perceived reduction in power imbalance:

"I found out so much stuff about people that I work with that I would never have done, you know, had I- had I not done flash, so for me I love that and I felt it was hugely relationally connecting and it was two people more on a parity having a conversation." (Christine)

Participants described this positively and expressed that they also enjoyed gaining a more holistic understanding of their client through conversations around the clients' PEF. This was contrasted with participants' experiences of sitting with clients in distress during other trauma-focused therapy sessions:

"I think there's less like- I would say there's less vicarious trauma from it, because actually I remember all the positive sort of- all the positive stories (smiling) and all the aspects that you wouldn't normally get into." (Sam)

However, some participants felt uncomfortable about the positive affect they experienced during FT sessions given the purpose of trauma-focused therapy is to contain distress associated with severely traumatic events. Participants contrasted their experiences of positive affect during FT sessions with their feelings of distress during other trauma-focused therapy sessions:

"I felt like a bit of a fraud to be honest because I'm sat doing therapy on- on horrible traumas but actually we're having a bit of a whale of a time talking about some really nice things." (Sam)

Discussion

Overview of Findings

This is the first study to explore therapists' experiences of FT and the first study to recruit UK participants to participate in FT research. The overarching findings of this study indicate participants experienced significant positive results when using FT to contain clients' distress associated with traumatic memories. This finding is supported by literature reporting the positive effects of FT according to clients (Manfield et al., 2017; Manfield et al., 2021; Shebini, 2019). Participants used FT to contain clients' distress prior to introducing trauma-processing techniques. This supports the proposed function of FT as a preparatory technique to help clients remain in their window of tolerance and increase the accessibility of subsequent trauma-processing techniques. Fisher and Ogden (2007) proposed that when clients are in their window of tolerance they are better able to tolerate affect and cognition and can therefore engage in trauma therapy. This may explain why some participants reported time spent in trauma processing phases of therapy was shorter than expected following the use of FT during the preparatory phases of the intervention. This was contrasted with experiences implementing TF-CBT and EMDR where long

periods of time were spent completing stabilisation before progressing to trauma processing during which clients were reported to become emotionally dysregulated, deactivating neural networks required for memory reprocessing (Siegel, 1999). As such, findings from this study may suggest that FT is not only an effective tool to contain clients' distress, but FT may contribute to more efficient trauma processing thus expediting the length of time taken to complete a therapeutic intervention.

Although specific demographic data was not collected, all but one participant mentioned working in NHS settings, it is therefore important to consider the potential influence of this context on participants' experiences. The National Audit Office (2023) estimated 1.2 million people were waiting for community-based NHS mental health services at the end of June 2022, highlighting significant pressures on services. This pressure may contribute to apprehensions reported by participants in this study about implementing FT which is currently supported by a limited evidence base. In particular, participants working within the NHS may perceive there to be additional moral responsibility to deliver evidence-based interventions given the NHS is publicly funded. On the other hand, waiting list pressures may mean therapists are more inclined to use FT with clients because of the reported reduced time taken to complete trauma-focused interventions that incorporate FT compared with interventions which do not include FT.

Initial feelings of scepticism reported by participants in this study may impact their implementation of FT and consequently the efficacy of the technique to contain participants' distress. In line with research around therapist allegiance (Wampold, 2001), participants who had positive experiences using FT spoke more enthusiastically about their use of the technique suggesting they developed an allegiance for the technique which may account for their reported positive outcomes. Whereas some participants who did not have the same initial positive experience using FT may have maintained their scepticism

impacting their delivery of the technique accounting for their continued lack of success. This highlights the importance of addressing therapists' feelings of scepticism, enabling them to use FT confidently as this is likely to increase both the efficacy of the technique and the likelihood of them using FT in the future.

Wampold (2001) extended the idea of therapist allegiance to researchers who develop therapeutic techniques as they are likely to have even greater levels of confidence in the therapeutic technique. A systematic review of RCTs investigating the efficacy of psychotherapeutic approaches found that experimenter allegiance, when at least one of the original developers of the therapeutic approach was included in the paper's authorship list, was associated with larger effect sizes in comparison with RCTs where the original authors are not involved (Dragioti et al., 2015). This may account for findings by Manfield et al. (2017) and Manfield et al. (2021) who have advanced knowledge and skill implementing FT and reported exclusively positive therapeutic outcomes using the technique. This is noteworthy because therapists unfamiliar to FT are unlikely to experience the same levels of success when implementing the technique as demonstrated by the findings of this study.

The perception of participants that clients did not experience distress during FT sessions may address clinicians' concerns that trauma-focused therapies cause distress. In line with previous research highlighting therapists' avoidance of trauma-focused therapy (van Minnen et al., 2012), participants in the current study identified a lack of confidence in their ability to contain the distress experienced by clients during NICE recommended trauma-focused therapies (NICE, 2018). However, according to participants, clients did not experience distress during FT and in fact enjoyed the positive focus of FT sessions. There is also a lower risk of re-traumatisation (Kilpatrick & Best, 1984) because FT does not require significant exposure to the trauma memory. Additionally, all participants reported

that clients' distress did not increase when they progressed to trauma processing phases of therapy. This evidence may reassure therapists that their practice aligns with the BPS Code of Ethics (BPS, 2021) and may strengthen the therapist allegiance with FT and subsequent trauma-focused therapeutic techniques. This is likely to contribute to more positive therapeutic outcomes for clients engaging in trauma-focused therapy.

Participants reported experiencing greater levels of positive affect during FT sessions in comparison with other trauma-focused therapy sessions. This may be accounted for by the fact that FT encourages active engagement with the clients' PEF whereas therapists are often exposed to high levels of distress during other trauma-focused approaches. Research has demonstrated associations between exposure components of trauma-focused therapies and therapists' risk of experiencing secondary traumatic stress (Devilly et al., 2009). Secondary traumatic stress can have negative implications for therapists' wellbeing (McCormack et al., 2018) which consequently may impair their clinical practice and have an overall negative impact on clients' care (Rupert et al., 2015). The lack of distress experienced by clients during FT sessions is therefore significant as, not only are therapists less likely to experience secondary traumatic stress, but use of the technique may in fact contribute to therapists' wellbeing.

Limitations

It is important to consider the researcher's position as an insider due to their role as a therapist. This may be a positive as participants may have spent less time explaining specific concepts, such as the window of tolerance, during the interview meaning conversations could focus on exploring participants' experiences at a deeper level. On the other hand, this assumption of shared understanding may limit the findings of the study due to the reduced detail gained about specific concepts which may have generated unanticipated insights. The researcher's role as a therapist may have further influenced

how participants shared their experiences if they felt self-conscious about the depth of their knowledge and understanding around FT. Participants may have felt uncomfortable discussing their experiences using FT particularly if they lacked confidence in their clinical ability to implement the technique or if they had experiences where FT did not successfully contain clients' distress. This may have impacted how much detail participants shared during the interview and therefore may have skewed the findings towards more positive experiences of FT.

This study did not collect any demographic data which limits the extent to which the qualitative data gathered can be discussed in relation to possible contextual factors. Data pertaining to, for example, participants' years of experience, theoretical orientation and client group may have played a role in how therapists experienced FT training and implementing FT into their clinical practice. Although qualitative research does not aim to generalise findings, the lack of demographic data limits discussions about how representative the study sample is of UK therapists. Future research should collect demographic data to contextualise qualitative data which could highlight potential mediating factors.

Clinical Implications

Participants reported that discussions with other FT trained therapists increased their confidence in the efficacy of the technique and consolidated their knowledge about implementation of FT with clients. This concurs with Morrison et al. (2023) who highlighted the need for peer and supervisory networks following a review of the literature exploring clinicians' perspectives of EMDR. Therefore, to increase therapists' confidence implementing FT with clients, EMDR supervisory groups should be adapted to incorporate discussions around FT covering topics such as, which clients to use FT with and the different ways to use the PEF. This may also encourage more EMDR trained clinicians to

also train in FT which will have the effect of increasing the availability of FT as a trauma-focused therapeutic technique to clients.

Participants highlighted the efficacy of FT at reducing clients' distress even in cases of significant trauma memories. In addition, some participants expressed their uncertainty about whether their clients would have been able to engage in trauma processing had they not used FT. This could have significant cost implications for mental health services as clients who are offered FT as part of a therapeutic intervention may be more likely to complete therapy and therefore less likely to re-present to services in the future. Additionally, many participants commented on the speed with which FT contained clients' distress and the possibility that using FT may have reduced overall time spent in therapy. This may also have significant implications for services, particularly those that are commissioned to offer time-limited interventions.

The possible benefits to therapists' wellbeing revealed by the current study may also contribute to significant cost implications for services. According to a report, poor mental health and wellbeing in staff costs the NHS an estimated £12.1 billion a year (Daniels et al., 2022), annual sickness absence rate from April 2021 to March 2022 for staff working in NHS mental health trusts in England was estimated to be 5.75% (NHS Digital, 2022). This highlights significant cost implications given that use of FT has the potential to not only decrease therapists' risk of experiencing secondary traumatic stress but to increase therapists' sense of confidence and fulfilment at work.

FT training should not market FT as a technique that is *always* successful. This may help therapists feel more at ease when implementing FT and encourage them to persevere even if they do not immediately witness significant positive effects as they are less likely to experience feelings of inadequacy.

Future Research

The limited evidence base for FT contributed to participants' apprehensions about implementing the technique into their clinical practice, as such future research should prioritise strengthening the evidence base for effectiveness of FT through RCTs. Based on the results of this study, RCTs could consider whether client or therapist factors mediate the efficacy of FT and whether the time taken to process the trauma memory, for example using EMDR, is expedited if the client's distress is first contained using FT. This may contribute to therapists' belief in FT which may prompt more frequent use of the technique and thus them becoming more confident implementing the technique which has the potential to positively impact therapeutic outcomes. This could also have the effect of increasing the accessibility of FT and therefore of trauma-focused approaches to clients who would otherwise be unable to benefit from trauma therapy.

Gaining a clear and unified view of the underlying mechanisms of FT may further increase therapists' confidence implementing FT. Future research could employ neuro-imaging techniques used by Seigel et al. (2017) to identify whether the vPFC does in fact remain online during FT as proposed by Wong (2021).

Conclusion

This is the first study that has explored the experiences of therapists using FT. The experiences of these participants suggested FT is a much-needed tool used by therapists to empower and resource clients as they begin their journey through trauma-focused therapy. The positive affect experienced by participants during FT highlighted significant positive implications for the wellbeing of therapists who deliver trauma-focused therapies. It is hoped that this research contributes to the growing momentum surrounding FT by sharing an insight into the thoughts and feelings of some therapists who have overcome their own apprehensions and implemented this new technique into their clinical practice.

Further research is needed to strengthen the evidence base for the effectiveness of FT which in turn is likely to increase therapists' confidence and use of the technique.

References

Allen, R. E., & Wiles, J. L. (2016). A rose by any other name: Participants choosing research pseudonyms. *Qualitative Research in Psychology*, *13*(2), 149-165.

Bisson, J. I., Roberts, N. P., Andrew, M., Cooper, R., & Lewis, C. (2013). Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults. *Cochrane Database of Systematic Reviews*, (12).

British Psychological Society (BPS). (2021). *Code of ethics and conduct.* https://explore.bps.org.uk/binary/bpsworks/bf9d9fead1dfec7c/3acfadeebe810a324dde720ea7b34b6e87a80cad1de5471be0810935dac0415b/inf94_2021.pdf

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise & Health, 11*(4), 589–97.

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *18*(3), 328-352.

The International Public Policy Observatory. (2022). *NHS staff wellbeing: Why investing in organisational and management practices makes business sense*. https://eppi.ioe.ac.uk/CMS/Portals/0/IPPO%20NHS%20Staff%20Wellbeing%20report_LO160622-1849.pdf

Devilly, G. J., Wright, R., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals. *Australian & New Zealand Journal of Psychiatry*, *43*(4), 373-385.

Dragioti, E., Dimoliatis, I., Fountoulakis, K. N., & Evangelou, E. (2015). A systematic appraisal of allegiance effect in randomized controlled trials of psychotherapy. *Annals of General Psychiatry*, *14*, 1-9.

Dunne, T., & Farrell, D. (2011). An investigation into clinicians' experiences of integrating EMDR into their clinical practice. *Journal of EMDR Practice and Research*, *5*(4), 177-188.

Ecker, B., Ticic, R., & Hulley, L. (2012). *Unlocking the emotional brain: Eliminating symptoms at their roots using memory reconsolidation.* Routledge.

Feeny, N. C., Zoellner, L. A., & Foa, E. B. (2002). Treatment outcome for chronic PTSD among female assault victims with borderline personality characteristics: A preliminary examination. *Journal of Personality Disorders*, *16*(1), 30-40.

Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 3–28). The Sidran Press.

Fisher, J., & Ogden, P. (2007). Sensorimotor psychotherapy. In C. A. Courtois & Ford J. D. (Eds.), *Treating complex post-traumatic disorders*. (pp.312-328). Guilford Press.

Kilpatrick, D. G., & Best, C. L. (1984). Some cautionary remarks on treating sexual assault victims with implosion. *Behavior Therapy, 15*(4), 421–423.

Manfield, P. E., Engel, L., Greenwald, R., & Bullard, D. G. (2021). The flash technique in a low-intensity group trauma intervention for healthcare providers impacted by COVID-19 patients. *Journal of EMDR Practice and Research*, *15*(2).

Manfield, P. E., Lovett, J., Engel, L., & Manfield, D. (2017). Use of the flash technique in EMDR therapy: Four case examples. *Journal of EMDR Practice and Research*, *11*(4), 195-205.

McCormack, H. M., MacIntyre, T. E., O'Shea, D., Herring, M. P., & Campbell, M. J. (2018). The prevalence and cause(s) of burnout among applied psychologists: A systematic review. *Frontiers in Psychology*, *9*, 1897.

Morrison, N. M. V., Morrison, B. W., & Mahlberg, J. (2023). *Clinician perspectives, attitudes, and experiences with eye-movement desensitization and reprocessing therapy: A systematic review.* [Manuscript submitted for publication].

National Audit Office (NAO). (2023). *Progress in improving mental health services in England.* Department of Health & Social Care. https://www.nao.org.uk/wp-content/uploads/2023/02/Progress-in-improving-mental-health-services-CS.pdf

National Institute for Health and Care Excellence. (2018). *Psychological interventions for the prevention and treatment of PTSD in adults; Treatment for adults (NICE Guideline NG116].* https://www.nice.org.uk/guidance/ng116/chapter/Recommendations#assessment-and-coordination-of-care

NHS Digital. (2022). NHS sickness absence rates, January 2022 to March 2022, and annual summary 2009 to 2022, provisional statistics. https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/nhs-sickness-absence-rates-january-2022-to-march-2022-and-annual-summary-2009-to-2020-provisional-statistics#

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), 1-13.

Rupert, P. A., Miller, A. O., & Dorociak, K. E. (2015). Preventing burnout: What does the research tell us? *Professional Psychology: Research and Practice*, *46*(3), 168-174.

Schottenbauer, M. A., Glass, C. R., Arnkoff, D. B., Tendick, V., & Gray, S. H. (2008). Nonresponse and dropout rates in outcome studies on PTSD: Review and methodological considerations. *Psychiatry: Interpersonal and biological processes*, *71*(2), 134-168.

Shapiro, F. (2007). EMDR, adaptive information processing, and case conceptualization. *Journal of EMDR Practice and Research*, *1*(2), 68-87.

Shapiro, F. (2018). *Eye movement desensitization and reprocessing (EMDR) therapy: Basic Principles, Protocols, and Procedures.* Guilford Publications.

Shebini, N. (2019). Flash technique for safe desensitisation of memories and fusion of parts in DID: Modifications and resourcing strategies. *Frontiers in the Psychotherapy of Trauma and Dissociation, 3*(2), 151-164.

Siegel, D. J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. Guilford Press.

Siegel, P., Warren, R., Wang, Z., Yang, J., Cohen, D., Anderson, J. F., Murray, L., & Peterson, B. S. (2017). Less is more: Neural activity during very brief and clearly visible exposure to phobic stimuli. *Human Brain Mapping*, *38*(5), 2466-2481.

Sprenkle, D. H., & Blow, A. J. (2004). Common factors and our sacred models. *Journal of Marital and Family Therapy*, *30*(2), 113-129.

Struik, A. (2019). Demystifying EMDR. *InPsych: The bulletin of the Australian Psychological Society, 41*(3). https://psychology.org.au/for-members/publications/inpsych/2019/june/demystifying-emdr

Ültanir, E. (2012). An epistemological glance at the constructivist approach: Constructivist learning in Dewey, Piaget, and Montessori. *International Journal of Instruction*, 5(2), 195-212.

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

Wampold, B. E. (2001). Contextualizing psychotherapy as a healing practice: Culture, history, and methods. *Applied and Preventive Psychology*, *10*(2), 69-86.

Wolpe, J. (1968). Psychotherapy by reciprocal inhibition. *Conditional reflex: a Pavlovian Journal of Research & Therapy*, *3*(4), 234-240.

Wong, S. L. (2021). A model for the flash technique based on working memory and neuroscience research. *Journal of EMDR Practice and Research*. *15*(3). 174-184.

Part Three: Appendices

Appendix A. Manual Preparation and Submission Instructions for Authors of the *Journal of Trauma and Dissociation*

GUIDE FOR AUTHORS

INTRODUCTION

The European Journal of Trauma & Dissociation / Revue Européenne du Trauma et de la Dissociation is the official journal of the European Society for Trauma and Dissociation and of the French language Association of Trauma and Dissociation. It is a new journal, launched in 2017. The journal is dedicated to publishing scientific and clinical literature on dissociation, the dissociative disorders, posttraumatic stress disorder, complex PTSD, psychological trauma, and attachment disturbances, in order to foster exchange among researchers, clinicians and other professionals. The European Journal of Trauma & Dissociation publishes manuscripts on theory, clinical treatment, and research related to psychological trauma and dissociation in children and adults. The journal welcomes contributions, including case studies, from anthropological, cross-cultural, historical, neurobiological, pharmacologic, physiologic, psychological, psychometric, psychotherapeutic, and social viewpoints. The journal is published quarterly.

Editorial policy

EJTD strives to adhere to the following standards and requirements:
COPE - Committee on Publication Ethics
ICMJE - International Committee of Medical Journal Editors
STM - International Association of Scientific, Technical # Medical Publishers
EJTD was created with 5 goals in mind:
- Promote the development and dissemination of knowledge about trauma (including abuse and neglect), dissociation and all disorders related to psychological trauma, regardless of their clinical expression.
- Raise awareness among professionals (psychiatrists, psychologists, psychotherapists, other mental health professionals...) and advanced students (doctoral students, ...) of the issues of dissociation, trauma and any disorder related to psychological trauma.
- Promote and enhance communication and scientific and clinical cooperation between specialists in the field.
- Enable an evolution and transformation of clinical and psychotherapeutic practices in the treatment of the sequelae of psychological trauma and dissociation.
- Promote European research that takes into account the historical and cultural background of the Old Continent in the development of scientific and clinical knowledge in the field of psychological trauma and dissociation, as well as their treatment.
All manuscripts submitted to the journal are subjected to peer review by international experts, and must: - Be written in excellent English, clear and easy to understand, precise and concise;
- Bring new, interesting, valid information - and improve clinical care or guide future research;
- Be solely the work of the author(s) stated including accuracy of the facts, statements, and citing resources.
- Not have been previously published elsewhere and not be under consideration by another journal;
- Be in accordance with the journal's Guide for Authors' instructions: manuscripts that fail to comply with these rules may be returned to the authors without being reviewed.
Facts and opinions are solely the personal statements of the respective authors and do not necessarily represent the views of the editors.
Under no circumstances does the journal guarantee publication before the editorial board makes its final decision.

Types of article

The journal publishes research papers, review articles, opinion papers, short communications, technical notes, correspondence, discussions, case reports.

Contact details for submission

Editor-in-chief : Professor Cyril Tarquinio - University of Lorraine, France. ejtd.contact@gmail.com

Page charges

This journal has no page charges.

Language

Manuscripts must be written preferably in English or in French.

Submission checklist

You can use this list to carry out a final check of your submission before you send it to the journal for review. Please check the relevant section in this Guide for Authors for more details.

Ensure that the following items are present:

One author has been designated as the corresponding author with contact details:
• E-mail address
• Full postal address

All necessary files have been uploaded:
Manuscript:
• Include keywords
• All figures (include relevant captions)
• All tables (including titles, description, footnotes)
• Ensure all figure and table citations in the text match the files provided
• Indicate clearly if color should be used for any figures in print
Graphical Abstracts / Highlights files (where applicable)
Supplemental files (where applicable)

Further considerations
• Manuscript has been 'spell checked' and 'grammar checked'
• All references mentioned in the Reference List are cited in the text, and vice versa
• Permission has been obtained for use of copyrighted material from other sources (including the Internet)
• A competing interests statement is provided, even if the authors have no competing interests to declare
• Journal policies detailed in this guide have been reviewed
• Referee suggestions and contact details provided, based on journal requirements

For further information, visit our Support Center.

BEFORE YOU BEGIN

Ethics in publishing

Please see our information on Ethics in publishing.

Studies in humans and animals

If the work involves the use of human subjects, the author should ensure that the work described has been carried out in accordance with The Code of Ethics of the World Medical Association (Declaration of Helsinki) for experiments involving humans. The manuscript should be in line with the Recommendations for the Conduct, Reporting, Editing and Publication of Scholarly Work in Medical Journals and aim for the inclusion of representative human populations (sex, age and ethnicity) as per those recommendations. The terms sex and gender should be used correctly.

Authors should include a statement in the manuscript that informed consent was obtained for experimentation with human subjects. The privacy rights of human subjects must always be observed.

All animal experiments should comply with the ARRIVE guidelines and should be carried out in accordance with the U.K. Animals (Scientific Procedures) Act, 1986 and associated guidelines, EU Directive 2010/63/EU for animal experiments, or the National Research Council's Guide for the Care and Use of Laboratory Animals and the authors should clearly indicate in the manuscript that such guidelines have been followed. The sex of animals must be indicated, and where appropriate, the influence (or association) of sex on the results of the study.

Informed consent and patient details

Studies on patients or volunteers require ethics committee approval and informed consent, which should be documented in the paper. Appropriate consents, permissions and releases must be obtained where an author wishes to include case details or other personal information or images of patients and any other individuals in an Elsevier publication. Written consents must be retained by the author but copies should not be provided to the journal. Only if specifically requested by the journal in exceptional circumstances (for example if a legal issue arises) the author must provide copies of the

consents or evidence that such consents have been obtained. For more information, please review the Elsevier Policy on the Use of Images or Personal Information of Patients or other Individuals. Unless you have written permission from the patient (or, where applicable, the next of kin), the personal details of any patient included in any part of the article and in any supplementary materials (including all illustrations and videos) must be removed before submission.

Declaration of interest

All authors must disclose any financial and personal relationships with other people or organizations that could inappropriately influence (bias) their work. Examples of potential competing interests include employment, consultancies, stock ownership, honoraria, paid expert testimony, patent applications/registrations, and grants or other funding. Authors must disclose any interests in two places: 1. A summary declaration of interest statement in the title page file (if double anonymized) or the manuscript file (if single anonymized). If there are no interests to declare then please state this: 'Declarations of interest: none'. 2. Detailed disclosures as part of a separate Declaration of Interest form, which forms part of the journal's official records. It is important for potential interests to be declared in both places and that the information matches. More information.

Declaration of generative AI in scientific writing

The below guidance only refers to the writing process, and not to the use of AI tools to analyse and draw insights from data as part of the research process.

Where authors use generative artificial intelligence (AI) and AI-assisted technologies in the writing process, authors should only use these technologies to improve readability and language. Applying the technology should be done with human oversight and control, and authors should carefully review and edit the result, as AI can generate authoritative-sounding output that can be incorrect, incomplete or biased. AI and AI-assisted technologies should not be listed as an author or co-author, or be cited as an author. Authorship implies responsibilities and tasks that can only be attributed to and performed by humans, as outlined in Elsevier's AI policy for authors.

Authors should disclose in their manuscript the use of AI and AI-assisted technologies in the writing process by following the instructions below. A statement will appear in the published work. Please note that authors are ultimately responsible and accountable for the contents of the work.

Disclosure instructions

Authors must disclose the use of generative AI and AI-assisted technologies in the writing process by adding a statement at the end of their manuscript in the core manuscript file, before the References list. The statement should be placed in a new section entitled 'Declaration of Generative AI and AI-assisted technologies in the writing process'.

Statement: During the preparation of this work the author(s) used [NAME TOOL / SERVICE] in order to [REASON]. After using this tool/service, the author(s) reviewed and edited the content as needed and take(s) full responsibility for the content of the publication.

This declaration does not apply to the use of basic tools for checking grammar, spelling, references etc. If there is nothing to disclose, there is no need to add a statement.

Submission declaration and verification

Submission of an article implies that the work described has not been published previously (except in the form of an abstract, a published lecture or academic thesis, see 'Multiple, redundant or concurrent publication' for more information), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language, including electronically without the written consent of the copyright-holder. To verify compliance, your article may be checked by Crossref Similarity Check and other originality or duplicate checking software.

Preprints

Please note that preprints can be shared anywhere at any time, in line with Elsevier's sharing policy. Sharing your preprints e.g. on a preprint server will not count as prior publication (see 'Multiple, redundant or concurrent publication' for more information).

Use of inclusive language

Inclusive language acknowledges diversity, conveys respect to all people, is sensitive to differences, and promotes equal opportunities. Content should make no assumptions about the beliefs or commitments of any reader; contain nothing which might imply that one individual is superior to another on the grounds of age, gender, race, ethnicity, culture, sexual orientation, disability or health condition; and use inclusive language throughout. Authors should ensure that writing is free from bias, stereotypes, slang, reference to dominant culture and/or cultural assumptions. We advise to seek gender neutrality by using plural nouns ("clinicians, patients/clients") as default/wherever possible to avoid using "he, she," or "he/she." We recommend avoiding the use of descriptors that refer to personal attributes such as age, gender, race, ethnicity, culture, sexual orientation, disability or health condition unless they are relevant and valid. When coding terminology is used, we recommend to avoid offensive or exclusionary terms such as "master", "slave", "blacklist" and "whitelist". We suggest using alternatives that are more appropriate and (self-) explanatory such as "primary", "secondary", "blocklist" and "allowlist". These guidelines are meant as a point of reference to help identify appropriate language but are by no means exhaustive or definitive.

Reporting sex- and gender-based analyses

Reporting guidance

For research involving or pertaining to humans, animals or eukaryotic cells, investigators should integrate sex and gender-based analyses (SGBA) into their research design according to funder/sponsor requirements and best practices within a field. Authors should address the sex and/or gender dimensions of their research in their article. In cases where they cannot, they should discuss this as a limitation to their research's generalizability. Importantly, authors should explicitly state what definitions of sex and/or gender they are applying to enhance the precision, rigor and reproducibility of their research and to avoid ambiguity or conflation of terms and the constructs to which they refer (see Definitions section below). Authors can refer to the Sex and Gender Equity in Research (SAGER) guidelines and the SAGER guidelines checklist. These offer systematic approaches to the use and editorial review of sex and gender information in study design, data analysis, outcome reporting and research interpretation - however, please note there is no single, universally agreed-upon set of guidelines for defining sex and gender.

Definitions

Sex generally refers to a set of biological attributes that are associated with physical and physiological features (e.g., chromosomal genotype, hormonal levels, internal and external anatomy). A binary sex categorization (male/female) is usually designated at birth ("sex assigned at birth"), most often based solely on the visible external anatomy of a newborn. Gender generally refers to socially constructed roles, behaviors, and identities of women, men and gender-diverse people that occur in a historical and cultural context and may vary across societies and over time. Gender influences how people view themselves and each other, how they behave and interact and how power is distributed in society. Sex and gender are often incorrectly portrayed as binary (female/male or woman/man) and unchanging whereas these constructs actually exist along a spectrum and include additional sex categorizations and gender identities such as people who are intersex/have differences of sex development (DSD) or identify as non-binary. Moreover, the terms "sex" and "gender" can be ambiguous—thus it is important for authors to define the manner in which they are used. In addition to this definition guidance and the SAGER guidelines, the resources on this page offer further insight around sex and gender in research studies.

Contributors

Each author is required to declare their individual contribution to the article: all authors must have materially participated in the research and/or article preparation, so roles for all authors should be described. The statement that all authors have approved the final article should be true and included in the disclosure.

Authorship

All authors should have made substantial contributions to all of the following: (1) the conception and design of the study, or acquisition of data, or analysis and interpretation of data, (2) drafting the article or revising it critically for important intellectual content, (3) final approval of the version to be submitted.

Changes to authorship

Authors are expected to consider carefully the list and order of authors **before** submitting their manuscript and provide the definitive list of authors at the time of the original submission. Any addition, deletion or rearrangement of author names in the authorship list should be made only **before** the manuscript has been accepted and only if approved by the journal Editor. To request such a change, the Editor must receive the following from the **corresponding author**: (a) the reason for the change in author list and (b) written confirmation (e-mail, letter) from all authors that they agree with the addition, removal or rearrangement. In the case of addition or removal of authors, this includes confirmation from the author being added or removed.

Only in exceptional circumstances will the Editor consider the addition, deletion or rearrangement of authors **after** the manuscript has been accepted. While the Editor considers the request, publication of the manuscript will be suspended. If the manuscript has already been published in an online issue, any requests approved by the Editor will result in a corrigendum.

Clinical trial results

In line with the position of the International Committee of Medical Journal Editors, the journal will not consider results posted in the same clinical trials registry in which primary registration resides to be prior publication if the results posted are presented in the form of a brief structured (less than 500 words) abstract or table. However, divulging results in other circumstances (e.g., investors' meetings) is discouraged and may jeopardise consideration of the manuscript. Authors should fully disclose all posting in registries of results of the same or closely related work.

Reporting clinical trials

Randomized controlled trials should be presented according to the CONSORT guidelines. At manuscript submission, authors must provide the CONSORT checklist accompanied by a flow diagram that illustrates the progress of patients through the trial, including recruitment, enrollment, randomization, withdrawal and completion, and a detailed description of the randomization procedure. The CONSORT checklist and template flow diagram are available online.

Registration of clinical trials

Registration in a public trials registry is a condition for publication of clinical trials in this journal in accordance with International Committee of Medical Journal Editors recommendations. Trials must register at or before the onset of patient enrolment. The clinical trial registration number should be included at the end of the abstract of the article. A clinical trial is defined as any research study that prospectively assigns human participants or groups of humans to one or more health-related interventions to evaluate the effects of health outcomes. Health-related interventions include any intervention used to modify a biomedical or health-related outcome (for example drugs, surgical procedures, devices, behavioural treatments, dietary interventions, and process-of-care changes). Health outcomes include any biomedical or health-related measures obtained in patients or participants, including pharmacokinetic measures and adverse events. Purely observational studies (those in which the assignment of the medical intervention is not at the discretion of the investigator) will not require registration.

Article transfer service

This journal uses the Elsevier Article Transfer Service to find the best home for your manuscript. This means that if an editor feels your manuscript is more suitable for an alternative journal, you might be asked to consider transferring the manuscript to such a journal. The recommendation might be provided by a Journal Editor, a dedicated Scientific Managing Editor, a tool assisted recommendation, or a combination. If you agree, your manuscript will be transferred, though you will have the opportunity to make changes to the manuscript before the submission is complete. Please note that your manuscript will be independently reviewed by the new journal. More information.

Copyright

Upon acceptance of an article, authors will be asked to complete a 'Journal Publishing Agreement' (see more information on this). An e-mail will be sent to the corresponding author confirming receipt of the manuscript together with a 'Journal Publishing Agreement' form or a link to the online version of this agreement.

Subscribers may reproduce tables of contents or prepare lists of articles including abstracts for internal circulation within their institutions. Permission of the Publisher is required for resale or distribution outside the institution and for all other derivative works, including compilations and translations. If

excerpts from other copyrighted works are included, the author(s) must obtain written permission from the copyright owners and credit the source(s) in the article. Elsevier has preprinted forms for use by authors in these cases.

For gold open access articles: Upon acceptance of an article, authors will be asked to complete a 'License Agreement' (more information). Permitted third party reuse of gold open access articles is determined by the author's choice of user license.

Author rights
As an author you (or your employer or institution) have certain rights to reuse your work. More information.

Elsevier supports responsible sharing
Find out how you can share your research published in Elsevier journals.

Role of the funding source
You are requested to identify who provided financial support for the conduct of the research and/or preparation of the article and to briefly describe the role of the sponsor(s), if any, in study design; in the collection, analysis and interpretation of data; in the writing of the report; and in the decision to submit the article for publication. If the funding source(s) had no such involvement, it is recommended to state this.

Open access
Please visit our Open Access page for more information.

Elsevier Researcher Academy
Researcher Academy is a free e-learning platform designed to support early and mid-career researchers throughout their research journey. The "Learn" environment at Researcher Academy offers several interactive modules, webinars, downloadable guides and resources to guide you through the process of writing for research and going through peer review. Feel free to use these free resources to improve your submission and navigate the publication process with ease.

Language (usage and editing services)
Please write your text in good English (American or British usage is accepted, but not a mixture of these). Authors who feel their English language manuscript may require editing to eliminate possible grammatical or spelling errors and to conform to correct scientific English may wish to use the English Language Editing service available from Elsevier's Author Services.

Submission
Our online submission system guides you stepwise through the process of entering your article details and uploading your files. The system converts your article files to a single PDF file used in the peer-review process. Editable files (e.g., Word, LaTeX) are required to typeset your article for final publication. All correspondence, including notification of the Editor's decision and requests for revision, is sent by e-mail.

Submit your article
Please submit your article via https://www.editorialmanager.com/ejtd/default.aspx

PREPARATION

Peer review
This journal operates a double anonymized review process. All contributions will be initially assessed by the editor for suitability for the journal. Papers deemed suitable are then typically sent to a minimum of two independent expert reviewers to assess the scientific quality of the paper. The Editor is responsible for the final decision regarding acceptance or rejection of articles. The Editor's decision is final. Editors are not involved in decisions about papers which they have written themselves or have been written by family members or colleagues or which relate to products or services in which the editor has an interest. Any such submission is subject to all of the journal's usual procedures, with peer review handled independently of the relevant editor and their research groups. More information on types of peer review.

Double anonymized review
This journal uses double anonymized review, which means the identities of the authors are concealed from the reviewers, and vice versa. More information is available on our website. To facilitate this, please include the following separately:

Title page (with author details): This should include the title, authors' names, affiliations, acknowledgements and any Declaration of Interest statement, and a complete address for the corresponding author including an e-mail address.
Anonymized manuscript (no author details): The main body of the paper (including the references, figures, tables and any acknowledgements) should not include any identifying information, such as the authors' names or affiliations.

Use of word processing software
It is important that the file be saved in the native format of the word processor used. The text should be in single-column format. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. In particular, do not use the word processor's options to justify text or to hyphenate words. However, do use bold face, italics, subscripts, superscripts etc. When preparing tables, if you are using a table grid, use only one grid for each individual table and not a grid for each row. If no grid is used, use tabs, not spaces, to align columns. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier). Note that source files of figures, tables and text graphics will be required whether or not you embed your figures in the text. See also the section on Electronic artwork.
To avoid unnecessary errors you are strongly advised to use the 'spell-check' and 'grammar-check' functions of your word processor.

Article structure

Subdivision - numbered sections
Divide your article into clearly defined and numbered sections. Subsections should be numbered 1.1 (then 1.1.1, 1.1.2, ...), 1.2, etc. (the abstract is not included in section numbering). Use this numbering also for internal cross-referencing: do not just refer to 'the text'. Any subsection may be given a brief heading. Each heading should appear on its own separate line.

Introduction
State the objectives of the work and provide an adequate background, avoiding a detailed literature survey or a summary of the results.

Material and methods
Provide sufficient details to allow the work to be reproduced by an independent researcher. Methods that are already published should be summarized, and indicated by a reference. If quoting directly from a previously published method, use quotation marks and also cite the source. Any modifications to existing methods should also be described.

Theory/calculation
A Theory section should extend, not repeat, the background to the article already dealt with in the Introduction and lay the foundation for further work. In contrast, a Calculation section represents a practical development from a theoretical basis.

Results
Results should be clear and concise.

Discussion
This should explore the significance of the results of the work, not repeat them. A combined Results and Discussion section is often appropriate. Avoid extensive citations and discussion of published literature.

Conclusions
The main conclusions of the study may be presented in a short Conclusions section, which may stand alone or form a subsection of a Discussion or Results and Discussion section.

Appendices
If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

Essential title page information

• ***Title.*** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible.

• ***Author names and affiliations.*** Please clearly indicate the given name(s) and family name(s) of each author and check that all names are accurately spelled. You can add your name between parentheses in your own script behind the English transliteration. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name and, if available, the e-mail address of each author.
• ***Corresponding author.*** Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. This responsibility includes answering any future queries about Methodology and Materials. **Ensure that the e-mail address is given and that contact details are kept up to date by the corresponding author.**
• ***Present/permanent address.*** If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Highlights
Highlights are optional yet highly encouraged for this journal, as they increase the discoverability of your article via search engines. They consist of a short collection of bullet points that capture the novel results of your research as well as new methods that were used during the study (if any). Please have a look at the examples here: example Highlights.

Highlights should be submitted in a separate editable file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point).

Structured abstract
A structured abstract, by means of appropriate headings, should provide the context or background for the research and should state its purpose, basic procedures (selection of study subjects or laboratory animals, observational and analytical methods), main findings (giving specific effect sizes and their statistical significance, if possible), and principal conclusions. It should emphasize new and important aspects of the study or observations.

Keywords
Immediately after the abstract, provide a maximum of 6 keywords, using British spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

Abbreviations
Define abbreviations that are not standard in this field in a footnote to be placed on the first page of the article. Such abbreviations that are unavoidable in the abstract must be defined at their first mention there, as well as in the footnote. Ensure consistency of abbreviations throughout the article.

Acknowledgements
Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).

Formatting of funding sources
List funding sources in this standard way to facilitate compliance to funder's requirements:

Funding: This work was supported by the National Institutes of Health [grant numbers xxxx, yyyy]; the Bill & Melinda Gates Foundation, Seattle, WA [grant number zzzz]; and the United States Institutes of Peace [grant number aaaa].

It is not necessary to include detailed descriptions on the program or type of grants and awards. When funding is from a block grant or other resources available to a university, college, or other research institution, submit the name of the institute or organization that provided the funding.

If no funding has been provided for the research, it is recommended to include the following sentence:

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Footnotes
Footnotes should be used sparingly. Number them consecutively throughout the article. Many word processors can build footnotes into the text, and this feature may be used. Otherwise, please indicate the position of footnotes in the text and list the footnotes themselves separately at the end of the article. Do not include footnotes in the Reference list.

Artwork

Electronic artwork
General points
• Make sure you use uniform lettering and sizing of your original artwork.
• Embed the used fonts if the application provides that option.
• Aim to use the following fonts in your illustrations: Arial, Courier, Times New Roman, Symbol, or use fonts that look similar.
• Number the illustrations according to their sequence in the text.
• Use a logical naming convention for your artwork files.
• Provide captions to illustrations separately.
• Size the illustrations close to the desired dimensions of the published version.
• Submit each illustration as a separate file.
• Ensure that color images are accessible to all, including those with impaired color vision.

A detailed guide on electronic artwork is available.
You are urged to visit this site; some excerpts from the detailed information are given here.
Formats
If your electronic artwork is created in a Microsoft Office application (Word, PowerPoint, Excel) then please supply 'as is' in the native document format.
Regardless of the application used other than Microsoft Office, when your electronic artwork is finalized, please 'Save as' or convert the images to one of the following formats (note the resolution requirements for line drawings, halftones, and line/halftone combinations given below):
EPS (or PDF): Vector drawings, embed all used fonts.
TIFF (or JPEG): Color or grayscale photographs (halftones), keep to a minimum of 300 dpi.
TIFF (or JPEG): Bitmapped (pure black & white pixels) line drawings, keep to a minimum of 1000 dpi.
TIFF (or JPEG): Combinations bitmapped line/half-tone (color or grayscale), keep to a minimum of 500 dpi.
Please do not:
• Supply files that are optimized for screen use (e.g., GIF, BMP, PICT, WPG); these typically have a low number of pixels and limited set of colors;
• Supply files that are too low in resolution;
• Submit graphics that are disproportionately large for the content.

Color artwork
Please make sure that artwork files are in an acceptable format (TIFF (or JPEG), EPS (or PDF) or MS Office files) and with the correct resolution. If, together with your accepted article, you submit usable color figures then Elsevier will ensure, at no additional charge, that these figures will appear in color online (e.g., ScienceDirect and other sites). Further information on the preparation of electronic artwork.

Figure captions
Ensure that each illustration has a caption. Supply captions separately, not attached to the figure. A caption should comprise a brief title (**not** on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

Tables

Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules and shading in table cells.

References

Citation in text
Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

Reference links
Increased discoverability of research and high quality peer review are ensured by online links to the sources cited. In order to allow us to create links to abstracting and indexing services, such as Scopus, Crossref and PubMed, please ensure that data provided in the references are correct. Please note that incorrect surnames, journal/book titles, publication year and pagination may prevent link creation. When copying references, please be careful as they may already contain errors. Use of the DOI is highly encouraged.

A DOI is guaranteed never to change, so you can use it as a permanent link to any electronic article. An example of a citation using DOI for an article not yet in an issue is: VanDecar J.C., Russo R.M., James D.E., Ambeh W.B., Franke M. (2003). Aseismic continuation of the Lesser Antilles slab beneath northeastern Venezuela. Journal of Geophysical Research, https://doi.org/10.1029/2001JB000884. Please note the format of such citations should be in the same style as all other references in the paper.

Web references
As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

Data references
This journal encourages you to cite underlying or relevant datasets in your manuscript by citing them in your text and including a data reference in your Reference List. Data references should include the following elements: author name(s), dataset title, data repository, version (where available), year, and global persistent identifier. Add [dataset] immediately before the reference so we can properly identify it as a data reference. The [dataset] identifier will not appear in your published article.

Preprint references
Where a preprint has subsequently become available as a peer-reviewed publication, the formal publication should be used as the reference. If there are preprints that are central to your work or that cover crucial developments in the topic, but are not yet formally published, these may be referenced. Preprints should be clearly marked as such, for example by including the word preprint, or the name of the preprint server, as part of the reference. The preprint DOI should also be provided.

References in a special issue
Please ensure that the words 'this issue' are added to any references in the list (and any citations in the text) to other articles in the same Special Issue.

Reference style
Text: Citations in the text should follow the referencing style used by the American Psychological Association. You are referred to the Publication Manual of the American Psychological Association, Seventh Edition, ISBN 978-1-4338-3215-4, copies of which may be ordered online.
List: references should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters 'a', 'b', 'c', etc., placed after the year of publication.
Examples:
Reference to a journal publication:
Van der Geer, J., Hanraads, J. A. J., & Lupton, R. A. (2010). The art of writing a scientific article. *Journal of Scientific Communications, 163*, 51–59. https://doi.org/10.1016/j.sc.2010.00372.
Reference to a journal publication with an article number:
Van der Geer, J., Hanraads, J. A. J., & Lupton, R. A. (2018). The art of writing a scientific article. *Heliyon*, *19*, Article e00205. https://doi.org/10.1016/j.heliyon.2018.e00205.
Reference to a book:
Strunk, W., Jr., & White, E. B. (2000). *The elements of style* (4th ed.). Longman (Chapter 4).

Reference to a chapter in an edited book:
Mettam, G. R., & Adams, L. B. (2009). How to prepare an electronic version of your article. In B. S. Jones, & R. Z. Smith (Eds.), *Introduction to the electronic age* (pp. 281–304). E-Publishing Inc.
Reference to a website:
Powertech Systems. (2015). *Lithium-ion vs lead-acid cost analysis*. Retrieved from http://www.powertechsystems.eu/home/tech-corner/lithium-ion-vs-lead-acid-cost-analysis/. Accessed January 6, 2016
Reference to a dataset:
[dataset] Oguro, M., Imahiro, S., Saito, S., & Nakashizuka, T. (2015). *Mortality data for Japanese oak wilt disease and surrounding forest compositions*. Mendeley Data, v1. https://doi.org/10.17632/xwj98nb39r.1.
Reference to a conference paper or poster presentation:
Engle, E.K., Cash, T.F., & Jarry, J.L. (2009, November). *The Body Image Behaviours Inventory-3: Development and validation of the Body Image Compulsive Actions and Body Image Avoidance Scales*. Poster session presentation at the meeting of the Association for Behavioural and Cognitive Therapies, New York, NY.
Reference to software:
Coon, E., Berndt, M., Jan, A., Svyatsky, D., Atchley, A., Kikinzon, E., Harp, D., Manzini, G., Shelef, E., Lipnikov, K., Garimella, R., Xu, C., Moulton, D., Karra, S., Painter, S., Jafarov, E., & Molins, S. (2020, March 25). *Advanced Terrestrial Simulator (ATS) v0.88 (Version 0.88)*. Zenodo. https://doi.org/10.5281/zenodo.3727209.

Journal abbreviations source
Journal names should be abbreviated according to the List of Title Word Abbreviations.

Video
Elsevier accepts video material and animation sequences to support and enhance your scientific research. Authors who have video or animation files that they wish to submit with their article are strongly encouraged to include links to these within the body of the article. This can be done in the same way as a figure or table by referring to the video or animation content and noting in the body text where it should be placed. All submitted files should be properly labeled so that they directly relate to the video file's content. In order to ensure that your video or animation material is directly usable, please provide the file in one of our recommended file formats with a preferred maximum size of 150 MB per file, 1 GB in total. Video and animation files supplied will be published online in the electronic version of your article in Elsevier Web products, including ScienceDirect. Please supply 'stills' with your files: you can choose any frame from the video or animation or make a separate image. These will be used instead of standard icons and will personalize the link to your video data. For more detailed instructions please visit our video instruction pages. Note: since video and animation cannot be embedded in the print version of the journal, please provide text for both the electronic and the print version for the portions of the article that refer to this content.

Supplementary material
Supplementary material such as applications, images and sound clips, can be published with your article to enhance it. Submitted supplementary items are published exactly as they are received (Excel or PowerPoint files will appear as such online). Please submit your material together with the article and supply a concise, descriptive caption for each supplementary file. If you wish to make changes to supplementary material during any stage of the process, please make sure to provide an updated file. Do not annotate any corrections on a previous version. Please switch off the 'Track Changes' option in Microsoft Office files as these will appear in the published version.

Research data
This journal encourages and enables you to share data that supports your research publication where appropriate, and enables you to interlink the data with your published articles. Research data refers to the results of observations or experimentation that validate research findings. To facilitate reproducibility and data reuse, this journal also encourages you to share your software, code, models, algorithms, protocols, methods and other useful materials related to the project.

Below are a number of ways in which you can associate data with your article or make a statement about the availability of your data when submitting your manuscript. If you are sharing data in one of these ways, you are encouraged to cite the data in your manuscript and reference list. Please refer to the "References" section for more information about data citation. For more information on depositing, sharing and using research data and other relevant research materials, visit the research data page.

Data statement
To foster transparency, we encourage you to state the availability of your data in your submission. This may be a requirement of your funding body or institution. If your data is unavailable to access or unsuitable to post, you will have the opportunity to indicate why during the submission process, for example by stating that the research data is confidential. The statement will appear with your published article on ScienceDirect. For more information, visit the Data Statement page.

AFTER ACCEPTANCE

Online proof correction

To ensure a fast publication process of the article, we kindly ask authors to provide us with their proof corrections within two days. Corresponding authors will receive an e-mail with a link to our online proofing system, allowing annotation and correction of proofs online. The environment is similar to MS Word: in addition to editing text, you can also comment on figures/tables and answer questions from the Copy Editor. Web-based proofing provides a faster and less error-prone process by allowing you to directly type your corrections, eliminating the potential introduction of errors.
If preferred, you can still choose to annotate and upload your edits on the PDF version. All instructions for proofing will be given in the e-mail we send to authors, including alternative methods to the online version and PDF.
We will do everything possible to get your article published quickly and accurately. Please use this proof only for checking the typesetting, editing, completeness and correctness of the text, tables and figures. Significant changes to the article as accepted for publication will only be considered at this stage with permission from the Editor. It is important to ensure that all corrections are sent back to us in one communication. Please check carefully before replying, as inclusion of any subsequent corrections cannot be guaranteed. Proofreading is solely your responsibility.

Offprints

The corresponding author will, at no cost, receive a customized Share Link providing 50 days free access to the final published version of the article on ScienceDirect. The Share Link can be used for sharing the article via any communication channel, including email and social media. For an extra charge, paper offprints can be ordered via the offprint order form which is sent once the article is accepted for publication. Corresponding authors who have published their article gold open access do not receive a Share Link as their final published version of the article is available open access on ScienceDirect and can be shared through the article DOI link.

AUTHOR INQUIRIES

Visit the Elsevier Support Center to find the answers you need. Here you will find everything from Frequently Asked Questions to ways to get in touch.
You can also check the status of your submitted article or find out when your accepted article will be published.

Appendix B. Critical Appraisal Skills Programme (CASP, 2018)

CASP
Critical Appraisal Skills Programme

Paper for appraisal and reference:

Section A: Are the results valid?

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

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes ☐
Can't Tell ☐
No ☐

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

Comments:

Is it worth continuing?

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

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

CASP
Critical Appraisal Skills Programme

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

Yes ☐
Can't Tell ☐
No ☐

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

Comments:

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

Yes ☐
Can't Tell ☐
No ☐

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

Comments:

CASP
Critical Appraisal Skills Programme

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

Yes ☐
Can't Tell ☐
No ☐

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

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

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

Comments:

CASP
Critical Appraisal Skills Programme

8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

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

Comments:

9. Is there a clear statement of findings?

Yes ☐
Can't Tell ☐
No ☐

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

Comments:

CASP
Critical Appraisal Skills Programme

Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider

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

Comments:	

Appendix C. Quality Assessment Ratings for Reviewed Studies

	Checklist Item										
Article	1. Was there a clear statement of the aims of the research?	2. Is a qualitative methodology appropriate?	3. Was the research design appropriate to address the aims of the research?	4. Was the recruitment strategy appropriate to the aims of the research?	5. Was the data collected in a way that addressed the research issue?	6. Has the relationship between researcher and participants been adequately considered?	7. Have ethical issues been taken into consideration?	8. Was the data analysis sufficiently rigorous?	9. Is there a clear statement of findings?	10. How valuable is the research?	Overall Score
Dittmann & Jensen (2014)	1	1	1	1	1	-	1	1	1	1	9
Kaminer et al. (2022)	1	1	1	1	1	-	1	-	1	1	8
Murray et al. (2014)	1	1	-	1	1	-	-	1	1	1	7
Okamura et al. (2020)	1	1	-	1	1	-	1	1	1	1	8
Salloum et al. (2015)	1	1	-	1	1	-	1	1	1	1	8
Eastwood et al. (2021)	1	1	1	1	1	1	1	1	1	1	10
Kroese et al. (2016)	1	1	1	1	1	-	1	1	1	1	9
Lowe & Murray (2014)	1	1	1	1	1	-	1	1	1	1	9
Murray et al. (2016)	1	1	1	1	1	-	-	1	1	1	8
Shearing et al. (2011)	1	1	1	1	1	1	-	1	1	1	9

Vincent et al. (2013)	1	1	1	1	1	1	1	1	1	1	10

Appendix D: Manual Preparation and Submission Instructions for Authors of the *Journal of EMDR Practice and Research*

Journal of EMDR Practice and Research

INSTRUCTIONS FOR AUTHORS

The *Journal of EMDR Practice and Research* is a quarterly, peer-reviewed publication devoted to integrative, state-of-the-art papers about Eye Movement Desensitization and Reprocessing Therapy. It is a broadly conceived interdisciplinary journal that stimulates and communicates research and theory about EMDR therapy, and their application to clinical practice. The Journal publishes theoretical, review, and methodological articles; experimental, case and field studies; brief reports; book reviews; and clinical practice papers. Content addresses a wide range of topics, such as treatment outcome; treatment of specific populations; treatment processes; role of eye movements / bilateral stimulation; mechanism of action; neurobiological components; theoretical issues; therapist training; and clinical challenges.

Manuscript Submission
Submit manuscripts, in English, in MS Word format electronically at www.editorialmanager.com/emdr. Manuscripts are acknowledged on receipt. Following preliminary review by the Editors, to ensure compliance with required elements, manuscripts are peer reviewed. Determination regarding potential publication is made upon completion of the review process.

Manuscript Style
The following are guidelines for developing and submitting a manuscript.

1. Manuscripts must be professionally prepared in accordance with the *Publication Manual of the American Psychological Association*, 6th edition, 2010.
2. Manuscripts should be double-spaced throughout and are generally expected to be 20-35 pages in length (about 6000-8000 words) including references, tables, and figures, etc.
3. The title page must include authors' names, positions, titles, affiliations, full contact information (address, phone, fax, and e-mail). This information should not be included elsewhere in the manuscript, to ensure blind review.
4. The second page should contain the title of the paper and an abstract of no more than 225 words as well as 4 to 6 key words or terms, listed below the abstract. Key words should express the precise content of the manuscript, as they are used for indexing purposes.
5. All articles must contain a comprehensive literature review. For example, a manuscript describing EMDR treatment of a certain disorder would summarize the literature about the nature of that disorder, review research studies that investigated outcomes of other treatments, as well as studies that evaluated EMDR treatment of that disorder. With the exception of seminal sources, the reviewed literature should be current and published within the last 10 years.
6. Articles that recommend a theoretical approach that differs from Shapiro's (2001) Adaptive Information Processing model should discuss these differences.

7. Non-research papers that recommend significant changes to EMDR standard procedures, must provide empirical support for that modification.
8. In order to promote critical thinking and an unbiased approach for the dissemination of ideas, recent advances, and current research, all articles must take an objective, scientific stance, and a respectful tone.
9. Photos and line art figures should be sent as tiff or jpg (300dpi) or eps (800ppi) files.
10. Contributors are responsible for obtaining written permission from copyright owners for illustrations, adaptations, or quotes of more than 300 words.

Appendix E. Epistemological Statement

The quality of psychological research is strengthened by the researcher's ability to reflect on their own position in relation to the research which is informed by their assumptions developed through previous experiences. A researcher's ontological assumptions refers to their beliefs about the nature of reality and thus what can be known about reality (Ormston et al., 2013). The different perspectives about ontology fall on a spectrum from realism to relativism (Willig, 2013). Realism suggests there is an observable reality comprised of objective, discoverable 'truths' (Ormston et al., 2013). Relativism assumes there to be multiple 'truths' which are subjective and context dependent (Willig, 2013). The researcher's relationship to their research carries further assumptions which is defined as epistemology; the epistemological position of the researcher denotes their assumptions about how knowledge of reality is acquired. At one end of the spectrum of epistemological perspectives lies positivism which assumes that through rigorous scientific procedure, it is possible to discover objective 'truths'. Whereas at the other end of the spectrum, social constructionism assumes that meaning is not discovered but constructed within a social context. The researcher's ontological and epistemological position influences the question their research seeks to answer as well as the methodological choices made along the way. On the spectrum of different ontological positions, critical realism sits between realism and relativism. Critical realism combines ontological realism, which assumes the existence of a truth, with epistemological relativism, which assumes that this 'truth' is obscured by the researcher's own subjectivity and the processes of knowledge production (Braun & Clarke, 2006). Critical realism recognises there is more to understand beyond the observable experience of reality. This observable reality cannot be understood through the human lens alone without knowledge of the underlying mechanisms causing the event (Fletcher, 2017).

The ontological stance most in line with the researcher's beliefs is critical realism which informed the research's pursuit of a knowable 'truth' while acknowledging the lens through which this truth is viewed (Fletcher, 2017). A critical realist ontology aligns with a constructivist epistemological position. Constructivism assumes that the meanings people create about the world reflect a point of view rather than an objective truth (Raskin, 2002). Thus, a constructivist epistemology assumes data gathered in research does not offer a clear reflection of reality but instead reflects participants' perception of their reality shaped by their cultural context.

During the design of the empirical paper, the researcher chose an exploratory approach to explore therapists' experiences of FT which is in line with the assumptions of constructivism instead of the formation of a testable hypothesis as this would be more aligned with epistemologies underpinned by a positivist ontological stance. The researcher's constructivist epistemological stance informed the decision to select a qualitative approach and centre participants' experience of FT while also considering proposed explanatory models of FT and clinical implications. Thematic analysis was selected as the method to analyse the data gathered relating to therapists' experiences. Constructivism encourages the acknowledgement of the active role of the researcher in knowledge production and therefore encourages reflectivity throughout the research process. A reflexive approach to thematic analysis was therefore taken which considers the role of the researcher's lens, shaped by their own experiences, when interpreting participants' perceptions of their reality (Braun & Clarke, 2021).

The researcher utilised an inductive approach to reflexive thematic analysis to identify and explore themes from participant experience. An inductive approach assumes analysis is located within, and coding and theme development are driven by the data (Braun & Clarke, 2021). This approach is recommended for new areas of research as the data is not coded

according to a pre-existing frame or the researcher's analytic preconceptions (Braun & Clarke, 2006). However, the researcher acknowledges that no theme can be entirely inductive, since the researcher's knowledge and preconceptions inevitably influenced the identification of themes by selecting those which were of interest.

The researcher's ontological and epistemological position also informed the direction of the systematic literature review. The constructivist assumption that knowledge is created by the person experiencing the phenomenon and is shaped by their past experiences informed the research question which sought to bring together subjective experiences of TF-CBT. Consequently, this informed the researcher's decision to use narrative synthesis to combine the findings from the included studies, understand how study findings may be connected and use this perspective to identify potential implications for the implementation of TF-CBT in clinical practice.

References

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

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *18*(3), 328-352.

Fletcher, A. J. (2017). Applying critical realism in qualitative research: methodology meets method. *International Journal of Social Research Methodology*, *20*(2), 181-194.

Ormston, R., Spencer, L., Barnard, M., & Snape, D. (2013). The foundations of qualitative research. In J. Ritchie, J. Lewis, C. Nicholls, & R. Ormston (Eds.), *Qualitative research practice: A guide for social science students and researchers* (pp.1-26). Sage Publications.

Raskin, J. D. (2002). Constructivism in psychology: Personal construct psychology, radical constructivism, and social constructionism. *American Communication Journal*, *5*(3), 1-25.

Willig, C. (2013). *Introducing qualitative research in psychology (3rd ed.)*. McGraw-Hill Education.

Appendix F: Reflective Statement

As I sit down to write this reflective statement I feel overwhelmed at the prospect of summing up my thoughts and feelings about the process of this research. I am drawn to use metaphor to explain my relationship with my research project and so I have chosen to adapt the boat metaphor used by Thomas Zimmerman to explain the process of EMDR (Zimmerman, 2022).

Zimmerman (2022) suggests that clients come to therapy in a boat, if they have experienced complex trauma their boats are often small, such as a canoe, and under-resourced. The goal of EMDR is to process clients' trauma memories. Zimmerman (2022) likens this to fishing, with smaller fish representing smaller traumatic memories and larger fish i.e. whales, representing the client's most significant trauma memories. Zimmerman (2022) points out that it is not possible to fish for whales in a canoe without the proper equipment in the same way that therapists cannot ask clients to process significant trauma memories without first equipping them with the resources to do so. During the first phases of EMDR, the therapist helps the client to catch smaller fish so that they can trade in their canoe for a more appropriately-sized boat for whaling. The client can also trade their fish in for new, better-suited equipment that the therapist supports the client to become more familiar with as they navigate the ocean of trauma therapy together. Starting this research three years ago, I felt as though I had been pushed out into the ocean of research in a rickety old canoe with very few resources. I hope this reflective statement will go some way to illustrate my progress from a rickety canoe to the more substantial motorboat I find myself in now.

When faced with choosing a research project I found myself caught between choosing a more 'straightforward' project area or one that I was excited about despite the likely associated challenges. Trainees and course staff emphasised the importance of choosing

a topic of genuine interest and so, for the first time in my academic career, my choice of research project was motivated not by strategy but by curiosity and a desire to produce a piece of research I would be proud of. There have been times throughout the research process when I have again felt a pull towards perceived ‘easier’ options but I retained my determination to make thoughtful decisions which has helped to create a sense of ownership over my work. I can recall my first conversation with Jo Beckett (Primary Research Supervisor) about FT and her enthusiasm, which quickly became a shared enthusiasm, for the potential of FT to increase the accessibility of trauma-focused therapy for clients. When Jo introduced me to FT in 2020 there were only a handful of papers published which mentioned FT and I remember scouring the internet for information about what it looked like in practice. Fortunately, I had the opportunity to observe a clinician use FT with a client and was amazed at the positive effect it had on this client’s distress. I have returned to those feelings of enthusiasm and hope a number of times over the last few years which helped me reconnect with my interest in the research area.

As I had predominantly completed quantitative research during my undergraduate degree I suddenly felt ill-equipped as I launched my little canoe into the unfamiliar ocean of qualitative research. I found myself comparing my canoe with other trainees’ more robust boats with their greater experience designing qualitative research. I soon learned how unhelpful comparison was during research and tried to focus on paddling my own canoe. As someone who constantly strives to be ahead, this was extremely difficult at first but the peace this acceptance brought me was worth it and I hope to carry this valuable lesson with me into my career and everyday life. In addition, discussions and reading recommendations shared during supervision were key in helping me to navigate decisions about research questions, inclusion criteria and methods for data analysis. Handing in the first versions of my research proposal which demonstrated the knowledge I had acquired

felt like trading in my rickety canoe for a newer dinghy ready to embark on the next part of my fishing adventure.

The process of obtaining ethical approval taught me how to find the balance between persistence and patience as I awaited a response and made suggested amendments. At the same time, I began collecting papers for my systematic literature review which helped me to feel I was progressing with my research even when other parts of the process felt stagnant. However, my systematic literature was not all plain sailing. I can still recall the stomach-drop moment when I found out that a review which exactly matched the aims of mine had been published earlier that month. I felt as though I was back at the beginning in my little canoe as I tried to identify a different focus for my review. However, I gradually realised that I was in fact still in my upgraded boat and, as a result of the hard work I had put into my previous literature search, I was familiar with the necessary equipment on board. This meant I was able to complete my second search more efficiently and confidently and, as I reflect on this now, I can see that the review I produced is of a higher quality.

As I began data collection I felt the familiar feeling that my boat was not equipped for the task ahead. At first, I felt bound to my interview schedule and did not deviate out of fear of influencing participants' responses. I reflected on this during research supervision with Emma Wolverson (Secondary Research Supervisor) who reminded me that the researcher can never be fully separate from their research and in fact reflexive thematic analysis views subjectivity as a relative strength rather than a weakness to be quashed. Clinical training has taught me how to be curious about people's experiences and so when I brought this curiosity to my conversations with therapists, they revealed richer insights and ultimately enabled me to gain a deeper understanding of their experiences using FT.

What struck me during the interviews was how candidly therapists spoke about their perseverance with implementing FT in their clinical practice for the sake of their clients, in spite of their initial discomfort. It made me wonder whether the therapists I was talking to were also in boats that felt a bit unsteady with new unfamiliar equipment. It also reminded me of the original meaning behind Zimmerman's (2022) boat metaphor; that clients often commence therapy with similar feelings of apprehension about the sea-worthiness of their boats. The determination of clients and therapists to develop their resources despite feeling ill-equipped and apprehensive inspired me to persevere with my own discomfort in relation to my research project. This parallel process between clients, therapists, and myself as a researcher strengthened my sense of connection to the research area.

During data analysis I was acutely aware of the context surrounding the participants experiences, most of whom mentioned working in NHS settings. As a trainee clinical psychologist also working in the NHS, my mind was often drawn to thinking about the potential time and cost implications of FT. There continue to be lengthy waiting lists for mental health services with an estimated 1.2 million people reportedly on the waiting list for community-based NHS mental health services at the end of June 2022 (National Audit Office, 2023) particularly for trauma-focused therapies which tend to require more sessions. I reflected on the potential of FT to increase the accessibility and time spent in trauma therapy and the implications this could have on waiting lists. However, I also considered the potential negative impacts of highlighting the time and cost implications, for example, increased pressure on services to decrease the number of sessions offered to clients. I tried to remain reflexive and consider my position as an insider by paying attention to the aspects of the data I was particularly drawn to and considering whether the same data would stand out to a different researcher who did not work in the NHS.

During my SLR data analysis, I found the process of synthesising data that I had not collected more challenging in comparison to analysing my own empirical study data. I was conscious of the fact that I was unaware of the context surrounding participants' quotes presented by the study authors. I often worried that I was assigning meaning to participants' experiences that did not align with the meanings they themselves had created. I found it helpful to consider the triple hermeneutic whereby I, as the reviewer, was constructing meaning about the original researchers' constructions of meaning about their participants' constructions of meanings about TF-CBT. This reminded me of the need to own the subjectivity we, as researchers, bring and that goal of review was not to find an objective truth but instead explore patterns of meaning.

When I began writing up my project I felt an enormous pressure to produce the 'perfect' paper in order to do justice to the therapists who had given up their time to participate in my empirical study. During supervision I reflected that striving for perfection was hindering my ability to write and my supervisors suggested it might help to "just let the drafts go" and to send them my work despite its imperfections. While this caused my inner perfectionist to panic, it was one of the best pieces of advice I received as it allowed me the freedom to write and make mistakes.

As I approach submission, I am now able to occupy the position of both knowing that the piece of work I have produced is not perfect and feeling immensely proud of all I have achieved. The research skills I have learnt during this research project have enabled me to trade in my canoe for a well-equipped boat fit to navigate the increasingly familiar waters of qualitative research and reel in the biggest fish of all: my portfolio thesis.

References

National Audit Office (NAO). (2023). *Progress in improving mental health services in England.* Department of Health & Social Care. https://www.nao.org.uk/wp-content/uploads/2023/02/Progress-in-improving-mental-health-services-CS.pdf

Zimmerman, T. (2022, November 11). *Understanding the AIP Model: The Boat Metaphor and the Mount Everest Metaphor* [Video]. YouTube. https://www.youtube.com/watch?v=aJIBfTB0JTg

Appendix G: Semi-Structured Interview Schedule

1. Can you tell me about why you trained in the Flash Technique?
   Prompt: How did you find out about the Flash Technique?
   Additional question: How did you feel before/during/after the training? How did you feel about different elements of the training? When did you start using the Flash Technique in your clinical practice after training?

2. Can you tell me about a clinical example of when you've used the Flash Technique with a client?
   Prompts: Why did you decide to use it? What went well? What didn't go so well? How did you feel? How do you think your client felt? When/under what circumstances would you typically use the Flash Technique?
   Additional question: How do you feel when the Flash Technique goes well/not so well?

3. What do you think the challenges/facilitators are to using the Flash Technique with clients?
   Prompt: do you use the Flash Technique as a standalone technique? Or as part of a longer therapy process? How do you feel the Flash Technique fits within the context in which you work i.e. NHS, private practice or other?
   Amended wording: what do you think the barriers/key ingredients are to using the Flash Technique?
   Removed question: How do you feel the Flash Technique fits within the context in which you work i.e. NHS, private practice or other?

4. How does the Flash Technique compare with other trauma-focused therapies you might use with a client?
   Amended wording: How does the Flash Technique compare/integrate/complement with other trauma-focused approaches you might use with a client?
   Additional question: How do you feel in Flash Technique sessions compared to other trauma-focused therapy session?

5. Is the Flash Technique something you will continue to use with clients?
   Prompt: Would you recommend using the Flash Technique to other therapists?
   Additional question: What has it been like to reflect on your experiences?

Note: Items in black font were included in original interview schedule; items in red font are alterations made to the interview schedule after completing 5 interviews.

Appendix H: Sources of Support Sheet

UNIVERSITY OF HULL

Version number and date: 1.2 – 19/03/22 [IRAS ID: 313329]

Thank you for taking part in this study

Sources of Support

At Work

Have a chat with your **Line Manager/Supervisor** as they can listen and help you to access appropriate support from within your service.

External Support

Speak to you **GP** who can advise and help you to manage physical and psychological health concerns. They can also signpost to other services including community groups and psychological therapy.

Improving Access to Psychological Therapies (IAPT) provide psychological support to individuals with common mental health difficulties. IAPT run a service in Hull called **Let's Talk**. This can be accessed through an online self-referral: hhttps://www.letstalkhull.co.uk or by telephone on: 01482 247 111. Alternatively, IAPT run a service in East Riding called the **East Riding Emotional Wellbeing Service**, they can be contacted by telephone on: 01482 335 451 or by email on: HNF-TR. SelfReferral@nhs.net. Alternatively, you can find your **nearest IAPT service** at https://www.nhs.uk/service-search/mental-health/find-a-psychological-therapies-service.

Additional Contacts

If you still have concerns which have been raised by taking part in this study, you may contact the researcher at: A.Townshend-2020@hull.ac.ukor by telephone on: However, please not they are unable to provide psychological advice or support and can only have a conversation about the impact of the research and signpost to other services.

UNIVERSITY OF HULL

NHS
Humber Teaching
NHS Foundation Trust

Version number and date: v1.2 29/03/22 [IRAS ID: 313329]

Thank you for taking part in this study

Sources of Support

At Work

Have a chat with your **Line Manager/Supervisor** as they can listen and help you to access appropriate support from within the service

The Chaplaincy Department provide the **Pastoral Care Service for Staff** which can be accessed 24 hours per day by email on: hnf-tr.patientandcarerexperience@nhs.net and by telephone on: 01482 389 167

Occupational Health services offer information and support to promote and maintain the physical and psychological health and wellbeing of employees in the workplace. Occupational health can be contacted by telephone on: 01482 389 333

Staff can access support from **Focus Counselling Service** via Occupational Health by telephone on: 01482 891 564.

External Support

Speak to you **GP** who can advise and help you to manage physical and psychological health concerns. They can also signpost to other services including community groups and psychological therapy.

Improving Access to Psychological Therapies (IAPT) provide psychological support to individuals with common mental health difficulties. IAPT run a service in Hull called **Let's Talk**. This can be accessed through an online self-referral: hhtps://www.letstalkhull.co.uk or by telephone on: 01482 247 111. Alternatively, IAPT run a service in East Riding called the **East Riding Emotional Wellbeing Service**, they can be contacted by telephone on: 01482 335 451 or by email on: HNF-TR. SelfReferral@nhs.net

Additional Contacts

If you still have concerns which have been raised by taking part in this study, you may contact the researcher at: A.Townshend-2020@hull.ac.uk. However, please not they are unable to provide psychological advice or support and can only have a conversation about the impact of the research and signpost to other services.

UNIVERSITY OF HULL

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Version number and date: v1.2 – 05/04/22 [IRAS ID: 313329]

Thank you for taking part in this study

Sources of Support

At Work

Have a chat with your **Line Manager/Supervisor** as they can listen and help you to access appropriate support from within the service

Occupational Health services offer information and support to promote and maintain the physical and psychological health and wellbeing of employees in the workplace. Occupational health can be contacted by email on: blackburn.clinic@people-am.com or telephone on: 01254 311300

Staff can access support from **The TEWV Employee Support Service** by **Positive Practice** by email on: tewv.employeesupportservice@nhs.net

External Support

Speak to you **GP** who can advise and help you to manage physical and psychological health concerns. They can also signpost to other services including community groups and psychological therapy.

Improving Access to Psychological Therapies (IAPT) provide psychological support to individuals with common mental health difficulties. IAPT run a service called **North Yorkshire IAPT** in Northallerton. This can be accessed through an online self-referral: https://northyorkshireiapt.co.uk/quick-contact/ or by telephone on: 01609 768 890. Alternatively, IAPT run a service in Durham and Darlington called **Talking Changes**, which can be accessed through an online self-referral: https://gateway.mayden.co.uk/referral-v2/c53195d6-f6db-4e81-bda3-63dcc7b81449. IAPT also run a service in **York and Selby IAPT** which can be accessed via an online self-referral form: https://yorkandselbyiapt.co.uk/online-referral-form/# or by telephone on: 01904 556 840.

Additional Contacts

If you still have concerns which have been raised by taking part in this study, you may contact the researcher at: A.Townshend-2020@hull.ac.uk. However, please not they are unable to provide psychological advice or support and can only have a conversation about the impact of the research and signpost to other services.

Appendix I: Ethical Approvals Granted by the University of Hull

Page removed for digital archiving.

Appendix J: Approvals Granted by the Health Research Authority

Page removed for digital archiving.

Page removed for digital archiving.

Page removed for digital archiving.

Page removed for digital archiving.

Page removed for digital archiving.

Appendix K: Study Information Sheet

UNIVERSITY OF HULL

Version number and date: v1.7 11/08/22 [IRAS ID: 313329]

INFORMATION SHEET FOR PARTICIPANTS

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of the study: An Exploration of Therapist Experiences of the Flash Technique for Individuals Experiencing Traumatic Stress

I would like to invite you to participate in a research project which forms part of my Clinical Psychology doctorate thesis research. The study is exploring therapists' experience of using the flash technique with individuals who are experiencing traumatic stress. The University of Hull is the sponsor for this research study.

Before you decide whether you would like to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish before making your decision as to whether you would like to be involved. Please ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

As the flash technique was only developed in the last five years, research around the flash technique is limited and much of the published research has been conducted by the original authors. This study will be conducted independent of the original authors and aims to strengthen the existing evidence base and generate momentum for the flash technique to become more widely accessible to clients who are unable to engage with other trauma-focused therapies.

The literature at present has focused on the effectiveness of the flash technique but experiences of the flash technique have not been explored despite the possibility of gathering rich qualitative data which could be used to inform clinical practice. The potential clinical implications of exploring therapist experiences using the flash technique include the fact that the flash technique procedure has been revised and updated since the original publication. As such, this study aims to identify themes in the experiences of therapists who have used the flash technique with clients to process traumatic memories. It is hoped that this study will inform clinical practice and future research into the flash technique.

Why have I been invited to take part?

You are being invited to participate in this study because you have attended EMDR and flash technique training. Eligible participants must be over 18 and a proficient English speaker. To take part in the study, you also need to have used or currently use the flash technique with adults to process trauma memories.

What will happen if I take part?

If you choose to take part in the study you will be asked to send me your contact details to the email address below. Then I will send a consent form and arrange a meeting at a convenient place and time. A Microsoft Teams meeting may be used if it is not convenient to meet in person. Face-to-face interviews will be conducted following government and local NHS COVID-19 safety guidelines at the time of the interview. If the decision is made to conduct the interview virtually, it is important that you have access to an electronic device, preferably a laptop or computer, so that you can use Microsoft Teams in a private space to ensure confidentiality. On the day of the interview, you will have the opportunity to ask any questions you may have. If we decide to meet remotely, you will be asked to return the consent form via email by the agreed interview time. On the day of the interview, we will read and discuss each item of the consent form to check understanding prior to the commencement of the interview.

The interviews will be audio-recorded with your consent. Interviews will be relaxed. They will last as long as you want them to but typically between 30-60 minutes with around 10 minutes before and after for introductions and endings. A maximum of 90 minutes will be required of you on the day of the interview. You will not be expected to stay any longer than the agreed time on the day. Discussions will involve talking about your experiences using the flash technique with clients to process traumatic memories. There are no right or wrong answers and the research is only interested in your opinions, your beliefs and your experiences of using the flash technique. Within the interview please remember to not disclose any names or identifiable information of the clients you work with. If you feel that the topic causes any distress, breaks can be taken at any time and the interview can also be ended at your request.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact me if you have any questions that will help you to make a decision about taking part. If you decide to take part, we will read through each item of the consent form and then I will ask you to sign the consent form. You will be given a copy of this consent form to keep.

What are the possible risks of taking part?

In total, participating in the study will require a minimum of 60 minutes and a maximum of 90 minutes of your time and although the researcher will endeavour to meet at a mutually convenient time and place, this may be inconvenient for you. Some people may find talking about work brings up difficult emotions but it can also be beneficial to reflect on experience. If this happens to you the researcher will offer the option to continue discussions around the topic or to terminate the interview. You will also be provided with a document signposting you to services where you will be able to receive further support if needed e.g. your supervisor or mental health charities.

What are the possible benefits of taking part?

We cannot promise that you will have any direct benefits from taking part in the study. However, sometimes people can find it useful to have the opportunity to reflect and talk about their experiences. We hope that the information that you give us will help us to gain a better understanding of therapist experiences of using the flash technique with individuals experiencing traumatic stress. As a result, this may help to inform the development of the use of the flash technique.

Data handling and confidentiality

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR).

We will need to use information from you for this research project. This information will include your name and contact details. People will use this information to do the research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study. Direct quotes from the discussion may be used in research publications and presentations but you will not be identified in these.

To protect the security of the audio recording, interviews will be recorded directly onto an encrypted laptop and saved to the University of Hull secure network drive. After the research is completed, all of the audio recordings will be destroyed. Anonymised transcripts of the recordings will be stored securely in an online storage repository at the University of Hull for a period of ten years. The only time that information cannot be kept confidential is if you disclose something that suggests that you or someone else is at risk of serious harm. If this happens during the interview the researcher will need to contact the appropriate authorities to ensure that you and other people are safe. It is unlikely that this will happen, and the researcher will try to discuss this with you.

You can stop being part of the study at any time, without giving a reason. You are able to withdraw your data from the study up until data analysis has commences, after which withdrawal of your data will no longer be possible as the data will have been anonymised and/or committed to the final report. If you choose to withdraw from the study before this point the data collected will be destroyed. Information collected from this study will be used for this study only and will not be used for any other purpose.

Data Protection Statement

The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under GDPR is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you. Information about how the University of Hull processes your data can be

found at https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/data-protection.aspx

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the University of Hull Data Protection Officer [dataprotection@hull.ac.uk]. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

How will we use information about you?

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

- Your name
- Your contact details

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

What are your choices about how your information is used?

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

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

You can find out more about how we use your information:

- At www.hra.nhs.uk/information-about-patients/
- Our leaflet available from www.hra.nhs.uk/patientdataandresearch
- By asking one of the research team
- By sending an email to researchgovernance@hull.ac.uk, or
- By ringing us on 01482 466308.

What if I change my mind about taking part?

You are free to withdraw at any point of the study before the data has been analysed without having to give reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up until two weeks following the interview, after which withdrawal of data

will not longer be possible as the interview data will be anonymised for data analysis. If you choose to withdraw from the study before this point we will not retain the information you have given thus far.

What will happen to the results of the study?

The results of the study will be summarised in a written thesis as part of a Doctorate in Clinical Psychology. The thesis will be freely available to access on the University of Hull's online repository https://hydra.hull.ac.uk. Once the final report has been completed, feedback will be shared with all participants who have requested it. It is hoped that feedback will be provided within twelve months of your involvement in this research. Participant information and any other details of individuals mentioned in the interview will be anonymised. Feedback will involve a summary of the main findings alongside some anonymised, verbatim quotes. The research may also be published in academic journals or presented at conferences. Participants will not be identifiable in the final study reports or in any conference presentations.

Who has reviewed this study?

Research studies are reviewed by an independent group of people, called a Research Ethics Committee, who protect the interests of people who participate in research. This study has been reviewed and has been given a favourable opinion by the Faculty of Health Sciences Ethics Committee at the University of Hull. The project has also received the required Health Research Authority (HRA) approval for NHS staff research.

What should I do next?

If you are still interested in taking part in the research, please contact me using the details below. You can also contact me if you have any further questions that you would like to be answered before registering interest in the study. If we agree an interview time, we will then meet. We will discuss informed consent and you will have the opportunity to ask any questions before we then begin the interview.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following details:

Annie Townshend
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Email address: A.Townshend-2020@hull.ac.uk

What if I have further questions, or if something goes wrong?

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the details below for further advice and information:

Dr Jo Beckett
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Telephone: 01482 463568
Email address: Jo.Beckett@hull.ac.uk

Alternatively please contact coo@hull.ac.uk

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

UNIVERSITY OF HULL

NHS
Humber Teaching
NHS Foundation Trust

Version number and date: v1.7 11/08/22 [IRAS ID: 313329]

INFORMATION SHEET FOR PARTICIPANTS

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of the study: An Exploration of Therapist Experiences of the Flash Technique for Individuals Experiencing Traumatic Stress

I would like to invite you to participate in a research project which forms part of my Clinical Psychology doctorate thesis research. The study is exploring therapists' experience of using the flash technique with individuals who are experiencing traumatic stress. The University of Hull is the sponsor for this research study.

Before you decide whether you would like to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish before making your decision as to whether you would like to be involved. Please ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

As the flash technique was only developed in the last five years, research around the flash technique is limited and much of the published research has been conducted by the original authors. This study will be conducted independent of the original authors and aims to strengthen the existing evidence base and generate momentum for the flash technique to become more widely accessible to clients who are unable to engage with other trauma-focused therapies.

The literature at present has focused on the effectiveness of the flash technique but experiences of the flash technique have not been explored despite the possibility of gathering rich qualitative data which could be used to inform clinical practice. The potential clinical implications of exploring therapist experiences using the flash technique include the fact that the flash technique procedure has been revised and updated since the original publication. As such, this study aims to identify themes in the experiences of therapists who have used the flash technique with clients to process traumatic memories. It is hoped that this study will inform clinical practice and future research into the flash technique.

Why have I been invited to take part?

You are being invited to participate in this study because you have attended EMDR and flash technique training. Eligible participants must be over 18 and a proficient English speaker. To take part in the study, you also need to have used or currently use the flash technique with adults to process trauma memories.

What will happen if I take part?

If you choose to take part in the study you will be asked to send me your contact details to the email address below. Then I will send a consent form and arrange a meeting at a convenient place and time. A Microsoft Teams meeting may be used if it is not convenient to meet in person. Face-to-face interviews will be conducted following government and local NHS COVID-19 safety guidelines at the time of the interview. If the decision is made to conduct the interview virtually, it is important that you have access to an electronic device, preferably a laptop or computer, so that you can use Microsoft Teams in a private space to ensure confidentiality. On the day of the interview, you will have the opportunity to ask any questions you may have. If we decide to meet remotely, you will be asked to return the consent form via email by the agreed interview time. On the day of the interview, we will read and discuss each item of the consent form to check understanding prior to the commencement of the interview.

The interviews will be audio-recorded with your consent. Interviews will be relaxed. They will last as long as you want them to but typically between 30-60 minutes with around 10 minutes before and after for introductions and endings. A maximum of 90 minutes will be required of you on the day of the interview. You will not be expected to stay any longer than the agreed time on the day. Discussions will involve talking about your experiences using the flash technique with clients to process traumatic memories. There are no right or wrong answers and the research is only interested in your opinions, your beliefs and your experiences of using the flash technique. Within the interview please remember to not disclose any names or identifiable information of the clients you work with. If you feel that the topic causes any distress, breaks can be taken at any time and the interview can also be ended at your request.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact me if you have any questions that will help you to make a decision about taking part. If you decide to take part, we will read through each item of the consent form and then I will ask you to sign the consent form. You will be given a copy of this consent form to keep.

What are the possible risks of taking part?

In total, participating in the study will require a minimum of 60 minutes and a maximum of 90 minutes of your time and although the researcher will endeavour to meet at a mutually convenient time and place, this may be inconvenient for you. Some people may find talking about work brings up difficult emotions but it can also be beneficial to reflect on experience. If this happens to you the researcher will offer the option to continue discussions around the topic or to terminate the interview. You will also be provided with a document signposting you to services where you will be able to receive further support if needed e.g. your occupational health department, your supervisor or mental health charities.

What are the possible benefits of taking part?

We cannot promise that you will have any direct benefits from taking part in the study. However, sometimes people can find it useful to have the opportunity to reflect and talk about their experiences. We hope that the information that you give us will help us to gain a better understanding of therapist experiences of using the flash technique with individuals experiencing traumatic stress. As a result, this may help to inform the development of the use of the flash technique within NHS services.

Data handling and confidentiality

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR).

We will need to use information from you for this research project. This information will include your name and contact details. People will use this information to do the research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study. Direct quotes from the discussion may be used in research publications and presentations but you will not be identified in these.

To protect the security of the audio recording, interviews will be recorded directly onto an encrypted laptop and saved to the University of Hull secure network drive. After the research is completed, all of the audio recordings will be destroyed. Anonymised transcripts of the recordings will be stored securely in an online storage repository at the University of Hull for a period of ten years. The only time that information cannot be kept confidential is if you disclose something that suggests that you or someone else is at risk of serious harm. If this happens during the interview the researcher will need to contact the appropriate authorities to ensure that you and other people are safe. It is unlikely that this will happen, and the researcher will try to discuss this with you.

You can stop being part of the study at any time, without giving a reason. You are able to withdraw your data from the study up until data analysis has commences, after which withdrawal of your data will no longer be possible as the data will have been anonymised and/or committed to the final report. If you choose to withdraw from the study before this point the data collected will be destroyed. Information collected from this study will be used for this study only and will not be used for any other purpose.

Data Protection Statement

The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under GDPR is a 'task in the public interest' You can provide

your consent for the use of your personal data in this study by completing the consent form that has been provided to you. Information about how the University of Hull processes your data can be found at https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/data-protection.aspx

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the University of Hull Data Protection Officer [dataprotection@hull.ac.uk]. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

How will we use information about you?

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

- Your name
- Your contact details

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

What are your choices about how your information is used?

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

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

You can find out more about how we use your information:

- At www.hra.nhs.uk/information-about-patients/
- Our leaflet available from www.hra.nhs.uk/patientdataandresearch
- By asking one of the research team
- By sending an email to researchgovernance@hull.ac.uk, or
- By ringing us on 01482 466308.

What if I change my mind about taking part?

You are free to withdraw at any point of the study before the data has been analysed without having to give reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up until two weeks following the interview, after which withdrawal of data will not longer be possible as the interview data will be anonymised for data analysis. If you choose to withdraw from the study before this point we will not retain the information you have given thus far.

What will happen to the results of the study?

The results of the study will be summarised in a written thesis as part of a Doctorate in Clinical Psychology. The thesis will be freely available to access on the University of Hull's online repository https://hydra.hull.ac.uk. Once the final report has been completed, feedback will be shared with all participants who have requested it. It is hoped that feedback will be provided within twelve months of your involvement in this research. Feedback will also be provided to relevant contacts at each research site and with the associated NHS Trusts. However, the Trust will not be informed about which staff have taken part in the research. Participant information and any other details of individuals mentioned in the interview will be anonymised. Feedback will involve a summary of the main findings alongside some anonymised, verbatim quotes. The research may also be published in academic journals or presented at conferences. Participants will not be identifiable in the final study reports or in any conference presentations.

Who has reviewed this study?

Research studies are reviewed by an independent group of people, called a Research Ethics Committee, who protect the interests of people who participate in research. This study has been reviewed and has been given a favourable opinion by the Faculty of Health Sciences Ethics Committee at the University of Hull. The project has also received the required Health Research Authority (HRA) approval for NHS staff research.

What should I do next?

If you are still interested in taking part in the research, please contact me using the details below. You can also contact me if you have any further questions that you would like to be answered before registering interest in the study. If we agree an interview time, we will then meet. We will discuss informed consent and you will have the opportunity to ask any questions before we then begin the interview.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following details:

Annie Townshend
Clinical Psychology

Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7 RX
Email address: A.Townshend-2020@hull.ac.uk

What if I have further questions, or if something goes wrong?

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the details below for further advice and information:

Dr Jo Beckett
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Telephone: 01482 463568
Email address: Jo.Beckett@hull.ac.uk

Alternatively please contact coo@hull.ac.uk

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

UNIVERSITY OF HULL

Tees, Esk and Wear Valleys NHS Foundation Trust

Version number and date: v1.7 11/08/22 [IRAS ID: 313329]

INFORMATION SHEET FOR PARTICIPANTS

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of the study: An Exploration of Therapist Experiences of the Flash Technique for Individuals Experiencing Traumatic Stress

I would like to invite you to participate in a research project which forms part of my Clinical Psychology doctorate thesis research. The study is exploring therapists' experience of using the flash technique with individuals who are experiencing traumatic stress. The University of Hull is the sponsor for this research study.

Before you decide whether you would like to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish before making your decision as to whether you would like to be involved. Please ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

As the flash technique was only developed in the last five years, research around the flash technique is limited and much of the published research has been conducted by the original authors. This study will be conducted independent of the original authors and aims to strengthen the existing evidence base and generate momentum for the flash technique to become more widely accessible to clients who are unable to engage with other trauma-focused therapies.

The literature at present has focused on the effectiveness of the flash technique but experiences of the flash technique have not been explored despite the possibility of gathering rich qualitative data which could be used to inform clinical practice. The potential clinical implications of exploring therapist experiences using the flash technique include the fact that the flash technique procedure has been revised and updated since the original publication. As such, this study aims to identify themes in the experiences of therapists who have used the flash technique with clients to process traumatic memories. It is hoped that this study will inform clinical practice and future research into the flash technique.

Why have I been invited to take part?

You are being invited to participate in this study because you have attended EMDR and flash technique training. Eligible participants must be over 18 and a proficient English speaker. To take part in the study, you also need to have used or currently use the flash technique with adults to process trauma memories.

What will happen if I take part?

If you choose to take part in the study you will be asked to send me your contact details to the email address below. Then I will send a consent form and arrange a meeting at a convenient place and time. A Microsoft Teams meeting may be used if it is not convenient to meet in person. Face-to-face interviews will be conducted following government and local NHS COVID-19 safety guidelines at the time of the interview. If the decision is made to conduct the interview virtually, it is important that you have access to an electronic device, preferably a laptop or computer, so that you can use Microsoft Teams in a private space to ensure confidentiality. On the day of the interview, you will have the opportunity to ask any questions you may have. If we decide to meet remotely, you will be asked to return the consent form via email by the agreed interview time. On the day of the interview, we will read and discuss each item of the consent form to check understanding prior to the commencement of the interview.

The interviews will be audio-recorded with your consent. Interviews will be relaxed. They will last as long as you want them to but typically between 30-60 minutes with around 10 minutes before and after for introductions and endings. A maximum of 90 minutes will be required of you on the day of the interview. You will not be expected to stay any longer than the agreed time on the day. Discussions will involve talking about your experiences using the flash technique with clients to process traumatic memories. There are no right or wrong answers and the research is only interested in your opinions, your beliefs and your experiences of using the flash technique. Within the interview please remember to not disclose any names or identifiable information of the clients you work with. If you feel that the topic causes any distress, breaks can be taken at any time and the interview can also be ended at your request.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact me if you have any questions that will help you to make a decision about taking part. If you decide to take part, we will read through each item of the consent form and then I will ask you to sign the consent form. You will be given a copy of this consent form to keep.

What are the possible risks of taking part?

In total, participating in the study will require a minimum of 60 minutes and a maximum of 90 minutes of your time and although the researcher will endeavour to meet at a mutually convenient time and place, this may be inconvenient for you. Some people may find talking about work brings up difficult emotions but it can also be beneficial to reflect on experience. If this happens to you the researcher will offer the option to continue discussions around the topic or to terminate the interview. You will also be provided with a document signposting you to services where you will be able to receive further support if needed e.g. your occupational health department, your supervisor or mental health charities.

What are the possible benefits of taking part?

We cannot promise that you will have any direct benefits from taking part in the study. However, sometimes people can find it useful to have the opportunity to reflect and talk about their experiences. We hope that the information that you give us will help us to gain a better understanding of therapist experiences of using the flash technique with individuals experiencing traumatic stress. As a result, this may help to inform the development of the use of the flash technique within NHS services.

Data handling and confidentiality

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR).

We will need to use information from you for this research project. This information will include your name and contact details. People will use this information to do the research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study. Direct quotes from the discussion may be used in research publications and presentations but you will not be identified in these.

To protect the security of the audio recording, interviews will be recorded directly onto an encrypted laptop and saved to the University of Hull secure network drive. After the research is completed, all of the audio recordings will be destroyed. Anonymised transcripts of the recordings will be stored securely in an online storage repository at the University of Hull for a period of ten years. The only time that information cannot be kept confidential is if you disclose something that suggests that you or someone else is at risk of serious harm. If this happens during the interview the researcher will need to contact the appropriate authorities to ensure that you and other people are safe. It is unlikely that this will happen, and the researcher will try to discuss this with you.

You can stop being part of the study at any time, without giving a reason. You are able to withdraw your data from the study up until data analysis has commences, after which withdrawal of your data will no longer be possible as the data will have been anonymised and/or committed to the final report. If you choose to withdraw from the study before this point the data collected will be destroyed. Information collected from this study will be used for this study only and will not be used for any other purpose.

Data Protection Statement

The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under GDPR is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you. Information about how the University of Hull processes your data can be

found at https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/data-protection.aspx

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the University of Hull Data Protection Officer [dataprotection@hull.ac.uk]. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

How will we use information about you?

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

- Your name
- Your contact details

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

What are your choices about how your information is used?

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

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

You can find out more about how we use your information:

- At www.hra.nhs.uk/information-about-patients/
- Our leaflet available from www.hra.nhs.uk/patientdataandresearch
- By asking one of the research team
- By sending an email to researchgovernance@hull.ac.uk, or
- By ringing us on 01482 466308.

What if I change my mind about taking part?

You are free to withdraw at any point of the study before the data has been analysed without having to give reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up until two weeks following the interview, after which withdrawal of data

will not longer be possible as the interview data will be anonymised for data analysis. If you choose to withdraw from the study before this point we will not retain the information you have given thus far.

What will happen to the results of the study?

The results of the study will be summarised in a written thesis as part of a Doctorate in Clinical Psychology. The thesis will be freely available to access on the University of Hull's online repository https://hydra.hull.ac.uk. Once the final report has been completed, feedback will be shared with all participants who have requested it. It is hoped that feedback will be provided within twelve months of your involvement in this research. Feedback will also be provided to relevant contacts at each research site and with the associated NHS Trusts. However, the Trust will not be informed about which staff have taken part in the research. Participant information and any other details of individuals mentioned in the interview will be anonymised. Feedback will involve a summary of the main findings alongside some anonymised, verbatim quotes. The research may also be published in academic journals or presented at conferences. Participants will not be identifiable in the final study reports or in any conference presentations.

Who has reviewed this study?

Research studies are reviewed by an independent group of people, called a Research Ethics Committee, who protect the interests of people who participate in research. This study has been reviewed and has been given a favourable opinion by the Faculty of Health Sciences Ethics Committee at the University of Hull. The project has also received the required Health Research Authority (HRA) approval for NHS staff research.

What should I do next?

If you are still interested in taking part in the research, please contact me using the details below. You can also contact me if you have any further questions that you would like to be answered before registering interest in the study. If we agree an interview time, we will then meet. We will discuss informed consent and you will have the opportunity to ask any questions before we then begin the interview.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following details:

Annie Townshend
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road

Hull
HU6 7RX
Email address: A.Townshend-2020@hull.ac.uk

What if I have further questions, or if something goes wrong?

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the details below for further advice and information:

Dr Jo Beckett
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Telephone: 01482 463568
Email address: Jo.Beckett@hull.ac.uk

Alternatively please contact coo@hull.ac.uk

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

Appendix L: Participant Consent Form

UNIVERSITY OF HULL

[INSERT HOSPITAL BADGE]

Version number and date: v1.4 11/08/22 [IRAS ID: 313329]

Consent Form

Title of the study: An Exploration of Therapist Experiences of the Flash Technique for Individuals Experiencing Traumatic Stress

Name of Researcher: Annie Townshend

Please write your initials in the box next to each statement to fully consent to taking part in the study:

1. I confirm that I have read the information sheet dated 11/08/22 v1.7 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw until data analysis begins in two weeks time without giving any reason. I understand that once the researcher has started analysing the data, I cannot withdraw my anonymised data. I understand that the data I have provided up to the point of withdrawal will be retained. I understand that if my data is withdrawn before analysis this means all data about me (personal information and research data) will be destroyed, as the information will not be used. ☐

3. I understand that the research interview will be audio recorded and that my anonymised quotes may be used in research reports and conference presentations. ☐

4. I give permission for the collection and use of my data to answer the research question in this study. ☐

5. I agree to take part in the above study

Participant name:	Participant signature:	Date:
_____	_____	_____
Researcher name:	Researcher signature:	Date:
_____	_____	_____

Optional:

6. I give permission for my contact details to be stored so that the researcher may contact me with the study findings upon completion of the study. ☐

Appendix M: Braun and Clarke's (2021) Tool for Evaluating Thematic Analysis

Table 1. A tool for evaluating thematic analysis (TA) manuscripts for publication: Twenty questions to guide assessment of TA research quality.

These questions are designed to be used either independently, or alongside our methodological writing on TA, and especially the current paper, if further clarification is needed.

Adequate choice and explanation of methods and methodology

1. Do the authors explain why they are using TA, even if only briefly?
2. Do the authors clearly specify and justify which *type* of TA they are using?
3. Is the use and justification of the specific type of TA consistent with the research questions or aims?
4. Is there a good 'fit' between the theoretical and conceptual underpinnings of the research and the specific type of TA (i.e. is there conceptual coherence)?
5. Is there a good 'fit' between the methods of data collection and the specific type of TA?
6. Is the specified type of TA consistently enacted throughout the paper?
7. Is there evidence of problematic assumptions about, and practices around, TA? These commonly include:
   - Treating TA as one, homogenous, entity, with one set of – widely agreed on – procedures.
   - Combining philosophically and procedurally incompatible approaches to TA without any acknowledgement or explanation.
   - Confusing summaries of data topics with thematic patterns of shared meaning, underpinned by a core concept.
   - Assuming grounded theory concepts and procedures (e.g. saturation, constant comparative analysis, line-by-line coding) apply to TA without any explanation or justification.
   - Assuming TA is essentialist or realist, or atheoretical.
   - Assuming TA is only a data reduction or descriptive approach and therefore must be supplemented with other methods and procedures to achieve other ends.
8. Are any supplementary procedures or methods justified, and necessary, or could the same results have been achieved simply by using TA more effectively?
9. Are the theoretical underpinnings of the use of TA clearly specified (e.g. ontological, epistemological assumptions, guiding theoretical framework(s)), even when using TA inductively (inductive TA does not equate to analysis in a theoretical vacuum)?
10. Do the researchers strive to 'own their perspectives' (even if only very briefly), their personal and social standpoint and positioning? (This is especially important when the researchers are engaged in social justice-oriented research and when representing the 'voices' of marginal and vulnerable groups, and groups to which the researcher does not belong.)
11. Are the analytic procedures used clearly outlined, and described in terms of what the authors actually did, rather than generic procedures?
12. Is there evidence of conceptual and procedural confusion? For example, reflexive TA (e.g. Braun and Clarke 2006) is the claimed approach but different procedures are outlined such as the use of a codebook or coding frame, multiple independent coders and consensus coding, inter-rater reliability measures, and/or themes are conceptualised as analytic inputs rather than outputs and therefore the analysis progresses from theme identification to coding (rather than coding to theme development).
13. Do the authors demonstrate full and coherent understanding of their claimed approach to TA?

A well-developed and justified analysis

14. Is it clear what and where the themes are in the report? Would the manuscript benefit from some kind of overview of the analysis: listing of themes, narrative overview, table of themes, thematic map?
15. Are the reported themes topic summaries, rather than 'fully realised themes' – patterns of shared meaning underpinned by a central organising concept?
    - If so, are topic summaries appropriate to the purpose of the research?
      - If the authors are using reflexive TA, is this modification in the conceptualisation of themes explained and justified?
    - Have the data collection questions been used as themes?
    - Would the manuscript benefit from further analysis being undertaken, with the reporting of fully realised themes?
    - Or, if the authors are claiming to use reflexive TA, would the manuscript benefit from claiming to use a different type of TA (e.g. coding reliability or codebook)?
16. Is non-thematic contextualising information presented as a theme? (e.g. the first 'theme' is a topic summary providing contextualising information, but the rest of the themes reported are fully realised themes). If so, would the manuscript benefit from this being presented as non-thematic contextualising information?
17. In applied research, do the reported themes have the potential to give rise to actionable outcomes?
18. Are there conceptual clashes and confusion in the paper? (e.g. claiming a social constructionist approach while also expressing concern for positivist notions of coding reliability, or claiming a constructionist approach while treating participants' language as a transparent reflection of their experiences and behaviours)
19. Is there evidence of weak or unconvincing analysis, such as:
    - Too many or two few themes?

(*Continued*)

Table 1. (Continued).

- Too many theme levels?
- Confusion between codes and themes?
- Mismatch between data extracts and analytic claims?
- Too few or too many data extracts?
- Overlap between themes?

20. Do authors make problematic statements about the lack of generalisability of their results, and or implicitly conceptualise generalisability as statistical probabilistic generalisability (see Smith 2017)?

Appendix N: Worked Example of Analysis

Transcript	Initial code generation	Initial theme generation
R: Thank you. I wonder, could you tell me a bit about your experience of the flash technique training?		
P: Yeah so I think probably I felt very sceptical, um it was kind of presented, (laughing) as so much is within EMDR, as kind of magical technique that makes everything you know acceptable to people. So you know I always go with a healthy dose of scepticism. But hopeful? Because you know you are looking for new ways to make therapy accessible to people and I do think the people I support with complex trauma have struggled to benefit from so many therapies and have quite harmful experiences of a lot of therapies, so you are always hopeful that	Therapists were sceptical about the efficacy of FT (pre-clinical experience). Therapists remember being told during training that FT will always be successful. FT makes therapists feel excited/hopeful for the future of trauma-focused therapy. FT gives therapists hope for clients. Therapists aim to maximise good and reduce harm which is why flash is appealing. FT is more accessible for clients (in distress) than other trauma-focused therapies.	Therapists felt sceptical/apprehensive about implementing FT Current trauma-therapies are inaccessible, FT offers a potential alternative Current trauma-therapies are inaccessible, FT offers a potential alternative

there is something that's going to be, you know, useful to people. P: Um I don't know if I can break it down specifically enough by section, I'm sorry it was quite a while back, it was definitely pre-COVID so there's been a lot since then. Um but yeah I think it was basically going through some very loose theory, but then more about how kind of the practical side of how to apply it. And then really for me the learning came in trying it with clients, taking it back to supervision, taking video recordings back to supervision. And also what clients reported from it? So that's when my scepticism got addressed because actually clients said it was massively helpful and they worked on memories they were certain they wouldn't have been able to tolerate. So that for me is kind of proof in the pudding stuff.	FT is a more acceptable trauma-focused technique to clients than other trauma-focused therapies. Making sense of FT as you go along Implementing FT into clinical practice is when most significant learning occurs Using supervision to troubleshoot issues within flash is important Clients reporting FT as helpful helped to therapists' own scepticism/apprehensions FT is effective at reducing clients' distress Success during FT means other, previously inaccessible material, is more available to be worked with. Clients report FT as helpful.	Therapists felt sceptical/apprehensive about implementing FT Therapists reported significant positive effects associated with FT