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Effectiveness of interviews based on narrative exposure therapy (NET) in  
community settings – a case study

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Project Proposal

**Effectiveness of interviews based on Narrative Exposure Therapy (NET) in  
community settings**

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**Background:**

Challenging events such as war, natural disasters or abuse can have lasting effects on people who have experienced them. The often chaotic, fragmented nature of memories from such events can make them difficult to overcome and be viewed objectively. Trauma-focused therapies have become standard treatment in this area and in recent years, one such intervention has emerged in the form of Narrative Exposure Therapy (NET).

NET is based on the concept of using narratives to aid people in understanding and processing challenging and potentially traumatic events which put into question their world view or their self-perception. Memories of such events are often fragmented and emotional. NET helps to put these memories into a coherent narrative of the event, and in context with a person's whole life story. This can be very helpful as trauma can be perpetuated by memory fragments of previous experiences characterized by high emotional arousal (Schauer, Neuner & Elbert, 2011). NET guides the participant to form a chronological account of their life experience in an autobiographic style. The narrative is recorded in written form and details high-arousal moments, such as physiological sensations, perceptions and highly emotive moments. The participant chooses what to include in their biography which they receive at the end of the intervention.

NET is a manualised intervention which is not limited to delivery by qualified psychologists. It has certain advantages, such as its suitability for implementation in low-income settings, over a small number of sessions which can still provide

considerable relief (Robjant & Fazel, 2010). The treatment has been recently used successfully with earthquake survivors in China (Zang, Hunt & Cox, 2013), and evidence points to its effectiveness in PTSD and trauma treatment in both child and adult refugees, victims of war and organised violence (e.g. Morina et. al, 2012; Schauer, Neuner & Elbert, 2011; Ruf et. al, 2010). Evidence has been emerging for its effectiveness in treating PTSD and trauma for individuals in higher-income communities (Colville, 2013; Milde, Nordling & Nordanger, 2012) who are not members of groups where collective trauma is prevalent (refugees, veterans). Improvement for trauma and PTSD symptoms has been evidenced as consistent and significant over a variety of trials across populations and countries, with NET sessions ranging in number from 3 to 12, and follow-up up to 12 months post-treatment. It then becomes an interest and a possibility to investigate whether NET can be beneficial in other pockets of the community where people are not necessarily part of a differentiated group like refugees or war veterans and have not been diagnosed with PTSD but have experienced trauma as a result of a personal rather than collective event. A way to contribute to this process would be to look at narrative interviews which use NET as a guiding tool, and to then determine their potential benefits in the community. This represents a lighter approach and does not involve formal therapy, but still capitalises on elements from NET – Lifeline session, interview structure, biography construction and repeated exposure to narrative.

### **Area of Investigation/Research Questions:**

NET will be used as a guideline to structure narrative interviews which will be used in this study. No formal therapy will be provided. The study will look at how NET-based narrative interviews are received in a community setting in the UK where the participants are not members of a specific group (e.g. veterans, refugees).

Questions posed:

- \*Will NET show a change in trauma symptoms?
- 
- \*Will NET show a change in anxiety and depression symptoms?

- \*Will NET prove a feasible and effective treatment for community-based, non-inpatient clients?

**Method:**

Nottingham Recovery Network, a support service for drug and alcohol abuse, has agreed to co-operate in the facilitation of this study. Keyworkers at the service will inform clients who are abstinent or in a stable condition about the study and provide them with participant information if it is requested. The researcher will be advised about the substance abuse behaviour of a client in order to decide whether participation in this study would be appropriate for them. Clients who wish to participate will meet with the researcher, be given the opportunity to ask questions. They will complete the IES-R and HADS questionnaires and will be asked about any relevant current or past diagnoses, as per exclusion criteria. If they do not fall within any of the exclusion criteria, they will be invited to continue their participation. Those for whom participation is not deemed appropriate will be debriefed and encouraged to make use of the counselling and support services offered on site at their centre or signposted to relevant services.

Participants will be briefed on the nature of trauma, NET and what the study will entail, and will be asked to sign a consent form. They will be informed that they can withdraw at any time and will not be linked to their data. Following completion of the questionnaires, they will take part in a Lifeline session and 2 sessions of narrative interviews. The first narrative interview will deal with an in-depth discussion of a traumatic event of the participant's choosing and will use approaches from NET to do this (focus on factual details, physical sensations, thoughts and emotions around the event, comparison of these aspects of the experience at the time of the event versus the time of the interview). A written narrative will be created over the course of the sessions in the style of a biography, which will be read and re-read by the participant who will have control over what information to add, remove or edit. In the end it will be signed off by the researcher and the participant, with the participant receiving a copy.

Participants will then attend a fourth session, where they will complete the HADS and IES-R questionnaires again and will receive the final version of their biography. Finally, they will participate in an interview designed to explore their experience and opinions of the narrative interviews, what they found helpful and unhelpful about the approach and any recommendations they may have.

## **Measures**

The Impact of Events Scale – Revised (IES-R), and the Hospital Anxiety and Depression Scale (HADS) will serve as a way to determine any potential effect that the interview process may have had which may not have been reflected in participants' verbal accounts. The IES-R is used to determine the impact of a challenging or traumatic event on an individual, and has been shown to have good reliability and validity (Beck et. Al, 2008). It is divided into subscales which measure intrusiveness, avoidance and hyperarousal symptoms in response to a distressing event and reminders about it. The HADS is widely used to assess anxiety and depression symptoms, and has also been shown to have good reliability and validity (Bjelland, Dahl, Haug & Neckelmann, 2002). It has one subscale to measure anxiety and one to measure depression.

A sample of 5-6 participants will be recruited for the study. Post-treatment assessment of trauma and PTSD symptoms will be carried out for both groups using the same questionnaires outlined above.

## **Participant exclusion criteria:**

- Age under 18
- New or recent diagnosis of anxiety or depression
- Any diagnosis of a psychotic disorder (e.g. schizophrenia, psychosis)
- Newly started or recently started use of medication prescribed to treat a psychotic disorder, anxiety or depression
- Any diagnosis of autism spectrum disorder (ASD), learning disability (LD) or personality disorder (PD).

- On-going heavy substance abuse

Regarding the criteria for age, if a participant is aged under 18, the KIDNET version of NET would be applicable which the researcher has not been trained in. Diagnoses which potentially affect the participant's ability to understand or engage with the process of the study (such as ASD, LD or PD) are exclusion criteria for this study because the researcher is not trained to work with such individuals and thus unable to make appropriate adjustments to the process to facilitate engagement. The medication exclusion criteria are present in order to minimise any confounding effects on the study outcome. Total abstinence from substances is not required, but heavy substance abuse is an exclusion criterion for similar reasons to disorders which impair communication. Key workers will advise the researcher on the presence and severity of substance abuse of potential participants.

### **Analysis**

The pre- and post-treatment questionnaire scores will be compared and any changes will be noted and discussed.

The participants' biographies formed over the course of the study will be used for thematic analysis following the guidelines in Braun and Clarke's 2006 paper on thematic analysis. Themes found in them will be compared between participants. Common themes and differing themes will both be presented with examples, and any links between themes will be discussed.

### **Discussion**

The study is small-scale and exploratory in nature but aims to add to a small group of community-based studies in high-income countries which look at the effectiveness of adapted NET and NET-based interviews for trauma and PTSD in individuals who do not

belong to a specific group (veterans, refugees). The project aims to help determine whether NET-based narrative interviews would be an effective option in these settings.

Word count: 1503

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# Ethics approval letter



UNITED KINGDOM · CHINA · MALAYSIA

**Investigators:** Polina Vasileva & Nigel Hunt

**Title of study:** Effectiveness of interviews based on narrative exposure therapy (NET) in a small community-based sample

**Duration of study:** Until September 2017

**Ethics reference number:** 1061

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A favourable opinion is given to the above named study on the understanding that the applicants conduct their research as described in the above numbered application, and adhere to all conditions under which the ethical approval has been granted and use only materials and documentation that have been approved. If any amendments to the study are required, an amendment should be submitted to the committee for approval.

A handwritten signature in black ink that reads 'David Daley'.

David Daley (Professor)

Co-Chair of DPAP Ethics Subcommittee

A handwritten signature in black ink that reads 'Amanda Griffiths'.

Amanda Griffiths (Professor)

Co-Chair of DPAP Ethics Subcommittee

## **Effectiveness of interviews based on narrative exposure therapy (NET) in community settings – a case study**

### **Abstract**

The researcher examined how narrative interviews which borrow narrative exposure therapy (NET) approaches were received in a drug and alcohol support service in the UK. A case study was conducted with a client from the service who attended a Lifeline session, two narrative interviews which used NET elements to construct a detailed narrative about her life story and a traumatic event she chose to discuss. The narrative was transcribed into a biography which was thematically analysed using guidelines from Braun and Clarke (2006). A separate interview explored the participant's experience, opinions and recommendations regarding the narrative interview approach. The IES-R and HADS were administered pre- and post-participation. No aggravation of hyperarousal and intrusiveness of traumatic memories and of anxiety and depression symptoms occurred. Avoidance symptoms were noticeably reduced. The end interview revealed a very favourable view of the narrative interview approach, with particular value placed on the lifeline session and a noticeable reduction of avoidance of reminders about the traumatic event. Self-reported drinking behaviour and desire to drink remained minor and unchanged. The study adds to a small evidence base of the use of NET-based approaches in higher-income settings and with individuals who are not part of a differentiated group where collective or complex trauma is prevalent (e.g. refugees, veterans).

Key words: narrative interview, trauma, case study, posttraumatic stress disorder, NET

## **Introduction**

Severely distressing events in a person's life have the potential to leave lasting negative effects in the form of psychological trauma and/or posttraumatic stress disorder (PTSD). Trauma is usually characterised by exposure (both direct or witnessed) to real or threatened serious injury, death or sexual violence, in a way that overwhelms a person's ability to cope, e.g. through causing panic or intense fear and failure to process emotions and cognitions around the event (Courtois, 2013). The resulting psychological damage is referred to as trauma. Some individuals with trauma may then go on to develop PTSD, which has had evolving definitions and diagnostic criteria that differ even now between diagnostic manuals (DSM-IV, DSM-V, ICD-10, ICD-11), but generally involves intrusiveness, avoidance and/or hyperarousal in relation to memories and reminders of the event (Stein et al, 2014). Intrusive reliving of the traumatic memories can persist for extended periods of time if untreated (Kevers, Rober, Derluyn & De Haene, 2016).

Trauma exposure and PTSD can also have significant negative physical effects on the body which have recently been observed at the cell and DNA level. Morath et al (2014) analysed the effect of psychological trauma on DNA strand breakage in an in-vivo study in individuals who had been exposed to trauma and ones who had not. While rates of single-strand repair were not affected in traumatised individuals, their base level of strand breakage was significantly higher than the control group. Trauma and PTSD are also known to be associated with various adverse effects on health, such as increased susceptibility to inflammatory and autoimmune disorders. Somershof et al (2009) looked for a direct causal link for this and studied T-cells in the blood - a key component of the immune system - in groups of individuals with PTSD, individuals who had been exposed to war and torture-related trauma but were not diagnosed with PTSD, and a control group. The findings showed

that the PTSD and trauma groups had significantly altered T-cell distributions and counts in several subsets of the cells, indicating a compromised immune response for those individuals which may explain the higher susceptibility of PTSD sufferers to disease. The effects remained significant after controlling for gender and smoking factors. The trauma-exposed (non-PTSD-diagnosed) group showed these effects to a lesser extent than the PTSD group, indicating a cumulative effect of trauma on compromised immune response. Bremner (1999) found an association between PTSD and short-term memory deficits in combat veterans and victims of severe childhood abuse, while a follow-up MRI study of the same groups also found decreased right hippocampal volume.

As the traumatic memory itself is crucial to activating the perceptions and behaviours which come to be characterised as a disorder, treatment which focuses on those memories becomes key. One option is the use of story-telling, or narrative, to access and explore these memories. The use of narratives has the advantage of a natural approach, as story-telling is universal and done regularly by most people. Tuval-Mashiach, Freedman, Bargai, Boker, Hadar and Shalev (2004) stressed the importance of narrative in integrating a traumatic experience into the broader story of one's life, and suggested that trauma-exposed individuals were more likely to develop PTSD if they were unable to construct a coherent story of their trauma. Trauma-focused therapies such as narrative exposure therapy (NET) use narrative to try to build a coherent account of the traumatic experience and to engage and change the neural fear-memory network that has been formed and which perpetuates trauma symptoms (Kevers, Rober, Derluyn & De Haene, 2016). NET in particular is a manualised intervention which borrows elements from testimony therapy and exposure therapy and works through habituation of experiencing the traumatic memories and through building a coherent account of the patient's entire life course. This includes other traumatic episodes and positive life events, helping to put the traumatic event in perspective and taking the initial painful,

emotional ‘edge’ off the experience (Schauer, Neuner & Elbert, 2011). NET aims to integrate the ‘cold’, factual memories of traumatic events with the ‘hot’, emotional ones which often involve physiological reactions as well – pounding heart, sense of numbness, shaking, nausea, etc. A link to the present is maintained by continuous comparisons of the patient’s sensations, emotions and cognitions ‘then’ (at the time of the event) vs ‘now’ (the time of narrating the event), which can help to avoid dissociative flashbacks while allowing constructive re-experiencing of the traumatic memories to achieve habituation. The narrative of the patient’s life is written in biographical form, is re-read throughout sessions with information being added, removed or edited according to the patient’s wishes, and at the end of treatment is signed off by both the therapist and patient, with the patient receiving the written biography. NET is recommended for trauma and PTSD sufferers who have been exposed to war, sexual violence, torture and organised violence, for children and especially for individuals with multiple and complex trauma (Schauer, Neuner & Elbert, 2011).

An advantage of NET is its flexibility of duration – it can be delivered effectively in anywhere between 3 and 12 or more sessions (Schauer, Neuner & Elbert, 2011). NET can also include the Lifeline model: a visual approach to exploring the participant’s life. String or something similar is often used to represent one’s life, and symbols like flowers or stars are used to denote positive events on the Lifeline, while stones or candles are used to mark negative events. Each memory or event is named and labelled with the date of the event or the participant’s age when it happened. The Lifeline is a useful approach included in NET in that it is straightforward, gives a clear visual representation of important moments in one’s life which can aid in putting a traumatic event in perspective, and can be useful for people who are illiterate. While proven beneficial, the Lifeline session is optional and NET has also been proven effective without it (Hijazi, 2012; Whalley, Robjant & Schauer, 2014).

Other advantages of NET are lower costs compared with other treatments due to it being able to be delivered by less highly qualified counsellors or by lay counsellors, and a comparatively low dropout rate. Dixon, Ales and Marques (2016), in their recent review of the effectiveness of PTSD treatments, noted the increase of paraprofessionals in the field, and also noted the ability of therapies like NET to significantly reduce PTSD and trauma symptoms even when delivered by unqualified members of the community. Neuner, Onyut, Ertl, Odenwald, Schauer and Elbert (2008) also found high rates of effectiveness for NET when delivered by lay counsellors with limited training in an RCT with 277 refugees. The trial featured a no-treatment control group, a flexible trauma counselling group and a NET treatment group. Post-treatment, 70% of the NET treatment group no longer met criteria for PTSD compared to 65% of the trauma counselling group and only 37% of the no-treatment group. Notably, there was a significant difference in dropout rates between the NET group (only 4% dropped out) and the trauma counselling group (21% dropped out).

### ***Further evidence for the effectiveness of narrative exposure therapy (NET)***

In the last 15 years a sizeable body of evidence for NET's effectiveness in PTSD and trauma treatment has been built through non-randomised studies, case studies, RCTs and systematic reviews, and is concentrated in populations of both adults and children in and from lower income countries like Iraq, Saudi Arabia, Syria, China and African countries (e.g., Nakeyar & Frewen, 2016; Pieloch, McCullough & Marks, 2016; Ruf, Schauer, Neuner, Catani, Schauer & Elbert, 2010; Hijazi, 2012; Zang, Hunt & Cox, 2013). Participants in these studies were adults and children suffering from PTSD and trauma as a result of war, torture or organised violence, and have included asylum seeker, refugee and veteran populations, and in the case of Zang, Hunt and Cox (2013) – survivors of a natural disaster.

Of particular interest is a study of 43 African refugees diagnosed with PTSD who were continuing to live in unsafe conditions (Neuner, Schauer, Klaschik, Karunakara & Elbert, 2004). They were divided into 3 groups who received 4 sessions of NET, 4 sessions of supportive counselling or 1 session of psychoeducation. One year post-treatment, 79% of the supportive counselling group and 80% of the psychoeducation group still fulfilled the criteria for PTSD versus only 29% of the NET group. Ruf et al (2010) also found a positive treatment outcome at the one year post-treatment follow-up of their group of 7 to 16-year-old refugee children who had received KIDNET, a version of NET adapted for children. This is worth considering, as NET is usually used as a short term treatment, and could potentially be used for those on waiting lists for other trauma-focused therapies. Waiting lists can often stretch for months, during which quality of life may be compromised.

It should be noted that NET has a more limited evidence base in community settings where a collective event like war, natural disaster or organised violence was not the cause of trauma or PTSD. This may be due to the fact that NET is mostly used in low-income settings, outside English-speaking countries and is recommended for complex trauma. This was highlighted in a comparison of prolonged exposure (PE) therapy and NET (Morkved et. al, 2014) which looked at 32 PE studies and 15 NET studies. The authors noted that NET was a newer and lesser-known treatment than PE, with fewer studies being found in literature searches. Nevertheless, some pilot studies using NET in high-income communities have found positive outcomes consistent with the evidence presented previously. An example is a 2015 pilot study in Germany by Steuwe et al who delivered NET to 11 in-patients with comorbid PTSD, Borderline Personality Disorder (BPD) and self-harming behaviours. While the sample was small, dropout rate was low (1 patient). Self-harming behaviour frequency was low throughout and it was not aggravated. BPD and PTSD symptoms were significantly reduced post-treatment and remained so at 12 months post-treatment for the majority of

patients. Secondary outcome measures such as depression, dissociation and quality of life were significantly improved. Steuwe et al also remarked that the generally lower dropout rate found in literature for NET compared to other trauma treatments may be due to the nature of NET as a highly empathetic treatment which tends to stimulate high levels of commitment and places emphasis on appreciation and acknowledgement of patients' difficult life stories. Another study in Norway looked at NET's effectiveness for 17 male and female adult outpatients with PTSD (Milde, Nordling & Nordanger, 2012). Dropout rate was low (3 patients dropped out), and there was a significant reduction in all symptoms post-treatment. Improvement for all symptoms except depression remained at 6 months post-treatment. 7 out of 14 patients no longer fulfilled criteria for PTSD after treatment.

In community settings, evidence in support of NET as an effective PTSD treatment has also emerged for veterans and offenders (Hermenau, Crombach & Elbert, 2015), and from a series of case studies in the UK of 4 parents with PTSD caused by their children's hospitalisation in intensive care units (Colville, 2013 & 2017). In the 2013 Colville case study, the participant dropped to below clinical cut-off for PTSD after NET, and the improvement of symptoms remained at the 3- and 8-month post-treatment follow-up. In the 2017 case series, decreases in PTSD symptoms on the Posttraumatic Stress Diagnostic Scale (PDS) and anxiety and depression symptoms on the Hospital Anxiety and Depression Scale (HADS) were observed. The average of PDS scores pre-treatment was 21 (indicating moderate to severe PTSD), declined to 9 at 2 months post-treatment and declined further to 4 at 6 months post-treatment (both in the mild category). NET was associated with significant decrease in PTSD symptoms (Cohen's  $d_s = 1.01-2.37$ ). Average score for anxiety on the HADS was 14 pre-treatment (in the 'abnormal' category), declined to 8 (considered 'borderline') at 2 months post-treatment, and declined further to 5 (falling in the 'normal' category) at 6 months post treatment. Average scores for depression were in the 'normal

category pre-treatment and remained so throughout.

### ***Study aims***

NET is an effective evidence-based treatment, but where the evidence base needs expansion is in higher-income communities, such as in the UK, and in diverse samples where trauma is not severe, as opposed to a sample belonging to a specific group with severe and/or multiple or complex trauma and PTSD (e.g. veterans, refugees). This study aims to contribute to the evidence base by exploring whether NET can effectively serve to inform a short series of therapeutic interviews. The study explores the effectiveness of a shortened, more informal but still NET-based approach in a community setting in the UK through qualitative analysis. It capitalises on the Lifeline session, the use of repeated exposure through narrative, the construction of a biography and the therapeutic nature of narrative itself, but does not deliver formal therapy. Instead it uses NET elements in semi-structured narrative interviews. This constitutes a lighter approach more akin to story-telling, which is a natural part of most people's lives, whereas the idea of formal therapy can be intimidating to someone who has never discussed their trauma in detail. This approach was chosen to better match the intended community setting where the participant was not an in- or out-patient and PTSD was not diagnosed but there was some exposure to trauma.

### **Methodology**

#### ***Recruitment***

The participant in this case study was recruited through Nottingham Recovery Network, a

support service for drug and alcohol abuse, from a branch which provided various support for clients who had already undergone a course of treatment and had stabilised (were not NHS patients). The consultant psychiatrist at the service pointed out that clients often presented with psychological trauma in addition to their substance-abuse and that this made the service a suitable medium through which to recruit a participant. The management and key workers were provided with a project proposal and thorough information about the study. Following this, the service gave written permission for the study to be conducted on their premises and for recruitment of one of their clients. As per the University of Nottingham's requirements and Recovery Network's request, the researcher obtained an Enhanced DBS check for the duration of the study, as the client at the service belonged to a vulnerable group. Approval for the study was given by the University of Nottingham's Division of Psychiatry and Applied Psychology Ethics Committee.

The participant in this case study, a 49-year-old female, was recruited via her keyworker. The participant contacted the researcher, stating her desire to participate after being given information about the study by her keyworker.

### ***Participant Exclusion and Inclusion Criteria***

Exclusion criteria were: age under 18, new or recent diagnosis of anxiety, depression or personality disorder (PD), any psychotic disorder (e.g. schizophrenia, psychosis), autism spectrum disorder (ASD) or learning disability (LD); newly or recently started course of medication for treatment of any of the above; on-going heavy substance abuse. Inclusion criteria were: limited substance abuse or current abstinence from substances (was confirmed by the participant's keyworker).

The reason for the criterion of age was that participants aged under 18 would require the

KIDNET version of NET. The exclusion criteria were set to ensure the good quality of the study and attempt to minimise factors which could influence the process and outcome, such as recently started medication or newly developed disorders which may impact the participant's comprehension or ability to communicate. ASD, PD and LD were exclusion criteria, as the researcher was not trained to work with individuals with these disorders. Diagnoses of anxiety or depression which were not new or recent, or having taken medication in the past for the aforementioned, were not criteria for exclusion. Total abstinence from substances was not required; keyworkers at the service were able to advise whether a service-user was suitable to participate or not, as stable or occasional minor substance-abusive behaviour did not prevent service-users from meaningful and beneficial engagement with groups at the service. However, on-going heavy substance-abuse was considered an exclusion criterion because of potential negative impact on communication and engagement with the study.

### *Measures*

The Hospital Anxiety and Depression Scale (HADS) and the Impact of Events Scale – Revised (IES-R) were used to determine any potential impact of the interview process that may not have been reflected in the participant's verbal account. The IES-R is used to determine the impact of a specific event on an individual, and has been shown to have good reliability and validity (Beck et. al, 2008). It is a self-report tool and assesses the symptoms resulting from a distressing or traumatic event in three sub-scales – intrusiveness, avoidance and hyperarousal. An overall score of 33 and above is considered to be a good cutoff for a probable diagnosis of PTSD, however, this scale is not in itself a diagnostic tool. The HADS is widely used to assess symptoms of anxiety and depression, and has also been shown to have good reliability and validity (Bjelland, Dahl, Haug & Neckelmann, 2002). It considers

scores of 0-7 in either category as 'normal', 8-10 as 'borderline' and 11-21 as an 'abnormal' case.

The interviews were not recorded but were put into the form of a biography, using as much of the participant's own words and phrases as possible. The participant read the biography at the first, second and end interview in order to verify that their account was accurate. The biography was then thematically analysed.

### ***Procedure***

The participant met with the researcher and asked questions before proceeding with the study. During this informal meeting, she was given some psychoeducation on the nature of traumatic memories and psychological trauma. She was informed of what NET was and how the interviews based off it would be structured. She signed a consent form and was asked questions about current and previous diagnoses as per the exclusion criteria. She was suitable to continue participation, and expressed her desire to do so.

During the second meeting the participant completed the HADS and IES-R. This took a longer than scheduled, so the Lifeline session was postponed for the next meeting. The Lifeline session took 3 hours and constructed an overview of the participant's entire life course from birth and the very first conscious memories until the time of her participation. It outlined positive and negative events which were impactful and/or important to her. This was done visually using twine laid out on the floor to represent the participant's life course, with flowers used to mark positive events and stones marking negative events. One end of the twine was kept coiled to represent the part of the participant's life which was in the future. The participant put flowers and stones accordingly on the line and labelled each event. At the end of this process, time was allowed to reflect on the lifeline and discuss any observations

the participant had. A photograph was taken of the Lifeline which was attached to the biography. It can be found in Figure 1.



Figure 1 – the participant's Lifeline

The first narrative interview took place a few days later. The first version of the biography which was constructed from the lifeline session was read by the participant and notes for desired amendments were made. The interview took 2 hours and focused on building a coherent account of the traumatic event the participant chose to discuss, which was an instance of sexual abuse by her step-father when she was aged 13-14. This was done through use of NET components, such as focusing on factual details of the situation, trying to remember physical sensations, perceptions (sights, sounds, smells, physical reactions, etc.), thoughts and emotions during the event, as well as drawing comparisons with how the participant experienced all those aspects of the event in the moment of the interview. As much detail as possible was drawn out, and the information was added to the biography.

The second narrative interview took place about a week later. The now-expanded biography was read for the second time. The interview then focused on gathering more detail about the participant's life after the traumatic event. NET elements in this session were used with particular focus on cognitions and emotions from 'then' vs 'now'. The information was then added to the biography. This narrative interview was conducted in 90 minutes.

The completed biography was read for the third time and signed off at the last session by the researcher and the participant, and the participant was given her copy to take away. Following this, the IES-R and HADS were re-administered and a semi-structured end interview was conducted which explored the participant's opinions on the approach of the narrative interviews, what she found helpful and unhelpful about the approach, and whether her participation had had any impact on her drinking behaviour, as she was a client at a drug and alcohol abuse support service. The interview questions and answers can be found in Appendix 1. The participant was then thanked for her participation and the session was drawn to a close.

### *Analysis*

Braun and Clarke's (2006) paper on thematic analysis was used to guide the analysis carried out in this study. The paper outlines what thematic analysis is, provides distinction between the different kinds of thematic analysis and provides clear guidelines for its application (Table 1). The paper also provides a list of criteria that a good thematic analysis should fulfil.

Phase	Process
1. Familiarization with data	Transcription of data, reading and re-reading data, noting initial observations.
2. Generation of initial codes	Systematically code notable or interesting features across whole data set, collate data relevant to respective codes.
3. Look for themes	Collate codes into possible themes, collecting all data relevant to every potential theme.

4. Review themes	See whether themes work with coded extracts and the whole data set, constructing a thematic 'map' of the analysis.
5. Refine and name themes	Continue analysis, refine details of every theme and the narrative of the analysis, give clear definitions and names of all themes
6. Produce report	Final stage of analysis. Choose impactful, representative examples, make final analysis of examples, relate whole analysis to research question and literature, produce scholarly report of analysis

Table 1 – steps to conducting thematic analysis. Adapted from Braun and Clarke (2006), p.87.

The researcher followed the above guidelines when analysing the data. The data was comprised of the participant's biography which had been put together from information obtained during the Lifeline session and two narrative interviews. The biography was transcribed from field and observational notes of the participant's narrative and detailing the participant's non-verbal reactions and body language (e.g. disgust, tearfulness). No audio or video recordings of any part of the meetings with the participant or the interviews were made. The final version of the biography had a length of 3877 words. The researcher also followed the criteria in Braun and Clarke (2006, p.96) when conducting the analysis.

## **Results**

### *Case details*

Some details about the participant's background and medical history are presented here as they could have had an impact on the process of this study and the participant's perceptions.

The participant had gone to G.P.s for help regarding her anxiety symptoms previously, but had never disclosed that she had been exposed to psychological trauma and that she experienced highly intrusive thoughts. It was made clear to her that while the IES-R was not a diagnostic tool and the researcher was not qualified to diagnose disorders, it was not

completely implausible that she may have developed PTSD. She was given psychoeducation on the nature of PTSD to help her decide whether or not she wanted to seek further information. She was told that it may be worth revisiting the issue with her G.P and disclose the fact that she had experienced psychological trauma and was experiencing highly intrusive thoughts. This suggestion was given in light of the fact that the participant had been given a diagnosis of anxiety in the past and had been prescribed medication for it which she claimed had not helped her. This was accepted well by the participant and she expressed a desire to revisit the issue with her G.P.

Another issue highlighted by the participant was severe sleep difficulties. She shared that for years and continuing into the present she struggled to get to sleep, sometimes had experiences similar to flashbacks and frequently had nightmares related to the traumatic event. The participant was also highly sensitive to certain noises, such as doors slamming, and these noises were sometimes challenging for her to ignore during sessions.

Below, a brief outline of the participant's life is presented (Table 2).

1968	Birth	Age 17	Forced out of home by step-father
1-2 years old	First claimed conscious memory; feeling happy looking at the sun from her pram	Age 26	Split with fiancée, began drinking
Age 4	First memory of sister – feeling left out and jealous	Age 26	Felt fulfilled at job
Age 4-5	Mother had aneurysm, nearly died; was admitted to hospital	Age 28	Felt attractive in a relationship for the first time
Age 4-5	Birth father left mum for another woman; participant left home with mother and sister	Age 29	Lost contact with birth father
Age 4-5	Having food with grandparents in summer	Age 30-31	Moved into a close-knit community
Age 5	Participated in a play	Age 35	Severe illness
Age 11-12	Started secondary school	Age 39	Excited to start new job
Age 11-12	Step-father forced family to move to a new town suddenly	Age 39	Made to feel inadequate by manager

Age 13-14	Step-father pulled her out of school for a holiday, missed exams	Age 45	Diagnosed with chronic fatigue
Age 13-14	Incident of sexual abuse by step-father	Age 45	Made redundant; lost friends; flare in anxiety and depression
Age 16	Ran away from home, subsequently returned	2014	Internship at disability college
Age 16	Reunited with birth father but he did not recognise her initially	2016	Entered Nottingham Recovery Network

Table 2 – brief outline of participant’s life story from Lifeline session, with positive events shaded green, negative events shaded orange and the traumatic event discussed shaded red.

### *Questionnaires*

At the start of the study, the participant scored 7 for depression and 13 for anxiety on the HADS. When the scale was re-administered at the last session, the participant scored 8 for depression and 13 for anxiety.

The participant scored 51 on the IES-R pre-participation which was a sum of 15 in the intrusion sub-scale, 18 in avoidance and 18 in hyperarousal. She scored 42 post-participation. This reduction came almost entirely from her avoidance score which dropped to 7. She scored 17 for intrusion and 18 for hyperarousal.

### *Thematic analysis*

The analysis outlined 4 major themes and 1 minor theme present throughout the entire biography, and 2 themes that were only found in the data from the interview discussing the traumatic event. The first major theme was ‘positive emotions’. Positive emotions were present when the patient was recalling positive events, and were always accompanying either a feeling of closeness and belonging, or one of fulfilment. The feeling of fulfilment was not closely linked to the feeling of closeness, but there was insufficient basis to establish it as a separate theme, as it occurred very rarely on its own. Fulfilment and other positive feelings

were grouped into one theme because overall, there was far less diversity within positive emotions as a theme as opposed to the other major themes.

‘...I have a good memory from that time, we were with our grandma and grandad. It was a lovely hot summer and we were at grandma and grandad’s house. I remember there were salads, and tea and rice pudding... [pauses, becomes tearful briefly]. It was such a nice memory, you know?’

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‘I moved to a lovely village then. It was in the countryside, such a nice community. I loved that everyone knew everyone, I’d never experienced that before. I felt like I belonged.’

The participant tended to speak more briefly about positive memories and emotions but enjoyed the equal focus given during the Lifeline session on both positive and negative events, and expressed a desire to keep positive events in perspective.

The next major theme was ‘controlled by step-father’. Most of the examples of this theme were found in the section of the biography which detailed the participant’s childhood and early teenage years, but some examples also occurred later in life.

‘...Steve controlled everything, even what we ate and how much we ate. If a piece of bread went missing, he’d get my sister and me and ask us who did it. If he didn’t get an answer, he’d punish both of us. We were always hungry, trying to get more food or sneak some more food. [*becomes tearful, pauses to think*] I don’t think he gave us enough food.’

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‘She [manager] thought I was inadequate, the same as Steve [thought]. Steve would always say things like “You’ll never amount to anything,” and she reminded me of that.’

From the second example we can see that even when others and not the participant’s step-father were triggering the feeling of being controlled, she still experienced it because she linked that feeling to her step-father. The participant also identified a long-standing problem with low self-esteem, but this was not found to occur independently as a separate theme in the biography, rather, it occurred paired with the examples of the ‘controlled by step-father’ theme. The participant struggled with a lingering feeling that her past with her step-father continued to control her life. When looking at the biography as a whole, it became apparent that as a child prior to the incident, the participant was comparatively more outgoing and had good self-esteem. Following the event, her quotes highlighted a more fearful, less confident and less outgoing persona. The participant reflected on her idea that the large portion of her childhood (5-6 to 16) spent in relative fear and isolation felt as if it had impaired the development of her social skills and ability to be independent.

The next and most prevalent major theme from the biography was ‘feeling abandoned or isolated’. This theme appeared most prominently, and occurred from the very first childhood memories all the way until the most recent events. The participant found herself isolated from other family and friends by her step-father’s controlling ways:

‘Eventually, he [Steve] completely isolated me, my mum and my sister. My sister and I didn’t have any friends, we didn’t keep in touch with family. When someone came to visit us, Steve would yell and make a scene over it.’

Later in life she felt abandoned and lonely as a result of relationship breakdowns, which also caused the start of alcohol abuse:

‘We split up [with fiancée] when I was 26 and I moved out on my own. I started drinking then. It started because of the breakup, I think, from loneliness.’

She again felt abandoned and isolated when she lost her job:

‘Work was all I knew. So when that was taken away I got so depressed. (...) I lost all my friends [*becomes tearful*]. No one reached out. I would barely leave my house. I couldn’t cope, I couldn’t even look for jobs.’

It is interesting to note that sadness was only ever found in conjunction with feelings of abandonment or isolation, and as a result of them. It was not seen to occur as a result of other events and did not occur independently in the biography, hence was not identified as a separate theme. Feelings of isolation also appear to have been the cause of the development of unhelpful coping mechanisms (drinking behaviour).

However, other negative emotions occurred independently of feelings of isolation, and occurred prominently enough to form the separate major theme ‘strong negative emotions’. Those were namely anger, indignation, and a sense of being wronged. The three emotions often occurred together in relation to an event. This theme occurred throughout life, sometimes as a result of remembering a period of reflection on a negative event which had not been processed adequately when it first happened, due to fear or a different overshadowing emotion. Anger also appeared sometimes as a separate memory in itself.

‘He was very controlling, he uprooted our family just like that (...) I was so angry, my future and my friends were left behind just so he could go do what he wanted.’

*[during incident of abuse]* Then he said “It probably would be wrong, wouldn’t it,” and he left. It makes me feel angry now, it’s like oh, that would be wrong, but the stuff he was doing before, coming in and messing around with my body wasn’t?!’

The interview which dealt specifically with discussing the traumatic event of sexual abuse provided two themes which were unique to it, but this is most likely due to the fact that this session featured more specific prompts in comparison to the Lifeline session and the second interview. It specifically guided and prompted the participant to explore all aspects of the event (cognitions, emotions, physical sensations) as much as possible. As a result, a theme was prevalent through this section of the biography which was called ‘fear sensations’ and included physical sensations related to fear and panic. Examples can be found below:

‘It made me feel ill when he was saying things like how “lovely” my body was (...) It was his tone, it was like a dog looking at a bone, like I was just a body for men to look at. I felt sick in my stomach.’

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‘Talking about it now it feels almost like an “exorcism”, like getting your demons out. My heart is pounding right now.’

Another prevalent theme for only this segment of the biography that was not found elsewhere was ‘numb and paralysed’. This encompassed both physical and mental states. It is interesting to note that although the participant claimed to remember feeling numb and paralysed more than anything else about the event, this theme appeared with nearly identical frequency to ‘fear sensations’, and it did not appear to be more intense.

‘I felt numb, paralysed when I woke up and realised what was happening. My body felt very stiff.’

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‘When he said it (...), I felt frozen, paralysed. I kept my eyes shut tight and shook my head ‘no’.’

Notably, the themes ‘fear sensations’ and ‘numb and paralysed’ occurred in a narrative about the same event and were contrasting to each other. It is possible that due to this contrast in terms of physical sensations the participant remembered them more vividly and felt compelled to say at the start of the interview that she remembered little else, when in fact, she was able to recall many thoughts she had had during the event, and was also able to draw comparison with her thoughts of the event at the time of narrating it.

‘It’s odd, I’m back there again now, and I’m not seeing him as the truly bad person that I do as an adult, I think completely differently now... ‘

The interview structure may have aided in drawing out thoughts from the time of the event that had been ‘buried’ previously, leading the participant to recognise how what she thought of the event had changed, and allowing her to begin a conscious process of comparison and acceptance once the narrative was first constructed.

The second narrative interview provided data in which a minor theme of ‘reflection’ was found accompanying memories of different stages of life, but the theme had not emerged prior. While this second interview was not as heavily structured as the first and did not directly prompt the participant to identify cognitions or emotions, the participant seemed to have ‘picked up’ the method of exploring and comparing thoughts of ‘then’ vs ‘now’ that was used in the first narrative interview, and applied it to her narrative on multiple occasions.

‘Since what happened with Steve, I’ve always had a hard time with them [men]. I used to think they were all horrible but I’ve changed my mind over time, after meeting some who were nice. I still have to remind myself that there are nice men out there, that not all of them are horrible.’

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‘I was still drinking, and someone at the employment centre recognised that. They recommended that I go into services, that I wasn’t ready to work. Now I think they were right.’

Some examples of reflection were also accompanied by confusion, which was an initial code, but was not established as a separate theme at the final stage of analysis. The example below reveals the participant’s confusion over her step-father’s uncharacteristic behaviour during the traumatic event:

‘Then he said ‘Do you want me to show you how to do it?’. I knew what he meant, but I felt really surprised and confused. I thought it was odd that he asked if I wanted to have sex.’

In Colville’s (2017) series of case studies which used NET with parents who had PTSD as a result of their children’s hospitalisation, a theme of struggling with the chronology of events was found. In the current case, this was not established as a separate theme in the biography, however, the participant did struggle with remembering chronological details of her traumatic experience. She could not recall anything in this context other than the season of the year and her age, could not recall what she had done the day of the event, or the duration of the event. This difficulty with the chronology of traumatic events was something Colville (2017) also noticed in her series of case studies.

Observing the participant's non-verbal presentation also yielded some insights. During the Lifeline session and the first narrative interview, the participant became tearful at least 4 times each session. In the second narrative interview, this went down to 2 times. For the first 2 sessions the participant's overall body language appeared very protective, she sat with her arms around herself, hunched over or with her knees drawn up in front of her body most of the time. This declined significantly in the third and fourth session, where she sat in a relaxed manner, only occasionally putting one arm around herself. In the latter two sessions, she was markedly more expressive with her hands and was more able to express anger.

In the final session which explored the participant's opinion and experience of the interview, the participant did not become tearful at all, but had a small anxiety attack when answering a question from the IES-R questionnaire related to physical reactions to reminders about the traumatic event. The session was briefly stopped in order to engage the participant in grounding techniques. During this time, the participant was able to articulate that while she was not currently emotionally upset and was actually feeling cheerful, she had been relatively more anxious than normal during the week prior to the interview as a result of events unrelated to it. Aside from this, her body language was the most open and relaxed during this session, and remained so after the anxiety subsided.

The participant evaluated the approach and structure of the interviews as 'helpful' and 'thorough'. She was unable to think of anything unhelpful about the approach. However, when asked how she thought other people might react to this approach, she said that she believed the approach was most suited to people who were 'ready' to talk about their trauma, and that the approach may not be effective for those who did not want to discuss it in detail. When asked what she found most helpful about the interviews, she placed most value on the Lifeline session and the ability to talk about the traumatic event with someone who she felt

was 'empathetic' and 'without judgement'. The value participants placed on the lifeline session was also highlighted by Colville's (2017). In the current study, the participant acknowledged that the approach for exploring the traumatic event in detail had been difficult for her but that she found it 'useful and interesting', and had been surprised by her previous cognitions around the event and how they had changed. She shared that she did not experience the lingering feeling that her past with her step-father controlled her as intensely.

It is interesting to note that almost all of the reduction of the participant's IES-R score post-participation resulted from the reduction in her avoidance symptoms. Evidence for reduced avoidance was also found in the participant's end interview:

'I think talking about things definitely got easier after doing it 3 times. Going over it made me able to think about it and accept it, rather than just pushing it out of my mind constantly or refusing to accept it. I realise that avoiding it wasn't helping me like I thought it was.'

This reduction of avoidance may have been caused by the nature of repeated exposure itself, which aims to combat avoidance during retelling. Alternatively, habituation may have been achieved to an extent, which could have had the effect of reducing sensitivity to the traumatic memories, thus reducing the need to purposefully avoid them.

During the end interview, the participant wanted to highlight some positives she believed to be a result of her participation. She was given space to do so, and no questions or prompts were given to guide her. She shared that she felt she was more able to express herself emotionally, and that she had been able to restore her relationship with her birth father and tell him about the incident for the first time. She also shared that she felt her participation had inspired her to search for more opportunities for support, and that she had contacted an organisation for adult survivors of childhood sexual abuse, wanting to become involved as a

volunteer. No assumptions or attempt to analyse this unstructured part of the interview session will be made, but it is mentioned here as the participant felt it was noteworthy.

## **Discussion**

While the HADS questionnaire scores denoted no difference in anxiety and depression symptoms pre- and post-participation, the participant disclosed that the nature of the anxiety she experienced had changed. Prior to participation, her anxiety had been very much rooted in her thought process, and would illicit physiological responses as a result. In contrast, in the week leading up to the last session, her anxiety had been more physiological and she had often been surprised by it, as she had not been thinking about distressing situations or traumatic memories when she started to feel physical symptoms (racing heart, restlessness). The participant also suggested that her anxiety symptoms in the week before the last session may have been exacerbated due to her home routine having been severely disrupted because of unrelated events. She noted that while the intensity of the symptoms felt similar, she felt she was more able to handle her anxiety and to recognise and direct her thoughts when they focused on the traumatic event. The participant shared that she still thought very often about the event, but that she felt the thoughts were less uncontrollable and less overwhelming.

While this study did not see improvements in symptoms of anxiety, depression or in intrusiveness and hyperarousal, it did highlight improvement in symptoms of avoidance which was palpable to the participant and valued by her. The participant's opinion of the approach was highly favourable, as was her perception of her experience with it. It is important to note that this participant was a client at a drug and alcohol support service and had been struggling with alcohol abuse for over 20 years. Her participation did not exacerbate her drinking behaviour or result in a heightened urge to drink, however, this was based on

self-report. Nevertheless, because it was made clear to the participant that the study was exploratory in nature, that no formal therapy was involved and that the researcher was not a qualified therapist, there was no immediately apparent reason to suspect any attempts of deception in the participant's answers to questions about her drinking.

### ***Limitations***

An obvious limitation of this study is that of a case study, and any statistically backed results were not achievable with the study's design. The inability to make recordings of the sessions is also a potential limitation, as a smaller amount of the participant's speech is able to be transcribed. However, the analysis guidelines used (Braun & Clarke, 2006) did not call for recordings over field notes or suggest either method was superior in accuracy.

Finally, the time constraints of this study meant that no follow-up could be made at a further point in time post-participation (e.g. 3 months, 12 months). This is a potential drawback, as no knowledge can be gained on whether the improvement of avoidance symptoms would be sustained in time, or whether symptoms of anxiety, depression, hyperarousal and intrusiveness would have been aggravated or improved at a later point.

### **Conclusion**

This case study utilised elements from NET to conduct narrative interviews in a community setting. While no formal therapy was used, the findings indicate that the NET-style approach was received well by the participant. The interview exploring the participant's experience and opinions of the narrative interviews and the thematic analysis of the participant's biography provided evidence for this. No aggravation of symptoms of anxiety, depression, hyperarousal or intrusiveness occurred, and there was no aggravation in self-

reported drinking behaviour. This suggests that narrative interviews could be a safe option for people who cannot or do not want to attend formal therapy but do want to talk about their traumatic experience. As suggested by the participant, the approach could be used as a precursor to formal therapy, and the biography created during the sessions can then be utilised to aid formal therapy as well. Narrative interviews could be of use for people on waiting lists for therapy both for the above reasons and to potentially improve symptoms of avoidance. Studies with larger samples or a randomised control trial could determine whether the reduction in avoidance symptoms is significant, and they would be the next logical step in researching the effectiveness of narrative interviews. Quantitative measures and follow-up could help in determining the longevity of avoidance symptom improvement and any potential change in other trauma symptoms following participation.

Word count: 7876 (Max.: 8000)

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## Appendix 1

### End interview questions and participant answers

Q: What do you think about the Lifeline element?

A: I found it really useful. I enjoyed seeing positive events stick out at me more, I feel it's important not to forget them and to put focus on them too. We spent so much time doing it but I felt like I wanted to put more on the line. Then again, after it was done, looking at it I thought I spent a bit too much time on things that didn't impact me very much. I'm happy about it overall.

Q: What do you think about the approach (focus on thoughts, emotions, physical sensations)?

It felt thorough. I suppose because I remembered more physical sensations, like how I said everything was so numb, it felt difficult to focus on feelings as well, but I felt it was useful and interesting. It made an impression on me how accepting [*expression of displeasure, disbelief*] I'd been of the control my step-dad had during that incident.

A: Are there any differences in how you think/feel about the incident?

It feels like it's less a part of me now. It used to be something that defined me in the past, that was controlling me, now it feels more just like a thing that happened.

Q: Are there any difference in how you think/feel about your life?

A: I'm definitely more hopeful about my life. It won't be dragging me down so much, I'll be fighting it when it wants to put me down. It's made me look into what other help there is, and I want to get involved with groups of adult survivors of sexual abuse. I was looking into NAPAC specifically, I wrote to them.

Q: Has participating in these interviews made any difference to your drinking?

A: It's not made it any worse, it's the same as normal. I say normal but I'm in the service and I've reduced *a lot* a lot, so the same it's been in my time in the service.

Q: Has it made any difference in you wanting to drink?

A: Well, because I said a lot of other things have been happening, I do still have a thought like "Oh god, I just need a drink right now", but not with regards to this [the interviews]. When I did have that thought, I didn't actually feel like drinking, it made me think like I'd be defeating the purpose and I didn't want that for myself.

Q: What was most helpful about these sessions?

A: The Lifeline definitely helped, it helped me to see my life visually. I'm a visual person and it really put things in a different perspective. I thought that everything would be all stones, all negative. It was helpful to talk about the incident with someone [the interviewer] who was empathic and without judgement. It was a huge part of it in the past that I was so afraid people could tell what had happened just by looking at me and that they were judging me or would judge me.

Q: What was unhelpful about these sessions?

A: Nothing. There's nothing I can think of.

Q: How do you think this approach would influence other people if they decided to participate?

A: Well for me, I felt like it would be useful before we even started. I'm someone who likes talking about my feelings but I still found it difficult. I think some people would like it because it's brief too. If they're someone who's willing to tell their story it could help with just that as well. I found it was a *huge* weight off me. Going over the incident is a vivid memory that's sticks out at me, maybe because we're in the same room now or because it was the first time I told anyone in detail, I don't know, but it's very vivid. Because of the biography bit, I felt like I was telling more people than just you [the interviewer], even though I wasn't. I think there's an element of "readiness" here. I felt ready to finally do something about the pain it was causing me, to talk to someone about it. If people aren't ready or absolutely don't want to tell anyone, I don't know if this approach would help them.

## Executive Summary

(project feedback for Nottingham Recovery Network)

### Background and rationale

Even with the IAPT programme, many people in the community are not able to access mental health services for various reasons. The idea of undergoing formal therapy may seem intimidating, especially to individuals who have been exposed to psychological trauma and have never disclosed it. Other reasons for not accessing psychological support services may be long waiting lists, or costs. The focus of research in this area then shifts to what other approaches might be of use in providing support for survivors of psychological trauma.

One such approach that has emerged in the last 15 years as an effective, low-cost treatment for trauma and posttraumatic stress disorder (PTSD) symptoms is narrative exposure therapy (NET) (Schauer, Neuner & Elbert, 2011). It centres around something people naturally do throughout life – storytelling, or creating narratives. NET capitalises on this natural approach to reduce sensitivity to the traumatic memories and reminders about them through habituation. The nature of these memories is often fragmented and disorganised, preventing the person from constructing a coherent mental ‘story’ of the event and putting it in perspective. NET helps with this through repeated, guided, constructive re-experiencing of the event through narrative. The focus is not solely on

the traumatic event. Instead, a narrative of the person's entire life course is constructed, with emphasis placed on valuing it in its entirety and all positive and negative events within it, including traumatic ones. In this way, 'cold', factual memories can be integrated with 'hot', emotional ones, helping to construct a coherent narrative of the traumatic event and integrate it within the person's broader life story. The neural fear-memory network that has been formed in response to the trauma and which perpetuates trauma symptoms is activated and altered, thus improving symptoms (Kevers, Rober, Derluyn & De Haene, 2016).

Advantages of NET are its flexible duration (anywhere from 3 to 12 sessions)(Schauer, Neuner & Elbert, 2011), its ability to be effectively delivered by lay people with limited training and its lower dropout rate in comparison with other trauma treatments (Dixon, Ales & Marques, 2016; Neuner, Onyut, Ertl, Odenwald, Schauer & Elbert, 2008). NET has a wide evidence base of effectiveness in developing countries, with refugee and veteran populations (including children), especially those with multiple or complex trauma (Nakeyar & Frewen, 2016; Pieloch, McCullough & Marks, 2016; Ruf, Schauer, Neuner, Catani, Schauer & Elbert, 2010, Schauer, Neuner & Elbert, 2011). However, its use is limited in higher-income countries and in populations where trauma is not the result of war, organised violence or natural disasters. Evidence from the UK specifically is sparse.

### Aims

The study aimed to contribute to the evidence base for NET-based approaches in higher-income settings. It used NET to inform a short series of narrative interviews in lieu of formal therapy. The study tested whether NET elements alone can be used to improve trauma symptoms. This constituted a lighter approach which alleviated more of the potential cost, as training required is further reduced. The design capitalised on NET elements such as repeated exposure through narrative, a Lifeline session and construction of a biography.

#### Data collection

This was a case study which took place at Nottingham Recovery Network, a support service for drug and alcohol abuse. The participant was a female client of this service who was in a stable condition and was suitable for the aims of the study. She was given She was given psychoeducation on the nature of trauma and traumatic memories, after which she signed a consent form. She filled in the Impact of Events Scale – Revised (IES-R) and the Hospital Anxiety and Depression Scale (HADS), then participated in a Lifeline session which outlined meaningful positive and negative events from birth until the moment of participation. Two narrative interviews using NET elements were then conducted. The first explored in detail the participant’s physical sensations, thoughts and emotions around a traumatic event she chose to discuss, and the second drew out detail about her life after this event. The information was transcribed into a biography which was expanded and re-read at every

interview, with the participant receiving a final version at the end. The IES-R and HADS were re-administered and an interview was conducted which explored the participant's experience, opinions and recommendations regarding the narrative interview approach.

### Analysis

Pre- and post-participation IES-R and HADS scores were compared but not statistically analysed. The biography was thematically analysed according to guidelines by Braun and Clarke (2006).

### Key findings

HADS scores	
Pre-participation	Post-participation
Depression: 7 ('normal')	Depression: 8 ('borderline')
Anxiety: 13 ('abnormal')	Anxiety: 13 ('abnormal')
IES-R scores	
Pre-participation	Post-participation
Intrusion: 15	Intrusion: 17
Avoidance: 18	Avoidance: 7
Hyperarousal: 18	Hyperarousal: 18
Total: 51	Total: 42

The participant had diagnoses of anxiety and chronic fatigue. No marked change in depression and anxiety occurred, both in self-report

and in questionnaire scores. No marked change in intrusion and hyperarousal was found, however, there was a marked reduction in avoidance symptoms. This was palpable to the participant and valued by her.

The end interview revealed a positive experience with the approach. The participant specifically valued the Lifeline session and being able to speak about her trauma and receive empathy and no judgement. When asked about changes in drinking behaviour, she reported no aggravation of her drinking behaviour or of her desire to drink.

### Implications and recommendations

This approach was well-received and did not aggravate any symptoms. The participant suggested that the approach could be a good precursor to formal therapy and that the biography could be a useful tool to aid future therapy. As this was a single-case study with an exploratory nature, further research is needed, specifically with larger samples and with implementation of follow-up to determine whether any change of symptoms would occur later after participation and whether the reduction of avoidance symptoms would be statistically significant and sustained in time. With further evidence, NET-based narrative interviews could be used for short-term support for people on waiting lists for therapy, or for people who cannot or do not want to receive formal therapy.

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# Effectiveness of interviews based on narrative exposure therapy (NET) in community settings – a case study

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## Rationale:

- NET – manualised, effective evidence-based treatment used in low-income settings for multiple and complex trauma and PTSD (\*Schauer, Neuner & Elbert, 2011)
- Limited use in higher-income settings
- Limited evidence in individuals who are not members of a differentiated group (e.g. veterans, refugees, in-patients)

## Aims:

- Use NET elements (Lifeline, biography, repeated exposure through narrative) to inform a short series of therapeutic interviews and explore effectiveness in a case study
- Employ approach in a local community setting in the UK
- Assess effectiveness for participant who is not diagnosed with PTSD and does not belong to a particular group (refugees, veterans)

\*Schauer, M., Neuner, F., Elbert T. (2011). Narrative Exposure Therapy: A short term treatment for traumatic stress disorders (2nd edition). Cambridge, MA: Hogrefe Publishing

# Methods

- Lifeline session and 2 narrative interviews conducted; information transcribed via field notes into a biography
- Thematic analysis used to examine biography, according to Braun and Clarke's (2006)\* guidelines
- Semi-structured end interview conducted to explore participant's experience and opinions of the process
- Impact of Events Scale – Revised (IES-R) and Hospital Anxiety and Depression Scale (HADS) administered pre- and post-participation to examine any potential effect of the interview process that was not reflected in the end interview

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

# Results

- No difference in HADS scores and in intrusion and hyperarousal IES-R subscales, but noticeable change in avoidance: decrease from 18 to 7
- Narrative of traumatic event characterised by difficulty with chronology – consistent with \*Colville's (2017) case studies findings
- Thematic analysis:
  - 4 main themes – 'positive emotions', 'controlled by step-father', 'feeling abandoned/isolated', 'strong negative emotions'
  - 2 incident-specific themes – 'fear sensations', 'numb and paralysed'
  - 1 minor theme – 'reflection'
- End interview – very favourable reception of narrative approach

\*Colville, G. A. (2017). Narrative exposure therapy with parents who have been traumatized in pediatric settings: A case series. *Clinical Practice in Pediatric Psychology*, 5(2), 161-169. doi:10.1037/cpp0000187

## Implications

- Narrative interviews: received well by client of drug and alcohol abuse support service
- No aggravation of anxiety, depression, hyperarousal, intrusiveness or drinking behaviour
- Potential as a safe option for people on waiting lists for other trauma-therapies
- Approach may be useful as a pre-cursor to formal therapy as it is a lighter approach and may have potential for reducing avoidance symptoms
- Biography could be useful tool to bring into future therapy

## Suggestions for future research

- Repeat study with larger sample
- Repeat narrative interviews in a randomised control trial
- Use quantitative analysis to determine significance of avoidance symptom reduction
- Include follow-up to determine persistence of avoidance symptom improvement and potential change in anxiety, depression, hyperarousal or intrusiveness

## Reflective Report

Reflective model used: Gibb's reflective cycle (1988)

### Conceptualisation

When choosing my subject area, I was particularly interested in new trauma research. I explored research in this area by academic staff at the university, and became particularly interested in Dr Nigel Hunt's recent research and work with narrative exposure therapy (NET). The topic resonated with me because of my previous experience in an adolescent mental health hospital where I had seen how widespread trauma was and how much it affected patients' recovery.

I researched NET and found that it had definite advantages for treating PTSD and trauma in low-income settings and as a short-term, flexible and cost-effective treatment (Dixon, Alles & Marquez, 2016, Schauer, Neuner & Elbert, 2011; Zang, Hunt & Cox, 2013). However, I was unable to find much research on NET's effectiveness in the UK. I did find a pilot in-patient study from Norway (Milde, Nordling & Nordanger, 2012), an out-patient study from Germany (Steuwe et. al, 2016) and a single case study from the UK (Colville, 2013). While small scale, all three studies had found significant positive results with NET and this inspired me to design a study to contribute to this evidence base. I wanted to see how NET would be accepted in community settings in the UK among people who were not part of a differentiated group such as

veterans or refugees. So I wrote a proposal idea and was placed to work with Dr Nigel Hunt.

I felt highly optimistic. At the same time, I was wary of not having existing affiliations with community services that I could use to set up the study. I knew that there were many free or charity-based support services for victims of trauma in the area, but I was not fully aware of the difficulties facing me as a researcher who was not already affiliated with a service. Yet, having never undertaken research like this before, there was no way to know this in advance. Now, having learned how the process works, I am much more aware of how to approach it and what to expect realistically.

### Preparation

I proceeded to expand my knowledge base around NET's implementation in various settings and I met with Dr Hunt to discuss the study design. I initially wanted to do a small-scale randomised control trial which was initially deemed feasible, however, when I began to contact services to gauge interest, it became apparent that an RCT would not be feasible time-wise. While frustrating, it was a learning experience which contributed to my building realistic expectations of what a researcher in my position could accomplish.

I spent the time from November and February contacting different services in the Nottingham area, presenting my project proposal to them. Because the services had varying degrees of expertise, I learned to write

informal proposals for different target audiences. Some services requested a literature review which I also compiled and provided. I found this useful as it challenged me and made me delve deeper into the subject area. It was also a challenge to face rejection from services. Sometimes the reasons for rejection I was given were entirely valid, such as the concerns the Topaz Centre had regarding their clients who were involved in on-going court cases against their abusers, but other times I received no reasons or reply whatsoever.

What felt most challenging and frustrating was the scepticism I faced regarding the claim that an approach like NET could be delivered by lay people who were not highly trained counsellors or psychologists. Even though I presented ample evidence that unqualified persons could deliver NET effectively with some training (Dixon, Alles & Marquez, 2016; Gwozdziowycs & Mehl-Madrona, 2013; Neuner, Onyut, Ertl, Odenwald, Schauer & Elbert, 2008), I was left with the impression that there was an ideological barrier to this in the field. I was not in a position to ask for reconsideration so I had to think constructively of how adapt the study design to something more acceptable. This taught me to be more flexible with my approach, which I have now come to value.

### Design

I met with my supervisor to discuss the difficulty I was having with finding a service to co-operate with me for the study. He directed me to narrative interviews as an alternative. He explained that they were

therapeutic in nature and borrowed approaches from NET but were not formal therapy and thus might be more acceptable for me to deliver. Because I was now even further pressed for time, we agreed to change the study design into fully qualitative and downsize it to a small series of case studies (about 5). It was disappointing to have to downscale my study but I accepted this easily as I now understood the challenges of research fully. With the new study design, I was able to secure co-operation (Figure 1) from Nottingham Recovery Network, a support service for drug and alcohol abuse.



Figure 1 – Written agreement from Nottingham Recovery Network’s service manager Julie Crosby

The intended design of the study was a series of 5-6 case studies, with each participant engaging in a Lifeline session, 2 narrative interviews and an end interview which would explore their experience and opinions of the narrative interviews. They would fill in the Impact of Events-Revised (IES-

R) scale and the Hospital Anxiety and Depression Scale (HADS) both pre- and post-participation. The content of the Lifeline session and the narrative interviews would be transcribed in the form of a biography which would be reread throughout the sessions and signed off at the end of participation, with the participant receiving a copy. Thematic analysis of the biographies would be conducted using the structure suggested by Braun and Clarke (2006).

The ethics application form was submitted April 3<sup>rd</sup> and study received ethical approval on June 13<sup>th</sup>. Immediately after this, I presented the approval to Nottingham Recovery Network and informed management I was ready to begin data collection. However, I was told because of the extended length of time since our agreement (March), the clients who had been interested in participating had moved on from the service, meaning the recruitment process would be delayed. In light of circumstances, I was forced to request an extension of the deadline until August 31<sup>st</sup>. I met with my supervisor and we agreed to make the project a single case study but otherwise keep its methodology. It was difficult for me to accept the circumstances but I found comfort in the fact that I would still manage to finish my project and contribute to an evidence base for narrative interviews that my supervisor was building with other students.

### Data collection

I began working with the participant mid-July. Data collection proceeded smoothly. I met with the participant informally first to answer

questions she had regarding the study. When we met for the second time she completed the IES-R and HADS and was given some psychoeducation on the nature of traumatic memories. A few days later, we had the Lifeline session. Another few days after this she participated in the first narrative interview which explored the traumatic event of sexual abuse she wanted to discuss. A little over one week was given between this narrative interview and the second one. The second interview dealt with exploring the participant's life after the traumatic event in more detail. About a week later, she participated in the end interview which explored her opinions and experience of the narrative interviews. The IES-R and HADS were re-administered and she received the completed version of her biography, which marked the end of her participation. This last session took place in the first week of August. Excluding the first informal meeting, data collection took approximately 3 weeks.

I immensely enjoyed working with the participant. I had prepared meticulously beforehand and felt confident in my skills while working with her. I felt fortunate working with someone who fully understood the challenges of discussing trauma in depth for the first time. I did find it slightly difficult to intervene when she sometimes veered off storytelling into negative ruminating, but this was thankfully a rare occurrence. If in the future I have to re-focus a participant's attention on their story, I would feel slightly better prepared to do so. I felt honoured to be able to transcribe her biography for her and I made every effort to relay her story as accurately as possible and in her own words. Data collection was a

highly enjoyable process for me and I feel confident in my abilities to undertake it in the future.

### Data analysis

While I had never used thematic analysis before or any type of qualitative measure, I found it relatively straightforward to conduct the thematic analysis of the participant's biography using Braun and Clarke's (2006) paper. I was used to having rigid statistical parameters from my previous academic background in conducting cognitive and neuropsychological studies, and was somewhat unsure of how to apply the more fluid guidelines in qualitative analysis initially. However, when I re-read the biography once again, I was able to think critically about it and begin classifying themes within it. I had already re-read it many times, thus completing the immersion step of Braun and Clarke's (2006) guidelines. From here, the process went by quite smoothly. I coded initial themes, then removed some which had insufficient basis and joined together others which converged. I received helpful comments from my supervisor on the draft of the analysis which challenged me to improve the analysis further, and I strived to implement them.

Because the biography I was analysing was not very long (3877) words, the process was relatively quick. I found the guidelines I was using helpful, and I feel quite confident in my ability to conduct thematic analysis in the future.

## Write up

Because I had already done the bulk of my literature review early in 2017 and had done the analysis portion of my write up quickly after data collection, I felt calm about the amount of time I had left to finish the paper. Writing the methodology section was quick and straightforward as I had already done a similar write up for proposals and for the ethics application form.

However, I then struggled with the order of my literature review. The original review I had done had a different target audience and I found myself spending a lot of time expanding each reference I had made with more details and changing the terminology I had used to reflect a more academic style. Additionally, since I had originally done the review, several papers specifically using NET in small scale studies had been published which I felt were relevant to my paper, so I spent additional time reviewing them. While I was pleased with the literature I had included, I struggled with what to include and in how much detail. Much of the research was in the form of RCTs as opposed to a case study like mine, and most articles were compressed to a very small format (5000-6000 words). I solved my issue by using their literature review sections as examples and guidelines for my own section, as my methodology and analysis sections were comparatively longer. I found the discussion section straightforward. I was overall pleased with the final version of my paper, but I did wish I had more space to include more suggestions for future research.

The process of conducting this project was absolutely indispensable. It gave me new skills for proposal writing and introduced me to qualitative research, gave me confidence to work face to face with a participant and greatly expanded my knowledge base in the area of trauma treatment and research. It also showed me the real, practical challenges to conducting research in the community. The experience I gained over the course of the year from this project will be incredibly useful in my future career, both as a practitioner and researcher.

**Word count: 1983**

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