Clinicians' perspectives on retraumatisation during trauma-focused interventions for post-traumatic stress disorder: A survey of UK mental health professionals

Lucy Purnell [a,1], Kenny Chiu [a,2], Gita E. Bhutani [b,c,3], Nick Grey [d,e], Sharif El-Leithy [f,4], Richard Meiser-Stedman [a,*,5]

[a] *Department of Clinical Psychology and Psychological Therapies, University of East Anglia, United Kingdom*
[b] *Lancashire & South Cumbria NHS Foundation Trust, Preston, United Kingdom*
[c] *University of Liverpool, Liverpool, United Kingdom*
[d] *Sussex Partnership NHS Foundation Trust, Worthing, United Kingdom*
[e] *School of Psychology, University of Sussex, Brighton, United Kingdom*
[f] *South West London and St George's Mental Health NHS Trust, London, United Kingdom*

ARTICLE INFO

ABSTRACT

Concerns regarding retraumatisation have been identified as a barrier to delivering trauma-focused therapy for post-traumatic stress disorder (PTSD). We explored clinicians' understanding of what constitutes potential signs of retraumatisation (PSoR), reported incidences of witnessing retraumatisation, use of (and confidence in) therapies for PTSD, fear of retraumatisation during therapy for PTSD, and whether having witnessed retraumatisation was associated with these variables. We surveyed 348 clinicians. There was variation in what clinicians viewed as PSoR. Retraumatisation was reported by clinicians in 3.4 % of patients undergoing trauma-focused therapy for PTSD. A variety of trauma-focused and non-trauma-focused therapies were routinely used, yet 14.4 % reported not using trauma-focused therapy. There was a significant negative correlation between participants' highest reported confidence in trauma-focused therapy and endorsement of PSoR ($r = -.25$) and fear of retraumatisation ($r = -.28$). Mean fear of retraumatisation was 30.3 ($SD=23.4$; a score we derived from asking participants out of 100 how much they worry about trauma-focused therapy being harmful in its own right/leading to a worsening of PTSD symptoms). Participants who had witnessed retraumatisation reported significantly greater endorsement of PSoR ($d=.69$ [95 % CI .37, 1.02]) and fear of retraumatisation ($d=.94$ [95 % CI .61, 1.26]). Confidence in using therapies for PTSD was varied and related to how clinicians understood retraumatisation. Retraumatisation is uncommon, but there is variability in clinicians' interpretation of what retraumatisation is, and its utility warrants research.

1. Introduction[6]

Post-traumatic stress disorder (PTSD) in ICD-11 (World Health Organization, 2022) comprises three key symptom clusters: re-experiencing the trauma, avoidance of trauma-related stimuli, including trauma-related thoughts and feelings, and increased arousal and reactivity from a persistent sense of threat. Trauma-focused cognitive behavioural therapy (TF-CBT) and eye movement desensitisation

---

and reprocessing (EMDR) have been found to be the most efficacious treatment approaches for PTSD by large meta-analyses (Lewis, Roberts, Andrew, Starling, & Bisson, 2020; Mavranezouli et al., 2020). The National Institute for Health and Care Excellence (NICE) defines that TF-CBT interventions include cognitive processing therapy (CPT), cognitive therapy for PTSD (CT-PTSD), narrative exposure therapy (NET) and prolonged exposure (PE; NICE, 2018). These interventions target patients' memories of traumatic event(s) and the meaning associated with these event(s). They typically include repeated exposure to reminders of the trauma (in vivo and/or imaginal), elaboration of the trauma narrative(s) and restructuring of negative beliefs about the trauma and its consequences (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013; Ehring et al., 2014). In a "Guide to Guidelines" for the treatment of PTSD in adults, all of the five included international guidelines strongly recommend trauma-focused therapies (Hamblen et al., 2019). Despite this recommendation, Finch and colleagues (2020) found that TF-CBT was self-reported to be implemented by less than 60% of 716 clinicians working in UK child and adolescent mental health services.

1.1. Retraumatisation as a barrier to delivering trauma-focused interventions

A recent systematic review suggested that one of the most common barriers for clinicians to deliver trauma-focused interventions for PTSD is a fear of "retraumatising" patients (Finch, Ford, Grainger & Meiser-Stedman, 2020). Duckworth and Follette (2012) recognised in a commentary that "retraumatisation" has been used with different meanings in PTSD literature to refer to 1) the response from multiple exposures to trauma and 2) the distress experienced when sharing a trauma narrative. In relation to the latter, it has been suggested that some clinicians worry that patients are likely to experience an increase in PTSD symptoms or distress during trauma-focused therapy (Murray et al., 2022) that could be permanent (Schock, Rosner, Wenk-Ansohn, & Knaevelsrud, 2010) and intolerable (Zoellner et al., 2011). However, there is a lack of evidence of what constitutes retraumatisation and seemingly a lack of consensus on what the term specifically refers to (e.g. no reference to retraumatisation in clinical practice guidelines). In response to these fears, it has been suggested that some clinicians may avoid or delay actively working with trauma memories (Murray & El-Leithy, 2022) or that clinicians may be overly cautious in the way they deliver therapy (Deacon et al., 2013). A survey of clinicians' attitudes towards trauma-focused interventions suggested that concerns about tolerability and dropout were among the main reasons for not using trauma-focused interventions (Becker, Zayfert, & Anderson, 2004). However, there is a lack of research to help us to understand the influences on clinicians' fears regarding retraumatisation and how this may create a barrier to delivering trauma-focused interventions (Finch et al., 2020).

One way to operationalise retraumatisation could be a reliable worsening of PTSD symptoms due to trauma memory processing (during or by the end of treatment). A study pooling data from two RCTs exploring PTSD symptom exacerbation (defined as an increase greater than 6.15 points on the Posttraumatic Diagnostic Scale [PDS; Foa et al., 2016a] or PTSD Symptom Scale [PSS; Foa et al., 2016b] at least once during treatment) reported that 20.0% of patients in the PE group and 28.6% of patients during CPT group experienced PTSD symptom exacerbation and that these patients were still highly likely to experience an improvement in symptoms by the end of treatment (Larsen, Wiltsey Stirman, Smith, & Resick, 2016). Further, participants within the Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE) group in an RCT of patients with PTSD and alcohol use disorder reported a low incidence rate (20.5%) of PTSD symptom exacerbation (based on the reliable deterioration calculation as described by Devilly and Foa, (2001) from session 3 to 5 (the period during which exposure is implemented), suggesting the symptom

exacerbation is uncommon even in complex presentations (Tripp et al., 2021). Studies have also examined symptom trajectories during trauma memory processing. For example, a study examining imaginal exposure found an increase in PTSD symptoms in only a minority (10.5%) of patients and that those who experienced an increase in symptoms showed similar outcomes at post-treatment compared to those who did not experience symptom increases during exposure (Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002). Research has also taken a qualitative approach and suggested that an increase in PTSD symptoms is tolerable and "worth the pain" (Shearing, Lee, & Clohessy, 2011). Lastly, a study from routine clinical practice found that only a small minority of patients (1.2%) experienced reliable exacerbation of PTSD symptoms (defined as an increase of greater than 6 on the PDS) between the first treatment session and the end of treatment during trauma-focused psychological interventions (Ehlers et al., 2013). There is a need to explore whether clinicians operationalise retraumatisation through an increase in PTSD symptoms.

No study has explored clinicians' perspectives on retraumatisation during trauma-focused psychological treatments. It is important to understand clinicians' perspectives on retraumatisation regarding trauma-focused interventions, as they may be a barrier to implementing trauma-focused interventions.

1.2. Aims

We collected data from clinicians with the aim of understanding:

i. their endorsement of certain patient experiences during or after a therapy session as potential signs of retraumatisation (PSoR; e.g. increased PTSD symptoms, increase in behaviours relating to risk to self); and whether there was a difference in total endorsement of PSoR between those clinicians who had, and had not, reported witnessing retraumatisation;

ii. the reported incidences of retraumatisation based on a specified definition i.e. the pooled proportion of patients with PTSD for whom clinicians reported that trauma-focused therapy had been harmful or had led to a worsening of PTSD symptoms;

iii. use of, and confidence in, trauma-focused and non-trauma-focused therapies for PTSD; whether this was different between professional groups and/or participants who had and had not reported retraumatisation, and whether there was a correlation between clinicians' highest confidence in trauma-focused or non-trauma-focused therapy (i.e. the therapy amongst trauma-focused/non-trauma-focused therapies that clinicians reported the highest confidence in out of 100) and total endorsement of PSoR;

iv. fear of retraumatisation during trauma-focused therapy for PTSD, and specifically whether there are differences in this between professional groups, participants who had and had not reported witnessing retraumatisation and/or participants who reported routinely offering and using trauma-focused therapies; and

v. the relationship between fear of retraumatisation and endorsement of PSoR, and highest confidence in delivering a trauma-focused therapy.

2. Method

2.1. Ethical approval

All procedures were approved by the University of East Anglia's (UEA) Faculty of Medicine and Health Sciences Ethics Committee (ETH2223–1282).

2.2. Participants

Mental health professionals (from any professional background) who

offered psychological therapy for people with PTSD within the UK National Health Service (NHS) were recruited. There were no limitations on the number of patients with PTSD professionals had treated. We included qualified professionals and those in training. In the UK, qualification is when professionals are registered with a regulatory body, e.g. the Health and Care Professions Council. People were not eligible to participate if they only provided psychological therapy privately, worked outside the UK or were Trainee Clinical Psychologists from the University of East Anglia 2021 cohort.

Recruitment occurred between February 2nd and June 30th 2023 via social media (Twitter, LinkedIn, and Facebook) and professional bodies that agreed to circulate recruitment materials (the British Association of Behavioural and Cognitive Psychotherapies, the Royal College of Occupational Therapists, the British Association for Music Therapies, the British Association for Dramatherapists, the UK Psychological Trauma Society, and the Association for Family Therapy). Participants confirmed their informed consent with a consent statement, consistent with guidance regarding proportionate consent for online surveys (Health Research Authority, 2017).

2.3. Procedures

This study used a cross-sectional online survey design. The survey, including the PSoR used, was developed with experts in the field of PTSD. Participants were provided with a participant information page, which provided information describing the purpose of the study and ethical considerations. Participants then confirmed their informed consent with a consent statement. On completion of the survey, participants were provided with debrief information.

2.4. Measures

2.4.1. Demographic and professional background

Participants were asked to provide their age, sex, gender, ethnic group, and highest level of education based on the Office for National Statistics (2021), as well as their core professional background, the number of years they had been training or qualified in this and the population(s) and setting(s) they worked with (participants could endorse more than one population and/or setting).

2.4.2. Use of and confidence in therapies for PTSD

Participants were asked which therapy modalities they routinely offered and used with people with PTSD, their confidence in delivering these (0–100%; 0%=not confident at all, 100%=extremely confident), and then whether they routinely integrated therapies (yes/no). If a participant reported to routinely offer and use at least one trauma-focused therapy for PTSD (TF-CBT, CT-PTSD, EMDR, Exposure, PE, CPT or NET), they were classified as routinely using trauma-focused therapies for PTSD.

For each participant, we extracted the therapy amongst both trauma-focused and non-trauma-focused therapies that they reported the highest confidence in (out of 100), and we refer to this as clinicians' highest confidence in trauma-focused or non-trauma-focused therapy (i.e. if, amongst trauma-focused therapies, they reported 50 for PE and 80 for CT-PTSD, we extracted 80 as the highest trauma-focused therapy confidence).

2.4.3. Patient reactions as PSoR

Participants were presented with a definition of retraumatisation ("the therapy experience as being harmful in its own right and potentially leading to a lasting worsening of PTSD symptoms") and asked to what extent 11 defined patient reactions suggested a patient is "undergoing retraumatisation," providing ratings of PSoR (0–100%; 0%= does not suggest retraumatisation at all; 100%=indicative of retraumatisation). We interpreted a score of ≥ 50 as indicating endorsement of the reaction as a sign of retraumatisation. There was strong internal

consistency between the 11 items ($\alpha = .94$). We summed the scores of all 11 items for each participant, giving a score between 0 and 1100.

2.4.3.1. Witnessing retraumatisation. Participants were asked whether they had witnessed trauma-focused therapy as being "harmful in its own right or leading to a worsening of PTSD symptoms" in any of their patients in the past six months (yes/no; a score we termed "witnessed retraumatisation"), and if so, how many patients they had witnessed this in. Participants were also asked to estimate how many patients with PTSD they had treated in the previous six months using trauma-focused therapy. These data were used to determine the proportion of patients for which participants reported they had witnessed retraumatisation during trauma-focused therapy in the previous six months.

2.4.3.2. Fear of retraumatisation. Participants were asked how much they worry about trauma-focused therapy being harmful in its own right (the therapy itself as harmful) or leading to a worsening of PTSD symptoms in their work with people with PTSD in general (0–100%; 0%=not worried at all; 100%=extremely worried; a score we termed "fear of retraumatisation").

2.4.4. Data analysis

Study data were cleaned, and sample characteristics were summarised using descriptive statistics. We categorised participants by a) whether they had "witnessed retraumatisation," b) whether they reported that they routinely used trauma-focused therapies for PTSD and c) their core professional background as Clinical Psychologist, CBT Therapist and "Other Professionals" (as many professional groups were too small for formal analysis). Detail on professional groups is provided in Table 1 below to provide context for these categorisations:

Descriptive statistics calculated i) the endorsement of PSoR, ii) the pooled proportion of patients that participants reported that trauma-focused therapy had been harmful or led to a worsening of PTSD symptoms, and iii) the mean confidence in, and number of, different trauma-focused and non-trauma-focused therapies, and the mean of the highest rated confidence in trauma-focused and non-trauma-focused therapies.

T-tests compared participants who reported retraumatisation and those who did not on i) total endorsement of PSoR, ii) confidence in, and number of, trauma-focused and non-trauma-focused therapies used for PTSD, and iii) fear of retraumatisation. T-tests were also used to compare participants who routinely used trauma-focused therapies for PTSD and those who did not on fear of retraumatisation. Correlations were conducted on fear of retraumatisation with i) total endorsement of PSoR and ii) highest confidence in trauma-focused and non-trauma-focused therapy. We ran follow-up regression analyses on highest trauma-focused confidence with the variables i) working at a Traumatic Stress Service and ii) being in training or qualified. Correlations were also conducted on highest confidence in trauma-focused and non-trauma-focused therapies and PSoR. As a post hoc analysis, we explored whether there were differences between professional groups by running a series of one-way ANOVAs.

Anonymised study data are available openly available in Open Science Framework at https://osf.io/5q4hj/. Analytic code is available on request. Statistical analysis was conducted using IBM SPSS Statistics Version 28 (I.B.M. Corp, 2021). Alpha level was set at .05 for all statistical analyses, and all significance testing was two-tailed.

3. Results

3.1. Sample characteristics

The participants were predominantly female, White British, aged 26–35, with a master's degree (44.8 %) or doctoral degree (42.8 %; Table 2). Most participants identified their "core professional

Table 1
Professional group descriptions.

Category for data analysis	Job title in the NHS	Years of training for qualification	Qualification requirement
Clinical psychologist	Clinical psychologist	3	Doctorate in Clinical Psychology
CBT Therapist	CBT Therapist	1	Postgraduate diploma in CBT
Other Professional	Practitioner Psychologists		
	Counselling psychologist	3 or more	Doctorate in Counselling Psychology or BPS Qualification in Counselling Psychology
	Health psychologist	Variable	Doctoral-level qualification (e.g. PhD) in health psychology
	Forensic psychologist	3 or more	Doctorate in Forensic Psychology or evidence supervised practice
Other Professional	Clinical Associate in Psychology	18 months	Apprenticeship leading to a Master's qualification
Other Professional	Adult Psychotherapist	4	Doctorate accredited by the United Kingdom Council for Psychotherapy, the Association of Child Psychotherapists or the British Psychoanalytic Council
Other Professional	Nurse	3	Undergraduate degree course or Degree Apprenticeship

Note. Further descriptions of core professions in the NHS can be found on the Psychological Professions Network (https://ppn.nhs.uk/resources-url/careers-map) and the NHS Health Careers website (https://www.healthcareers.nhs.uk/explore-roles/psychological-therapies/roles-psychological-therapies).

Table 2
Sample demographic characteristics.

	Total sample (n = 348), n (%)	
Age		
18 – 25	23	(6.6)
26 – 35	189	(54.3)
36 – 45	86	(24.7)
46 – 55	39	(11.2)
56 – 65	9	(2.6)
66 +	2	(0.6)
Gender identity		
Female	292	(83.9)
Male	54	(15.5)
Non-binary	2	(0.6)
Ethnic group		
Asian/Asian British	16	(4.6)
Black/Black British/ Caribbean/ African	4	(1.2)
Mixed/multiple ethnic groups	8	(2.3)
White British	256	(73.6)
Any other White background	58	(16.7)
Any other	6	(1.7)
Highest completed education level[a]		
Below BSc	4	(1.2)
BSc/equivalent	34	(9.8)
Certificate of Higher Education/equivalent	4	(1.2)
MSc/equivalent	156	(44.8)
Doctorate/equivalent	149	(42.8)
Core professional background[c]		
Clinical Psychologist	173	(49.7)
CBT Therapist	76	(21.8)
Practitioner Psychologists (i.e., Counselling/Forensic/Health)	18	(5.2)
Clinical Associates in Psychology	19	(5.5)
Adult Psychotherapist	11	(3.2)
Nurse	10	(2.9)
Professional groups with fewer than 10 participants (e.g., Occupational Therapists, Psychiatrists, Social Workers)	41	(11.8)
Number of patients with PTSD worked with in the previous six months using trauma-focused therapy[b]		
≤ 2	84	(25.1)
3 – 9	166	(49.7)
≥ 10	84	(25.1)

[a] Missing data $n = 1$
[b] Missing data $n = 14$
[c] Descriptions of these core professions can be found in Table 1.

background" (even if in training) as Clinical Psychologist (49.7 %) or CBT Therapist (21.8 %; Table 2). Of those reporting their "core professional background" qualification status ($n = 314$), 66.6 % ($n = 209$) were qualified, with a mean of 7.5 years (SD=7.3) practising since qualification; 33.4 % were in training with a mean of 1.9 years (SD=1.4) in training. Participants reported working with a mean of 7.8 patients

(standard deviation=11.0) with PTSD using trauma-focused therapy in the prior six months to participation, and a breakdown of the number of patients with PTSD worked with is shown in Table 2.

Participants worked with a variety of populations (adult, 82.5 %; older adult, 20.4 %; child and adolescent, 17.8 %; youth, 6.3 %) and in various NHS settings (outpatient, 66.7 % [i.e. community teams/ specialist outpatient e.g. perinatal, outpatient eating disorder, etc.]; NHS Talking Therapies, 22.7 % [a UK-wide NHS service that offers evidence-based psychological therapies for depression and anxiety disorders only]; inpatient, 14.4 %; specialist trauma service, 8.1 %; staff wellbeing, 4.6 %; crisis, 2.0 %; day patient, 2.0 %) with 25.0 % of participants reporting working with multiple populations and 23.0 % in multiple settings.

3.2. Potential signs of retraumatisation

Table 3 shows clinicians' ratings of PSoR, separated by in-session and after-session, ordered by the mean endorsement, and the number of participants that endorsed the item ≥ 50 (out of 100). The table also shows the total sum endorsement of all potential retraumatisation signs (0–1100; mean score of all ratings summed together for each participant). For the total sample, the most strongly endorsed item was an increase in behaviours relating to risk to self; this item was also the most commonly endorsed sign.

We compared participants who reported having witnessed retraumatisation and those who did not on endorsement of PSoR, and this data is shown in Table 3. Participants who reported witnessing retraumatisation had a significantly higher total endorsement of PSoR (M=469.3, SD=258.4) compared to those who reported not witnessing retraumatisation (M=300.6, SD=240.4; $t(294) = 4.25, p < .001, d$= .69 [95 % CI .37, 1.02]).

There was a main effect of professional group on mean total endorsement of PSoR ($F_{2,313}$ =15.6, $p < .001$, see Supplementary Material B); post hoc tests revealed a significant difference between Other Professionals and Clinical Psychologists as well as CBT Therapists.

3.3. Reported incidences of retraumatisation

We categorised participants by those who witnessed retraumatisation ($n = 45$) and those who did not witness retraumatisation ($n = 264$). Of the 2618 patients whom participants reported they had treated for PTSD in the past 6 months, participants reported that therapy had been harmful or led to a worsening of PTSD symptoms in 89 patients (3.4 %). These 89 patients were reported by 42 participants (12.1 %, missing data=17 including three participants who witnessed retraumatisation), with 24 participants who had witnessed this in one patient, seven in two patients, five in three patients, and the remaining six participants who

Table 3
Participants' ratings of possible signs of retraumatisation.

	Total sample N = 315[a]				Reported witnessing retraumatisation[a] N = 44[b]				Did not report witnessing retraumatisation[a] N = 252[c]			
			Endorsing ≥ 50				Endorsing ≥ 50				Endorsing ≥ 50	
	M (/100)	(SD)	N	%	M (/100)	(SD)	N	%	M (/100)	(SD)	N	%
In a session												
Tearful	9.3	(16.1)	11	3.5	18.9	(23.8)	4	9.1	8.0	(14.1)	7	2.8
Flashback	26.6	(28.2)	64	21.3	43.0	(32.3)	17	38.6	23.2	(26.7)	41	16.3
Zoning out/dissociating	28.3	(27.2)	67	20.6	45.2	(33.1)	21	47.7	25.4	(25.7)	44	17.5
Panic attack	28.9	(28.0)	65	20.3	43.8	(32.2)	17	38.6	26.2	(26.6)	44	17.5
After a session												
Feeling more anxious	25.7	(26.4)	66	21.0	38.8	(29.1)	16	36.4	22.7	(25.3)	43	17.1
More nightmares	28.2	(27.8)	69	24.1	41.7	(28.4)	18	40.9	24.7	(26.4)	41	16.3
Feeling jumpier	28.4	(27.9)	76	22.9	40.8	(28.9)	17	38.6	25.5	(27.6)	52	20.6
More flashbacks	28.6	(28.1)	72	21.9	41.7	(31.5)	16	36.4	25.4	(27.3)	46	18.3
Increased substance use	40.4	(31.0)	119	37.8	49.3	(30.1)	22	50.0	37.1	(30.8)	83	32.9
Not attending sessions	41.5	(21.7)	130	41.3	51.3	(31.8)	23	52.3	38.4	(31.2)	92	36.5
Increase in behaviours relating to risk to self	46.9	(33.2)	148	47.0	54.9	(32.3)	22	50.0	44.2	(33.2)	111	44.0
Total (0 −1100)	332.9	(247.5)	68[d]	21.5[e]	469.3	(258.4)	19[d]	43.2[e]	300.6	(240.4)	43[d]	17.1[e]

Note. Although the question on PSoR was after the questions on whether they had witnessed retraumatisation, 19 participants reported that they had not treated any patients with PTSD in the past 6 months; hence, they were not categorised by the "witnessed retraumatisation" variable yet they were included in the main analysis of PSoR.
[a] Missing data $n = 33$ (exited survey before questions on PSoR)
[b] Missing data $n = 1$ (reported witnessed retraumatisation but then exited survey before questions on PSoR)
[c] Missing data $n = 12$ (reported did not witness retraumatisation but then exited survey before questions on PSoR)
[d] N Total ≥ 550
[e] % Total ≥ 550

had witnessed this in four or more patients. There was no significant effect of professional groups on the proportion of the caseload in which retraumatisation was reported ($F_{2,328} =2.67, p = .070$; see Supplementary Material B).

3.4. Use of, and confidence in, trauma-focused and non-trauma-focused therapies

Participants reported routinely offering and using a mean of 2.4 (SD=1.5) TF therapies and 3.9 (SD=3.3) non-TF therapies to treat PTSD (Table 4). Routinely integrating psychological therapies was reported by 77.9 % of participants. TF-CBT was the most commonly endorsed TF therapy, with 68.7 % of all participants routinely offering and using it to treat PTSD. Therapies that are considered different forms of TF-CBT were also commonly endorsed, and when TF-CBT was removed, CT-PTSD was the most commonly endorsed TF therapy (56.9 % of participants). CBT was the most commonly endorsed non-TF therapy (85.6 % of participants). The mean confidence of the most strongly endorsed TF therapy (M=68.7, SD=24.5) was similar to that of non-TF therapy (M=66.0, SD=23.1). When CBT was removed from the non-TF therapies, the mean confidence on the most strongly endorsed of the remaining non-TF therapies was 57.9 (SD=33.6).

There was no significant difference between professional groups in the highest confidence in TF ($F_{2,295} = 2.16, p = .12$) or non-TF therapies ($F_{2,345} =.85, p = .43$; see Supplementary Material A).

Highest confidence in TF therapies was similar between participants who had witnessed retraumatisation (M=74.0, SD=17.8, $n = 37$) and those who had not (M=76.0, SD=19.7, $n = 239$; $t(274) = −.58, p < .28, d= −.10$). Further, there was no significant difference in the number of TF therapies endorsed between participants who had witnessed retraumatisation (M=2.7, SD=2.0, $n = 45$) and those who did not (M=2.5, SD=1.6, $n = 264$; $t(207) = .87, p < .19, d= .14$). Highest confidence in non-TF therapies was also similar between participants who had witnessed retraumatisation (M=67.1, SD=41.2, $n = 45$) and those who had not (M=69.3, SD=39.7, $n = 264$; $t(307) = −.35, p < .37, d= −.06$). However, participants who witnessed retraumatisation reported offering significantly more modalities of non-TF therapies (M=6.8, SD=4.4, $n = 43$) compared to those who did not (M=3.5, SD=2.9, $n = 264$; $t(307) = 5.60, p < .001, d= .90$ [95 % CI .58, 1.23]).

There was a significant negative relationship between total endorsement of PSoR and highest confidence in TF therapies ($r = −.25$ [95 % CI −.36, −.14]; Table 5), i.e. endorsing more PSoR was associated with poorer confidence in treating PTSD using TF therapies. However, there was no significant relationship between PSoR and highest confidence in non-TF therapies ($r = .02$ [95 % CI −.10,.13]).

3.5. Fear of retraumatisation during trauma-focused therapy for PTSD

The sample mean fear of retraumatisation was 30.3 ($N = 335$, SD=23.4); 78 participants (23.3 %) reported a fear of retraumatisation equal to or over 50 (out of 100). There was a main effect of profession on fear of retraumatisation ($F_{2332}=5.99, p = .003$, partial $\eta^2 =.035$ [95 % CI .005,.078]); post-hoc tests revealed that CBT therapists (M=23.2, SD=21.6, $n = 74$) had a significantly lower fear of retraumatisation than Other Professionals (M=35.5, SD=26.0, $n = 95$). Clinical Psychologists (M=30.5, SD=21.8, $n = 166$) did not differ from the other groups (see Supplementary Material B).

There was a significant positive correlation between fear of retraumatisation and total endorsement of PSoR ($r = .59$ [95 % CI .51,.66]; Table 5). Participants who witnessed retraumatisation had a significantly higher mean fear of retraumatisation (M=47.4, SD=25.9, $n = 45$) compared to those who had not witnessed retraumatisation (M=26.7, SD=21.4, $n = 264$; $t(307) = 5.82, p < .001, d= .94$ [95 % CI .61, 1.26]).

Participants who routinely offer and use TF therapies for PTSD had a significantly lower mean fear of retraumatisation (M=29.1, SD=23.0, $N = 289$) compared to participants who do not routinely offer and use TF therapies for PTSD (M=37.8, SD=24.3, $N = 46$; $t(333) = −2.36, p < .019, d= .37$ [95 % CI .69,.06]). Taking only participants who routinely use TF therapies, there was a significant negative correlation between fear of retraumatisation and the highest confidence in TF therapy ($r = −.28$ [95 % CI −.38, −.17]; Table 5); follow-up regression analyses confirmed that this relationship remained even when controlling for working in a Traumatic Stress Service ($p = .93$) or being in training vs qualified in core professional background ($p = .34$).

4. Discussion

This study aimed to gain an understanding of the concept of

Table 4
Confidence in trauma-focused (TF) and non-trauma-focused (non-TF) therapies.

Variable	Total sample				Reported witnessing retraumatisation				Did not report witnessing retraumatisation				Reported witnessing RT v not witnessing RT	
	N = 348				n = 45[c]				n = 264[c]					
	M	(SD)	n	%	M	(SD)	n	%	M	(SD)	n	%	t	p
Confidence: TF														
TF-CBT[a]	68.7	(24.5)	239	68.7	67.4	(24.7)	28	62.2	70.7	(26.0)	193	73.1		
CT-PTSD	65.6	(24.2)	198	56.9	53.3	(21.4)	26	57.8	69.5	(27.5)	160	60.6		
EMDR	64.4	(29.1)	131	37.6	56.6	(30.6)	18	40.0	66.3	(33.3)	105	39.8		
Exposure	59.7	(25.0)	130	37.4	57.0	(22.4)	23	51.1	60.9	(30.9)	100	37.9		
PE	54.1	(28.0)	68	19.5	47.7	(22.5)	13	28.9	55.7	(34.8)	52	19.7		
CPT	44.8	(32.4)	48	13.8	46.9	(27.2)	15	33.3	45.1	(35.0)	32	12.1		
NET[b]	75.3	(13.6)	22	6.3	60.0	-	1	2.2	76.6	(20.2)	19	7.2		
Most strongly endorsed TF	74.6	(20.3)	298	85.6	74.0	(17.8)	37[d]	82.2	76.0	(19.7)	239[e]	90.5	−.58	< .28
N TF therapies endorsed	2.4	(1.5)	348	100	2.7	(2.0)	45	100	2.5	(1.6)	264	100	.87	< .19
N did not endorse any TF therapies			50	14.4			8	17.8			25	9.5		
Confidence: non-TF														
CBT	66.0	(23.1)	298	85.6	57.0	(26.3)	40	88.9	68.8	(23.7)	227	86.0		
CFT	58.7	(24.6)	214	61.5	51.5	(26.8)	33	73.3	60.2	(27.1)	163	61.7		
ACT	47.8	(23.6)	161	46.3	44.0	(25.0)	28	62.2	48.5	(26.3)	116	43.9		
Narrative	51.9	(26.3)	109	31.3	52.0	(32.9)	23	51.1	52.2	(27.7)	73	27.7		
MBT	47.5	(29.5)	95	27.3	42.0	(25.3)	23	51.1	48.8	(33.5)	62	23.5		
Group therapy	54.0	(26.2)	74	21.3	46.9	(29.6)	20	44.4	57.5	(33.3)	47	17.8		
Person-centred	60.9	(29.3)	72	20.7	61.0	(26.3)	17	37.8	61.1	(36.8)	50	18.9		
CAT	42.1	(27.7)	73	21.0	35.0	(25.5)	17	37.8	47.2	(32.1)	47	17.8		
Family therapy	45.7	(28.5)	65	18.7	46.5	(28.8)	22	48.9	45.9	(20.1)	35	13.3		
Counselling	56.8	(31.8)	61	17.5	56.2	(28.1)	18	40.0	56.5	(38.0)	35	13.3		
Art therapy	39.2	(31.4)	28	8.0	43.5	(28.4)	13	28.9	37.9	(29.2)	14	5.3		
Psychodynamic	37.5	(27.3)	56	16.1	43.4	(24.6)	17	37.8	36.9	(29.0)	34	12.9		
Music therapy	45.4	(34.5)	21	6.0	52.2	(32.2)	10	22.2	43.0	(30.9)	10	3.8		
Drama therapy	42.1	(35.4)	21	6.0	41.5	(29.9)	8	17.8	45.8	(33.3)	12	4.5		
DBT[b]	73.6	(10.7)	8	2.3	70.0	(17.8)	3	6.7	75.8	(10.4)	5	1.9		
Most strongly endorsed non-TF	76.0	(19.3)	329	94.5	74.8	(25.1)	43	95.6	76.6	(24.0)	253	95.8	−.35	< .37
N non-TF therapies endorsed	3.9	(3.3)	348	100	6.8	(4.4)	43	95.6	3.5	(3.1)	264	100	5.60	< .001
N did not endorse any non-TF therapies			19	5.5			2	4.4			11	4.2		

Note. Percentages are calculated excluding missing data. We did not define the therapy modalities. ACT = Acceptance and Commitment Therapy; CAT = Cognitive Analytic Therapy; CBT = Cognitive Behavioural Therapy; CFT = Compassion Focused Therapy; CPT = Cognitive Processing Therapy; CT-PTSD = Cognitive Therapy for PTSD (a memory focused type of TF-CBT); DBT = Dialectic Behavior Therapy; EMDR = Eye Movement Desensitization and Reprocessing; MBT = Mentalization Based Therapy; NET = Narrative Exposure Therapy; non-TF = non-trauma-focused; PE = Prolonged Exposure; TF = trauma-focused.

[a] TF-CBT is an umbrella term used for interventions including CPT, CT-PTSD, NET, and PE.

[b] NET and DBT were added as frequently endorsed by participants as 'other' therapy.

[c] Missing data n = 39 (n exited survey early=13, n reported no PTSD patients in past 6 months=26).

[d] Of the 45 participants who did witness retraumatisation, n = 8 reported to not routinely offer or use any TF therapy modalities.

[e] Of the 264 participants who did not witness retraumatisation, n = 25 reported to not routinely offer or use any TF therapy modalities.

retraumatisation, estimate its prevalence through a specified definition and relate this to clinicians' confidence in trauma-focused psychological interventions.

4.1. How clinicians recognise retraumatisation

Regarding the PSoR, items relating to increased risk to self and decreased therapy attendance had the highest mean endorsement (at least 40 out of 100) and were rated as more indicative of retraumatisation than increased PTSD symptoms during and after sessions. However, there was considerable variation, and therefore little agreement, in the endorsement of each item and the total endorsement of PSoR. For example, although the mean for having a flashback or zoning out in a session was low at 26.6 and 28.3, respectively, over 20 % of participants endorsed these items more than 50 out of 100. Since avoidance of trauma-related reminders is a key symptom of PTSD, perhaps it seems logical to some clinicians that patients experience an increase in symptoms when processing trauma memories, whereas for others, perhaps this is interpreted as a harmful effect of therapy. Such data suggests that clinicians do not have a shared view of retraumatisation in practice. Further, there could be other signs that clinicians recognise as PSoR that we did not include in the items presented in the survey and notably, the PSoR could be explained by factors other than retraumatisation (e.g., decreased therapy attendance has been suggested to be

Table 5
Correlates of confidence in trauma-focused and non-trauma focused therapies.

	Correlation, Pearson's r (n) [95 % CI]	
	3	4
1. Highest confidence in TF therapy[a]	−.28 *** (289) [−.38, −.17]	−.25 *** (273) [−.36, −.14]
2. Highest confidence in non-TF therapy[b]	−.09 (316) [−.20,.02]	.02 (298) [−.10,.13]
3. Fear of retraumatisation	-	.59 *** (316) [.51,.66]
4. Total endorsement of PSoR	-	-

*** p < .001

[a] Uses the highest score endorsed by the participant for any of the trauma-focused therapies.

[b] Uses the highest score endorsed by the participant for any of the non-trauma-focused therapies.

associated with a variety of client and clinician-related factors (Najavits, 2015). This study questions whether retraumatisation is a valid and useful construct and, as a minimum, highlights a need for a better working definition of retraumatisation, with consideration of the perspectives of people who have received trauma-focused therapy.

4.2. Prevalence of retraumatisation

Using the definition of therapy as harmful or leading to a worsening of PTSD symptoms, participants reported retraumatisation in a small minority of patients (3.4 %), and these cases were reported by about 12 % of participants, i.e. the overwhelming majority did *not* report witnessing trauma-focused therapy as harmful in the past six months. It is noteworthy that participants who reported retraumatisation had a higher total endorsement of PSoR compared to those who did not (*d*=.69). This could suggest that those who reported witnessing retraumatisation had a lower threshold for what they considered to be retraumatisation. This suggestion could be further supported by the strong positive correlation between fear of retraumatisation and the total endorsement of retraumatisation signs (*r* = .59) and the finding that participants who reported retraumatisation had a significantly greater fear of retraumatisation (*d*=.94). However, it could also be that all these constructs are associated with a third, unmeasured, characteristic (e.g. clinician neuroticism).

4.3. Clinician confidence

Clinicians' highest confidence in trauma-focused therapy (using their most strongly endorsed) was approximately 75, but this was accompanied by a large amount of variance (*SD*=20.3). A substantial minority of participants (14.4 %) did not endorse using any trauma-focused therapy. Clinician confidence was related in various respects to how they understood retraumatisation; there was a significant negative correlation between participants' highest reported confidence in trauma-focused therapy and total endorsement of PSoR (*r* = −.25) and fear of retraumatisation (*r* = −.28). Although the mean fear of retraumatisation was relatively low (30 out of 100), it was characterised by considerable variation (*SD*=23.4), and over 20 % of participants reported a fear of retraumatisation above or equal to 50. However, this variation could be due to clinician's interpretations of the question regarding how much they worry about trauma-focused therapy being harmful in its own right or leading to a worsening of PTSD symptoms and might not be reflective of their "fear of retraumatisation" if this is understood as a different concept by clinicians.

Although there was no significant difference in the number of trauma-focused therapies offered by participants who reported they had and had not witnessed retraumatisation, those reported retraumatisation offered significantly more types of *non-trauma-focused* therapies (6.8) compared to those who reported they did not witness retraumatisation (3.5, *d*=.90). This could suggest that clinicians who report witnessing retraumatisation are more frequently using non-trauma-focused therapies, potentially as an adjunct to or instead of trauma-focused therapies.

4.4. Clinical implications

The data reported here suggest that retraumatisation, as per our definition, is not common during trauma-focused treatments for PTSD. Further, there was some evidence to suggest that even when it is reported, it may, in part, reflect different clinician interpretations of experiences during PTSD treatment (i.e. the threshold for what might be considered retraumatisation was lower for participants who reported retraumatisation than those who denied observing retraumatisation). There was a large degree of variation in confidence in the trauma-focused therapies recommended by clinical guidelines (e.g. NICE, 2018), suggesting that clinician training to increase confidence in trauma-focused therapies may be warranted. Literature on adverse reactions to therapies has recommended that clinician training should address adverse effects in therapy (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010), and the variation in the endorsement of items relating to PSoR suggests that training should also include information on common patient reactions during trauma-focused treatment.

However, our data suggest that specifically referring to "retraumatisation" may be unhelpful, given the lack of consistency in understanding what it looks like in clinical practice. Other terms may be more useful and potentially less emotive. For example, the incidences of harm criteria outlined by Hoppen, Lindermann & Morina (2022) consisting of i) PTSD symptom exacerbation, ii) aversive but non-lethal events (e.g. increased severity of a comorbid mental health disorder) and iii) more "serious" potentially lethal events (e.g. acute suicidality). Overall, it should be noted that the prevalence of retraumatisation would likely vary with different definitions.

A variety of therapies were reported as being used with patients with PTSD, with a mean of 2.4 trauma-focused and 3.9 non-trauma-focused types of therapy. This study suggests that trauma-focused interventions for PTSD that are recommended by NICE (2018) for healthcare in England are being implemented in the NHS but that other, non-trauma-focused interventions are being routinely used to treat PTSD as well. Despite not providing a definition of integration, routinely integrating different therapies was very common (reported by 77.9 % of participants), and so there is a need to study this aspect of care with people with PTSD. While the use of a range of approaches may reflect a willingness to address a variety of needs (e.g. a comorbid condition), there is also the possibility that it reflects another variable e.g. a lack of confidence or competence to deliver trauma-focused therapies, therapist avoidance or clinician personal characteristics (e.g. heightened neuroticism or conscientiousness). Therefore, it needs to be understood how clinicians are integrating therapies, in particular how this relates to critical therapy components of trauma-focused PTSD treatment (e.g. memory work).

Our study suggests that training efforts on retraumatisation might be usefully focused on Other Professionals (i.e. mental health clinicians who are not CBT Therapists/Clinical Psychologists) in the UK NHS. In terms of professional groups, although there was no significant difference in the highest confidence in TF or non-TF therapies, CBT therapists had a significantly lower fear of retraumatisation than Other Professionals, and Other Professionals had a significantly higher endorsement of PSoR compared to the other professional groups. We suggest that these professionals might receive less training on trauma-focused interventions compared to Clinical Psychologists and CBT Therapists, or other anxiety disorders where a degree of exposure is included in psychological treatment.

4.5. Study strengths, limitations, and future directions

We cannot draw conclusions about the direction of the effects observed in this study, i.e. we cannot establish whether witnessing retraumatisation increases fear of retraumatisation, fear of retraumatisation makes it more likely for a clinician to interpret a reaction as retraumatisation, or whether another factor (e.g. tendency to use or integrate certain therapies, or clinician characteristics) explains both observing and fearing retraumatisation. Similarly, witnessing perceived retraumatisation could make clinicians more aware of the related patient reactions and, therefore, endorse them more highly.

The PSoR were designed for this study and have not been used in previous research. While there was strong internal consistency between the items, and they were developed with a group of experts in PTSD, the measure has not been validated, and there is no research into its psychometric properties. Similarly, we operationalised variables (e.g. fear of retraumatisation, witnessing retraumatisation, and use of and confidence in non-trauma-focused and trauma-focused therapies for PTSD) in novel ways, and so there is no literature to compare our results with.

The study results may be influenced by response bias and self-report bias and may not provide an accurate representation of practice. This could be reflected in the finding that the rate of 3.4 % found in this study of therapy as being harmful or leading to a worsening of PTSD symptoms is lower than the reliable deterioration rate (7.1 %) reported in NHS Talking Therapies for PTSD (NHS Digital, 2022). It is also important to

note that "confidence" in a therapy does not necessarily translate into competence or effective implementation. In future research, it would be useful to understand clinician confidence and competence for PTSD in relation to other mental health disorders.

In terms of participants, since we used a convenience sample, the generalisability of our results may be somewhat limited. For example, there may be a response bias towards the types of clinicians likely to participate. Further, the results may not be generalisable as all the participants worked in the NHS. However, a strength is the representation of professions. Although Clinical Psychologists consisted of roughly 50 % of participants and only 23 % of psychological professionals in the 2023 Workforce Census (NHS Benchmarking Network, 2023), Psychological Wellbeing Practitioners represented 21 % of psychological professionals, and this role does not treat PTSD, potentially explaining the higher representation of Clinical Psychologists.

Lastly, this study only surveyed clinicians, yet the views of people with PTSD who have received trauma-focused therapy for PTSD are key. This is especially important since research has found that therapists can make poor clinical judgments as to whether patients experience adverse effects of therapy (Hatfield, McCullough, Frantz, & Krieger, 2010). Qualitative research with clinicians and people with PTSD who have received trauma-focused therapy would be useful to explore whether there is a difference between potential adverse effects of therapy and retraumatisation. In particular, research into experiences in trauma-focused treatments that are difficult but potentially ultimately beneficial and whether this is viewed as acceptable by people with PTSD. Alongside this, since there is little reporting on adverse impacts during RCTs of psychological therapies (Nutt & Sharpe, 2008), quantitative analysis of routine service data or available data from RCTs could be useful to further define these categories.

5. Conclusion

This study highlights the need for more research to clarify specifically what retraumatisation is as a concept and suggests that, currently, there is not a shared view as to how retraumatisation is understood in practice. We found that confidence in trauma-focused treatments for PTSD is generally high but that there is also a high degree of variation and that fear of retraumatisation is present for at least a significant minority of clinicians. We found that participants reported trauma-focused treatment as harmful or leading to a worsening of PTSD symptoms in a small minority of cases. However, we highlight that the reporting of this may be linked to the interpretation of reactions that could be viewed as PSoR.

Funding statement

CRediT authorship contribution statement

Nick Grey: Writing – review & editing, Methodology. **Gita E. Bhutani:** Writing – review & editing, Methodology. **Kenny Chiu:** Writing – review & editing, Supervision. **Lucy Purnell:** Writing – review & editing, Writing – original draft, Visualization, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization. **Richard Meiser-Stedman:** Writing – review & editing, Visualization, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization. **Sharif El-Leithy:** Writing – review & editing, Methodology.

Declaration of Competing Interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: GB, NG, SE-L and RMS occasionally give paid workshops on CT-PTSD. All other authors declare they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.janxdis.2024.102913.

References

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*, 277–292. https://10.1016/S0005-7967(03)00138-4.

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*, CD003388. https://doi.org/10.1002/14651858.CD003388.pub4

Castonguay, L. G., Boswell, J. F., Constantino, M. J., Goldfried, M. R., & Hill, C. E. (2010). Training implications of harmful effects of psychological treatments. *American Psychologist, 65*(1), 34. https://doi.org/10.1037/a0017330

Deacon, B. J., Farrell, N. R., Kemp, J. J., Dixon, L. J., Sy, J. T., Zhang, A. R., & McGrath, P. B. (2013). Assessing therapist reservations about exposure therapy for anxiety disorders: the Therapist Beliefs about Exposure Scale. *Journal of Anxiety Disorders, 27*(8), 772–780. https://doi.org/10.1016/j.janxdis.2013.04.006

Devilly, G. J., & Foa, E. B. (2001). The investigation of exposure and cognitive therapy: Comment on tarrier et al. (1999). *Journal of Consulting and Clinical Psychology, 69*, 114–116. https://doi.org/10.1037/0022-006X.69.1.114

Duckworth, M. P., & Follette, V. M. (2012). *Retraumatization: Assessment, Treatment, and Prevention.* Routledge. https://doi.org/10.4324/9780203866320

Ehlers, A., Grey, N., Wild, J., Stott, R., Liness, S., Deale, A., Handley, R., Albert, I., Cullen, D., Hackmann, A., Manley, J., McManus, F., Brady, F., Salkovskis, P., & Clark, D. M. (2013). Implementation of Cognitive Therapy for PTSD in routine clinical care: Effectiveness and moderators of outcome in a consecutive sample. *Behaviour Research and Therapy, 51*(11), 742–752. https://doi.org/10.1016/j.brat.2013.08.006

Ehring, T., Welboren, R., Morina, N., Wicherts, J. M., Freitag, J., & Emmelkamp, P. M. (2014). Meta-analysis of psychological treatments for posttraumatic stress disorder in adult survivors of childhood abuse. *Clinical Psychology Review, 34*(8), 645–657. https://doi.org/10.1016/j.cpr.2014.10.004

Finch, J., Ford, C., Grainger, L., & Meiser-Stedman, R. (2020). A systematic review of the clinician related barriers and facilitators to the use of evidence-informed interventions for post traumatic stress. *Journal of Affective Disorders, 263*, 175–186. https://doi.org/10.1080/20008198.2020.1815281

Finch, J., Ford, C., Lombardo, C., & Meiser-Stedman, R. (2020). A survey of evidence-based practice, training, supervision and clinician confidence relating to post-traumatic stress disorder (PTSD) therapies in UK child and adolescent mental health professionals. *European Journal of Psychotraumatology, 11*(1), Article 1815281. https://doi-org.uea.idm.oclc.org/10.1080/20008198.2020.1815281.

Foa, E. B., Zoellner, L. A., Feeny, N. C., Hembree, E. A., & Alvarez-Conrad, J. (2002). Does imaginal exposure exacerbate PTSD symptoms? *Journal of Consulting and Clinical Psychology, 70*(4), 1022–1028. https://doi-org.uea.idm.oclc.org/10.1037/0022-006X.70.4.1022.

Foa, E. B., McLean, C. P., Zang, Y., Zhong, J., Powers, M. B., Kauffman, B. Y., Rauch, S., Porter, K., & Knowles, K. (2016a). Psychometric properties of the posttraumatic diagnostic scale for DSM–5 (PDS–5). *Psychological Assessment, 28*(10), 1166–1171. https://doi.org/10.1037/pas0000258

Foa, E. B., McLean, C. P., Zang, Y., Zhong, J., Rauch, S., Porter, K., Knowles, K., Powers, M. B., & Kauffman, B. Y. (2016b). Psychometric properties of the Posttraumatic Stress Disorder Symptom Scale Interview for DSM–5 (PSSI–5). *Psychological Assessment, 28*(10), 1159–1165. https://doi.org/10.1037/pas0000259

Hamblen, J. L., Norman, S. B., Sonis, J. H., Phelps, A. J., Bisson, J. I., Nunes, V. D., Megnin-Viggars, O., Forbes, D., Riggs, D. S., & Schnurr, P. P. (2019). A guide to guidelines for the treatment of posttraumatic stress disorder in adults: An update. *Psychotherapy, 56*(3), 359–373. https://doi.org/10.1037/pst0000231

Hatfield, D., McCullough, L., Frantz, S. H., & Krieger, K. (2010). Do we know when our clients get worse? An investigation of therapists' ability to detect negative client change. *Clinical Psychology & Psychotherapy, 17*(1), 25–32. https://doi.org/10.1002/c

Health Research Authority. (2017). Applying a proportionate approach to the process of seeking consent. Health Research Authority. 2023 〈https://s3.eu-west-2.amazonaws.com/www.hra.nhs.uk/media/documents/applying-proportionate-approach-process-seeking-consent_R3gbJKn.pdf〉.

Hoppen, T. H., Lindemann, A. S., & Morina, N. (2022). Safety of psychological interventions for adult post-traumatic stress disorder: Meta-analysis on the incidence

and relative risk of deterioration, adverse events and serious adverse events. *British Journal of Psychiatry*, 1–10. https://doi.org/10.1192/bjp.2022.111

I.B.M. Corp. Released 2021. IBM SPSS Statistics for Macintosh, Version 28.0. Armonk, NY: IBM Corp.

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

Lewis, C., Roberts, N. P., Andrew, M., Starling, E., & Bisson, J. I. (2020). Psychological therapies for post-traumatic stress disorder in adults: Systematic review and meta-analysis. *European Journal of Psychotraumatology, 11*(1), Article 1729633. https://doi.org/10.1080/20008198.2020.1729633

Mavranezouli, I., Megnin-Viggars, O., Daly, C., Dias, S., Welton, N. J., Stockton, S., Bhutani, G., Grey, N., Leach, J., Greenberg, N., Katona, C., El-Leithy, S., & Pilling, S. (2020). Psychological treatments for post-traumatic stress disorder in adults: a network meta-analysis. *Psychological Medicine, 50*(4), 542–555. https://doi.org/10.1017/S0033291720000070

Murray, H., & El-Leithy, S. (2022). *Working with Complexity in PTSD: A Cognitive Therapy Approach Taylor & Francis*. https://doi.org/10.4324/9781003288329

Murray, H., Grey, N., Warnock-Parkes, E., Kerr, A., Wild, J., Clark, D. M., & Ehlers, A. (2022). Ten misconceptions about trauma-focused CBT for PTSD. s1754470×22000307 *Cognitive Behaviour Therapy, 15*. https://doi.org/10.1017/S1754470×22000307.

National Institute for Health and Care Excellence. (2018). Post-traumatic stress disorder. Retrieved July 20, 2023 from ⟨https://www.nice.org.uk/guidance/ng116⟩.

Najavits, L. M. (2015). The problem of dropout from "gold standard" PTSD therapies. *F1000prime Reports, 7*, 43. https://doi.org/10.12703/P7-43

NHS Benchmarking Network. (2023). The National Psychological Professions Workforce Census: England workforce data 2022/23. 2024⟨https://www.nhsbenchmarking.nhs.uk/psychological-professions⟩.

NHS Digital. (2022). Psychological Therapies, Annual report on the use of IAPT services, 2021–22. https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2021-22.

Nutt, D. J., & Sharpe, M. (2008). Uncritical positive regard? Issues in the efficacy and safety of psychotherapy. *Journal of Psychopharmacology, 22*(1), 3–6. https://doi.org/10.1177/0269881107086283

Office for National Statistics. (2021). Question development. Office for National Statistics. 2023 ⟨https://www.ons.gov.uk/census/planningforcensus2021/questiondevelopment#:~:text=People%20and%20relationships,overnight%20visitors%20for%20Census%202021⟩.

Schock, K., Rosner, R., Wenk-Ansohn, M., & Knaevelsrud, C. (2010). Retraumatization - A conceptional approach. *Psychotherapie Psychosomatik Medizinische Psychologie, 60* (7), 243–249. https://doi.org/10.1055/s-0030-1248268

Shearing, V., Lee, D., & Clohessy, S. (2011). How do clients experience reliving as part of trauma-focused cognitive behavioural therapy for posttraumatic stress disorder? *Psychology and Psychotherapy: Theory, Research and Practice, 84*(4), 458–475. https://doi.org/10.1111/j.2044-8341.2010.02012.x

Tripp, J. C., Haller, M., Trim, R. S., Straus, E., Bryan, C. J., Davis, B. C., Lyons, R., Hamblen, J. L., & Norman, S. B. (2021). Does exposure exacerbate symptoms in veterans with PTSD and alcohol use disorder? *Psychological Trauma: Theory, Research, Practice, and Policy, 13*(8), 920–928. https://doi-org.uea.idm.oclc.org/10.1037/tra0000634.

World Health Organization. (2022). International Classification of Diseases, Eleventh Revision (ICD-11). Retrieved October 25, 2023 from ⟨https://icd.who.int/⟩.

Zoellner, L. A., Feeny, N. C., Bittinger, J. N., Bedard-Gilligan, M. A., Slagle, D. M., Post, L. M., & Chen, J. A. (2011). Teaching trauma-focused exposure therapy for PTSD: Critical clinical lessons for novice exposure therapists. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*(3), 300–308. https://doi.org/10.1037/a0024642