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Adapting Narrative Exposure Therapy for Autistic Adults Experiencing Traumatic Stress

Sophie Dinsdale, BSc, MSc

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Acknowledgements

"The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma"

Judith Herman, 1992

For the autistic community – a population all too often misunderstood.

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Table of Contents

Page

Journal Paper……..……. 11

Abstract……..…… 13

Background……..…….. 14

Methodology……..……..... 21

Results……..…….. 27

Discussion…….….. 61

References……..…… 70

Extended Paper…… 84

1.0 Extended background…….. 85

2.0 Extended methodology……..…… 122

3.0 Extended results…….. 148

4.0 Extended discussion……...… 182

5.0 Reflections ……. 184

6.0 Extended references ……..… 191

Appendices…….. 228

Poster……..... 294

List of Tables

Page

Table 1: Proposed Adaptations Generated from EBP Responses in Round One…….…….. 31

Table 2: Proposed Adaptations Generated from EBE Responses in Round One……...……..…..... 36

Table 3: Adaptations Rated as Inconsistent but Feasible by NET Experts……..... 51

Table 4: NET for Autistic Adults Experiencing Traumatic Stress – The Adapted Protocol……..…….. 56

Table 5: ADAPT Guidance Checklist…… 116

Table 6: Applying the Delphi Method to Psychological Treatment Adaptation, adapted from King et al. (2021)…… 131

Table 7: Experts by Profession Demographics……... 148

Table 8: Experts by Experience Demographics……... 149

Table 9: Expert Ratings on the Helpfulness of Potential Adaptations……. 151

Table 10: Expert by Profession Proposed Adaptations – Clarification Requirements……. 152

Table 11: Expert by Experience Proposed Adaptations - Clarification Requirements……. 158

Table 12: Clarifications on Ambiguous or Subjective Adaptations……. 162

Table 13: Important Adaptations - Adaptations Reaching ≥80% Consensus in Both Expert Groups…… 175

Table 14: Potentially Important Adaptations for Some Autistic Adults - Adaptations Meeting Consensus in One Expert Group……..…. 178

List of Figures

Page

Figure 1: Study Process and Participant Contribution……. 28

Figure 2: EBP Ratings in Round 2…….. 40

Figure 3: EBE Ratings in Round 2…….. 41

Figure 4: NET Expert Ratings of the Proposed Adaptations……...… 45

Figure 5: EBP Ratings of EBE Proposed Adaptations…… 171

Figure 6: EBE Ratings of EBP Proposed Adaptations…… 173

List of Appendices

Page

Appendix A: Submission Guidelines for the Journal of Autism and Developmental Disorders…….. 229

Appendix B: ADAPT Guidance (Moore et al., 2021)…….,……. 230

Appendix C: Participant Advertisement Email: Experts by Profession……...… 231

Appendix D: Participant Advertisement Poster: Experts by Profession…….. 232

Appendix E: Participant Information Sheet: Experts by Profession……..... 233

Appendix F: Participant Consent Form: Experts by Profession…….. 238

Appendix G: Participant Advertisement Email: Experts by Experience……. 240

Appendix H: Participant Advertisement Poster: Experts by Experience……..... 241

Appendix I: Participant Information Sheet: Experts by Experience…… 242

Appendix J: Participant Consent Form: Experts by Experience…….. 247

Appendix K: Participant Advertisement Email: NET Experts……..... 249

Appendix L: Participant Advertisement Poster: NET Experts……..... 250

Appendix M: Participant Information Sheet: NET Experts……..... 251

Appendix N: Participant Consent Form: NET Experts……. 256

Appendix O: Stage One Round One Questionnaire – Experts by Profession……..… 258

Appendix P: Stage One Round One Questionnaire – Experts by Experience……. 267

Appendix Q: Focus Group Topic Guide – NET Experts……. 276

Appendix R: Ethical Approval……. 277

Appendix S: Qualitative Content Analysis Coding Schedule – Proposed Adaptations……. 278

Appendix T: Qualitative Content Analysis Coding Schedule – Adaptations Requiring Clarification…….. 280

Appendix U: Qualitative Content Analysis Coding Schedule – NET Expert Focus Group…….…….. 281

Appendix V: Duplicated Proposed Adaptations Between Groups …….……. 282

Appendix W: EBP Near-Consensus Adaptations, Re-rated in Round Three…….…….. 283

Appendix X: EBE Near-Consensus Adaptations, Re-rated in Round Three…… 284

Appendix Y: Sensitivity Analysis……. 285

Appendix Z: ADAPT Guidance Framework……. 288

Appendix AA: ADAPT Reporting Guidelines for Adapted Interventions…… 289

Appendix BB: Ethical Approval – Amendment…… 290

Appendix CC: Data Management Plan……. 291

Portfolio Abstract

Introduction

Autistic individuals are at an elevated risk of exposure to multiple traumatic events and subsequent traumatic stress. A body of literature is emerging to suggest that adaptations to psychological therapy can be helpful for autistic clients. Whilst advancements have been made in understanding how trauma-focused therapies such as cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing therapy (EMDR) can be adapted for this population, the evidence base for therapies that are more suited to treating traumatic stress resulting from cumulative traumatic experiences is less established. Such therapies include narrative exposure therapy (NET), a trauma-focused therapy recommended by the National Institute for Health and Care Excellence; however, despite the elevated risk of cumulative traumatic events in this population, its use with autistic adults remains unexplored.

Aims

This study aimed to adapt NET for use with autistic adults by consulting with experts by profession (EBP) and experts by experience (EBE). Once adaptations had been made, the study aimed to explore whether the adapted protocol was consistent with the principles of NET and feasible in practice.

Methods

The study comprised two stages. Stage One involved a three-round e-Delphi study, where EBE (n = 15) and EBP (n = 15) completed three online questionnaires. During Round One, EBE and EBP provided their views on how NET could be adapted. In Rounds Two and

Three, they rated the importance of the adaptations that had been proposed. Adaptations that were endorsed as important by ≥80% of participants were included in the adapted protocol. Stage Two involved an online survey and focus group with NET experts (n = 3), who rated each of the proposed adaptations' consistency with the principles of NET and feasibility in practice.

Results

Following the initial round in Stage One, analyses identified 76 adaptations from EBP responses and 54 from EBE responses. Following two further rounds, consensus was achieved on 28 adaptations in both expert groups and were subsequently included in the adapted protocol as important adaptations. A further 27 adaptations achieved consensus in one expert group but not the other and were included in the adapted protocol as potentially important adaptations for some autistic adults. Following Stage Two, the NET expert group agreed for one adaptation to be excluded due to it being inconsistent with the principles of NET and thus infeasible in practice. A further six adaptations were amended to improve consistency and feasibility.

Conclusions

The study identified 54 adaptations that may guide the delivery of NET with autistic clients. The adapted protocol builds upon the existing body of literature towards more inclusive trauma-focused therapy and warrants further refinement and piloting to assess the feasibility of NET for autistic adults in practice.

Statement of Contribution

- Project design: Sophie Dinsdale, Professor Thomas Schröder, Dr Rohan Naidoo, Dr Mark Hudson, Dr Sarah Wilde
- Application for ethical approval: Sophie Dinsdale
- Recruiting participants: Sophie Dinsdale
- Data collection and analysis: Sophie Dinsdale under the supervision of Professor Thomas Schröder and Dr Mark Hudson
- Write-up: Sophie Dinsdale under the supervision of Professor Thomas Schröder and Dr Mark Hudson

Journal Paper

Formatted in preparation for submission to 'Autism' in 'Frontiers in Psychiatry'

(see Appendix A for journal submission guidelines)

Adapting Narrative Exposure Therapy for Autistic Adults Experiencing Traumatic Stress

Sophie Dinsdale, Thomas Schröder, Mark Hudson

Department of Mental Health and Clinical Neurosciences,

School of Medicine,

University of Nottingham

Corresponding author: Thomas Schröder, Mental Health and Clinical Neurosciences Unit, School of Medicine, University of Nottingham, C16, Institute of Mental Health, Jubilee Campus, Triumph Road, Nottingham, NG7 2TU, United Kingdom, thomas.schroder@nottingham.ac.uk, ORCID: 0000-0002-6466-4960

Author Note

The authors have no conflicts of interest.

Abstract

Introduction

Autistic individuals are at an elevated risk of exposure to traumatic events and subsequent traumatic stress. Narrative Exposure Therapy (NET) is recommended for the treatment of traumatic stress, buts its use with autistic adults remains unexplored. This study aimed to identify potential adaptations to NET for this population.

Methods

The study comprised two stages. Stage one was a three-round e-Delphi study, where experts by experience (EBE) (n = 15) and experts by profession (EBP) (n = 15) shared their views on important adaptations to NET for autistic adults. Adaptations endorsed by ≥80% of participants were included in the adapted protocol. Stage two involved an online survey and focus group with NET experts (n = 3), who rated each adaptation's consistency with NET, with further discussion around disputed adaptations.

Results

Analyses identified 76 adaptations from EBP responses and 54 from EBE responses. Consensus for importance was reached by both groups on 28 adaptations, and by one group on 27 further adaptations. Following NET expert consultation, one adaptation was excluded as inconsistent and infeasible, and six were amended.

Conclusion

The study identified 54 potential adaptations to guide the delivery of NET with autistic adults. The adapted protocol builds upon the existing body of literature towards more

inclusive trauma therapy and now warrants further refinement and piloting to assess feasibility in practice.

Keywords: Autism Spectrum Disorder, Post-traumatic Stress Disorder, Trauma-focused Therapy, Narrative Exposure Therapy

Background

Autism

Autism[1] is a neurodevelopmental condition characterised by differences in social communication and interaction, alongside the presence of repetitive and restrictive behaviours[2] (American Psychiatric Association, 2013a; World Health Organization, 2022). It is often associated with challenges in cognitive and behavioural flexibility (Petrolini et al., 2023), differences in sensory sensitivity and processing (Robertson & Baron-Cohen, 2017), and difficulties with emotional regulation (Mazefsky, et al., 2013). Given its onset in the early developmental period (Harris, 2018; Wolff, 1991) and the notion that early diagnosis and support can improve outcomes (NICE, 2021), autism has historically been viewed as a paediatric condition (O'Nions et al., 2023). Consequently, clinical and research efforts have focused on childhood recognition and intervention (Lai & Baron-Cohen, 2015), contributing to a limited understanding of autism in adulthood[3] (Howlin, 2021; Wise, 2020). Only recently has research begun to explore outcomes in adulthood (Huang, et al., 2020), with increasing attention to the high rates of co-occurring mental health conditions in this population[4] (Buck et al., 2014; Russell et al., 2016; Underwood et al., 2023).

Psychological Trauma

An event can be described as traumatic when the individual experiencing it appraises it as deeply distressing or threatening (Kerns et al., 2022). Where the individual's ability to respond to the threat is overwhelmed, the resulting psychological injury – traumatic stress – can significantly impair emotional functioning and the capacity to cope (Allen, 2008; Levine,

[1] See extended paper 1.1
[2] See extended paper 1.2
[3] See extended paper 1.3
[4] See extended paper 1.4

2005). When this is pervasive and lasts for more than one month, it may be described as post-traumatic stress disorder (PTSD) (American Psychiatric Association, 2013b). PTSD is characterised by intrusive and involuntary recollections of the event, leading the individual to feel as though they are experiencing the event in the present moment. This contributes to negative alterations in mood and cognition and heightened rates of physiological arousal. To manage this, the individual may engage in behaviours that are avoidant and reinforce their distress in the long term, such as persistent avoidance of related stimuli. To meet diagnostic criteria for PTSD, the individual must fulfil the criteria outlined above as well as additional diagnostic requirements[5]. As such, not all experiences of traumatic stress will be described as PTSD, hence the use of the terminology 'traumatic stress' in the present study.

Trauma in the Context of Autism

It is well documented in the research literature that autistic individuals are more vulnerable to adverse experiences than non-autistic individuals[6] (Peterson et al., 2019; Rumball, 2019; Stack & Lucyshyn, 2019). These experiences include, but are not limited to, events typically recognised as traumatic – such as interpersonal victimisation (Pearson et al., 2022; Trundle et al., 2023) – and events not typically perceived as traumatic by non-autistic individuals – such as sensory overwhelm, disruptions to routine, and difficulties navigating social environments (Kerns et al., 2022; Rumball et al., 2021).

These challenges are frequently compounded by societal misunderstandings and a lack of appropriate support, further intensifying their impact (Turnock et al., 2022). The cumulative effect of repeated stressors, particularly in a population who may already experience

[5] See extended paper 1.5
[6] See extended paper 1.6

difficulties with self-regulation and sense-making (Cai et al., 2023; Maiese, 2021), may result in the chronic activation of the stress response (Chu et al., 2025), thereby increasing susceptibility to adverse events, threat appraisal, and traumatic stress (Bishop-Fitzpatrick et al., 2015; Lobregt-van Buuren et al., 2021). Despite this, traumatic stress often goes unrecognised and undiagnosed in autistic individuals[7] (Rumball, 2019). When considered alongside the limited research on effective treatments for traumatic stress in this population (Quinton et al., 2024), this underscores a significant gap in care and illustrates how autistic individuals are frequently underserved and at heightened risk of unmet psychological needs (Bradshaw et al., 2019).

Trauma-focused Psychological Therapy in the Context of Autism

The National Institute for Health and Care Excellence (NICE, 2018a) outlines individual trauma-focused cognitive behavioural therapy (CBT) as the first-line treatment for traumatic stress. Recommended modalities within this include cognitive processing therapy, cognitive therapy, narrative exposure therapy, and prolonged exposure therapy[8]. However, these recommendations are applied universally, irrespective of neurodevelopmental profile. This is despite the underlying evidence base being derived predominantly from studies involving non-autistic populations (NICE, 2018b).

Given the distinct cognitive, communicative, and sensory profiles often associated with autism (Ousley & Cermak, 2014), it is plausible that autistic individuals may benefit from a tailored therapeutic approach. A number of studies have explored how CBT (Carrigan & Allez, 2017; Dempsey & Ha, 2017; Gerhardt & Smith, 2020) and EMDR (Barol & Seubert,

[7] See extended paper 1.7
[8] See extended paper 1.8

2010; Kosatka & Ona, 2014; Mevissen et al., 2011) may be adapted for autistic clients experiencing traumatic stress[9]. The reported adaptations include the use of standardised measures to probe for emotional expression (Kosatka & Ona, 2014), spending additional time on building therapeutic rapport (Barol & Seubert, 2010), and placing a greater emphasis on stabilisation early in therapy (Dempsey & Ha, 2017; Barol & Seubert, 2010). While not all studies evaluated treatment outcomes, those that did reported reductions in trauma-related symptoms (Barol & Seubert, 2010; Carrigan & Allez, 2017; Gerhardt & Smith, 2020; Kosatka & Ona, 2014; Mevissen et al., 2011), suggesting that with adaptation, trauma-focused therapies are effective for this population.

Whilst these studies show promise, the methodologies employed – primarily case studies and case series – involved the application of adaptations in an unsystematic manner. Although this reflects common clinical practice and acknowledges the value of flexibility in maintaining a client-centred approach, it can compromise treatment fidelity and consistency by deviating from empirically validated protocols (Bennett & Shafran, 2023), potentially limiting therapeutic efficacy (McHugh et al., 2009; von Thiele Schwarz et al., 2021). Consequentially, there is a need for therapy adaptations to be developed through more systematic and structured processes that incorporate stakeholder perspectives and include an assessment of fidelity to the core treatment model (Movsisyan et al., 2021; Chlebowski et al., 2020; Treichler et al., 2022).

Narrative Exposure Therapy

Narrative Exposure Therapy (NET) is a trauma-focused therapy suitable for individuals who have experienced multiple traumas (Schauer et al., 2011). In NET, the client constructs a

[9] See extended paper 1.9

chronologically elaborated narrative of their life with a focus on their traumatic experiences[10] (Elbert et al., 2015). NET builds upon testimonial therapy[11] (Cienfuegos & Monelli, 1993) – where the client repeatedly discusses the event to construct an in-depth, coherent narrative – and allows for the process of exposure and habituation[12] (Marks, 1978; Pavlov, 1927), where the individual becomes accustomed to the memories of the event and their experience of this in the here-and-now, thus reducing the intensity of distress associated with the memory (Schauer et al., 2011). NET also integrates theories of autobiographical integration[13] (Schauer et al., 2017,) where the individual reconstructs their memories of the event in detail so they can be integrated into their autobiographical memory, rather than their situationally accessible memory where memories remain fragmented and rich in sensory and emotional detail (i.e., dual representation theory)[14] (Brewin et al., 1996), leading to trauma becoming 'stuck' within a fear structure (i.e., emotion processing theory)[15] (Foa & Kozak, 1986).

The evidence base[16] for NET is growing (Lely et al., 2019) and studies suggest sustained treatment results (Siehl et al., 2021) and lower dropout rates than other trauma-focused therapies (Varker et al., 2021). NET has been adapted for use with various populations including children[17] (KIDNET; Westby, 2020), individuals with intellectual disability[18] (IDNET; Marlow et al., 2022), and forensic offender rehabilitation[19] (FORNET; Hecker et al., 2015).

[10] See extended paper 1.10
[11] See extended paper 1.11
[12] See extended paper 1.12
[13] See extended paper 1.13
[14] See extended paper 1.14
[15] See extended paper 1.15
[16] See extended paper 1.16
[17] See extended paper 1.17
[18] See extended paper 1.18
[19] See extended paper 1.19

To date, there is one publication reporting a case example where an autistic individual experiencing psychosis was treated with NET (Fazel et al., 2020). The participant was aged 15, and had experienced physical and sexual abuse, which was believed to drive their symptoms of psychosis. The adaptations made included: additional time exploring each traumatic event, verbal and written repetition of the treatment rationale, additional time to process information, the use of written prompts of the questions the therapist may ask, and the use of movement to reduce distress (i.e., walking up and down a corridor). Following this, there was a reduction in symptoms of traumatic stress, suggesting that NET may be a potentially feasible therapy for the autistic population[20].

The Present Study

The present study was completed in accordance with the ADAPT guidance[21] (Moore et al., 2021) (Appendix B) to develop an adapted NET protocol for use with autistic adults, using the Delphi method (Dalkey & Helmer, 1963) to allow autistic adults (experts by experience) and autism professionals (experts by profession) to collaboratively identify and prioritise potential adaptations. This systematic process of consensus-building directly addresses a key limitation of the current evidence-base – namely the lack of co-produced adaptations developed through a structured, transparent methodology – and lays a foundation for future clinical implementation.

[20] See extended paper 1.20
[21] See extended paper 2.21

Research Questions

The research questions can be divided into two 'stages'; Stage One – the development of a draft adapted NET protocol for use with autistic adults – and Stage Two – the exploration of the adapted protocol's fidelity to the core principles of NET.

Stage One

1) What are the views of experts by profession on how NET should be adapted for autistic adults experiencing traumatic stress?
2) What are the views of experts by experience on how NET should be adapted for autistic adults experiencing traumatic stress?
3) How do experts by profession and experts by experience evaluate the adaptations proposed by the other group?

Stage Two

4) Are the proposed adaptations consistent with the principles of NET and feasible in practice?

Methods

Design

Stage One: Adapting the Protocol

The Delphi method[22] (Dalkey & Helmer, 1963) was used to establish consensus among two groups of experts – experts by profession (EBP) and experts by experience (EBE) – on how

[22] See extended paper 2.1

NET should be adapted for use with autistic adults. The method is grounded in the assumption of the 'wisdom of crowds', which suggests that collective judgments are more valid than those of individuals (Mannes et al., 2014; Surowiecki, 2005). The process followed guidance by King et al. (2021)[23] for adapting psychological therapies using the Delphi method and was conducted over three rounds.

Stage Two: NET Expert Consultation

An online survey was administered to gather the views of clinicians experienced in NET on whether the adapted protocol was consistent with the principles of NET and feasible in practice. This was followed by a focus group [24] (Merton et al., 1956) to explore areas of disagreement in more detail and consider whether adaptations could be amended to better align with NET.

Participants

Three groups of participants were recruited: experts by profession (EBP), experts by experience (EBE), and NET experts.

Stage One

Experts by Profession. Fifteen professionals with expertise in autism were recruited using purposive sampling. Autism charities and professional networks were contacted (Appendix C) and requested to circulate the study advertisement (Appendix D), which included a QR code linking to the participant information sheet (Appendix E) and a virtual consent form (Appendix F), which, once signed, linked to the first questionnaire. The

[23] See extended paper 2.2
[24] See extended paper 2.3

inclusion criteria[25] outlined that participants must: 1) Be aged 18 years or older; 2) Be English-speaking; 3) Hold a profession recommended by the National Institute for Health and Care Excellence (2014) as part of a specialist autism team (e.g., psychologist, nurse, occupational therapist, psychiatrist, social worker, speech and language therapist, or member of support staff); 4) have a minimum of two years' experience working with autistic individuals.

Experts by Experience. Fifteen autistic adults were recruited through purposive sampling by circulating the study advertisement (Appendices G and H) on the websites of various autism charities. Potential participants contacted the primary researcher to confirm eligibility and then received the link to access the information sheet (Appendix I) and consent form (Appendix J). The inclusion criteria[26] outlined that participants must: 1) Be aged 18 years or older; 2) Be English-speaking; 3) Have a confirmed diagnosis of autism, 4) Have the capacity to provide informed consent.

Stage Two

NET Experts. Three clinicians with expertise in NET were recruited via purposive and snowball sampling, thorough the NET Institute (Appendix K). The study advertisement (Appendix L) included a QR code linking to the participant information sheet (Appendix M) and consent form (Appendix N). The inclusion criteria[27] outlined that participants must: 1) Hold a profession relating to mental health; 2) Have completed or taught the NET Institute Fundamentals Training.

[25] See extended paper 2.4
[26] See extended paper 2.5
[27] See extended paper 2.6

Procedure

Stage One

Round One. Two tailored questionnaires were developed for EBP and EBE groups (Appendices O and P). Prior to data collection, the EBE questionnaire was reviewed individually by a group of six autistic EBE independent to the study to ensure its clarity, relevance, and acceptability to the target population. Feedback was incorporated to enhance the questionnaire in this way[28]. The questionnaires were then completed by the sample of EBP and EBE recruited to the study using an online survey platform. All participants answered questions pertaining to their demographics and were then provided a description of NET and the following elements core to the process: 1) assessment and psychoeducation, 2) the lifeline, 3) narration, 4) re-narration, 5) total number and duration of sessions. Participants indicated whether adaptations to each element would be helpful and, if so, proposed specific adaptations; if not, they explained why. Responses were analysed to generate an initial list of proposed adaptations.

Round Two. In the second questionnaire, participants reviewed the adaptations identified by their group, rating each as 'very important', 'somewhat important', or 'not important'. Participants were presented only with the adaptations relevant to the elements of NET for which they had previously indicated that adaptations would be helpful (e.g., if a participant responded 'yes' or 'unsure' for all elements except the lifeline, they were shown adaptations for all elements except the lifeline). Adaptations rated as 'very important' by

[28] See extended paper 2.7

≥80% of participants were accepted at this stage. Those rated ‘very important’ by 70-79% were re-presented in Round Three. Adaptations rated below 70% were excluded.

Round Three. Participants re-rated adaptations that fell just below the consensus threshold in Round Two. They also rated adaptations proposed by the other group that had been rated ‘very important’ by ≥70% of that group. Duplicates between groups were removed prior to presentation. Participants also clarified certain adaptations to improve objectivity. Adaptations rated as ‘very important’ by ≥80% in both groups were included as important; those rated ≥80% in one group were included as potentially important. Adaptations below this threshold were excluded.

Sensitivity Analysis. Participants who had indicated in Round One that adaptations would not be helpful for a given element of NET were not presented with adaptations for that element in subsequent rounds. This approach aimed to ensure consistency and respect participants’ initial judgments, as presenting them with adaptations they had already deemed unnecessary could have undermined the validity of their responses. Specifically, it could have conflated their rejection of the element itself with an evaluation of specific adaptations, potentially inflating ‘not important’ ratings and producing an overly conservative estimate of consensus.

Stage Two

Pre-Focus Group Questionnaire. NET experts completed an online questionnaire, where they answered questions pertaining to their demographics and were presented the adapted protocol. They rated each adaptation as ‘consistent with NET

principles and feasible', 'not entirely consistent but feasible' or 'inconsistent and infeasible'. Adaptations rated as consistent and feasible by all were accepted. Those rated by at least one participant as 'inconsistent and infeasible' and 'not entirely consistent but feasible' were highlighted for further discussion.

Focus Group. The NET experts participated in an online focus group (Appendix Q) to discuss the highlighted adaptations. They explored why certain adaptations were perceived as inconsistent with NET, and whether amendments could bring them closer to the principles of NET. Adaptations unanimously agreed as inappropriate were excluded; those agreed as modifiable were amended and retained.

Ethics

Ethical approval[29] was granted by the Mental Health and Clinical Neurosciences Research Ethics Sub-Committee at the University of Nottingham (Reference: 3145) (Appendix R).

Data Analysis

Stage One

Round One. Qualitative content analysis [30] (Berelson, 1952; Krippendorff, 2018) was conducted by the primary researcher to identify proposed adaptations. An inductive approach was used, with emerging codes and categories (i.e., potential adaptations) identified from participants responses (Appendix S). The data was organised around the elements of NET (i.e., assessment and psychoeducation, the lifeline, narration, re-narration,

[29] See extended paper 2.8
[30] See extended paper 2.9

and duration/total number of sessions). The analysis focused on the manifest content to remain close to participants' words and minimise interpretation bias, ensuring that the adaptations reflected participants' explicit views rather than inferred meanings (Graneheim & Lundman, 2004). This approach was also used to understand responses where participants indicated that adaptations would not be helpful or necessary.

Rounds Two and Three. Descriptive statistics (percentages) were calculated to assess consensus within and between groups. In Round Three, clarifications provided by participants were analysed using inductive, manifest qualitative content analysis to refine the adaptations and summarise how many participants endorsed each clarification (Appendix T).

Stage Two

Pre-Focus Group Questionnaire. Responses were summarised using descriptive statistics.

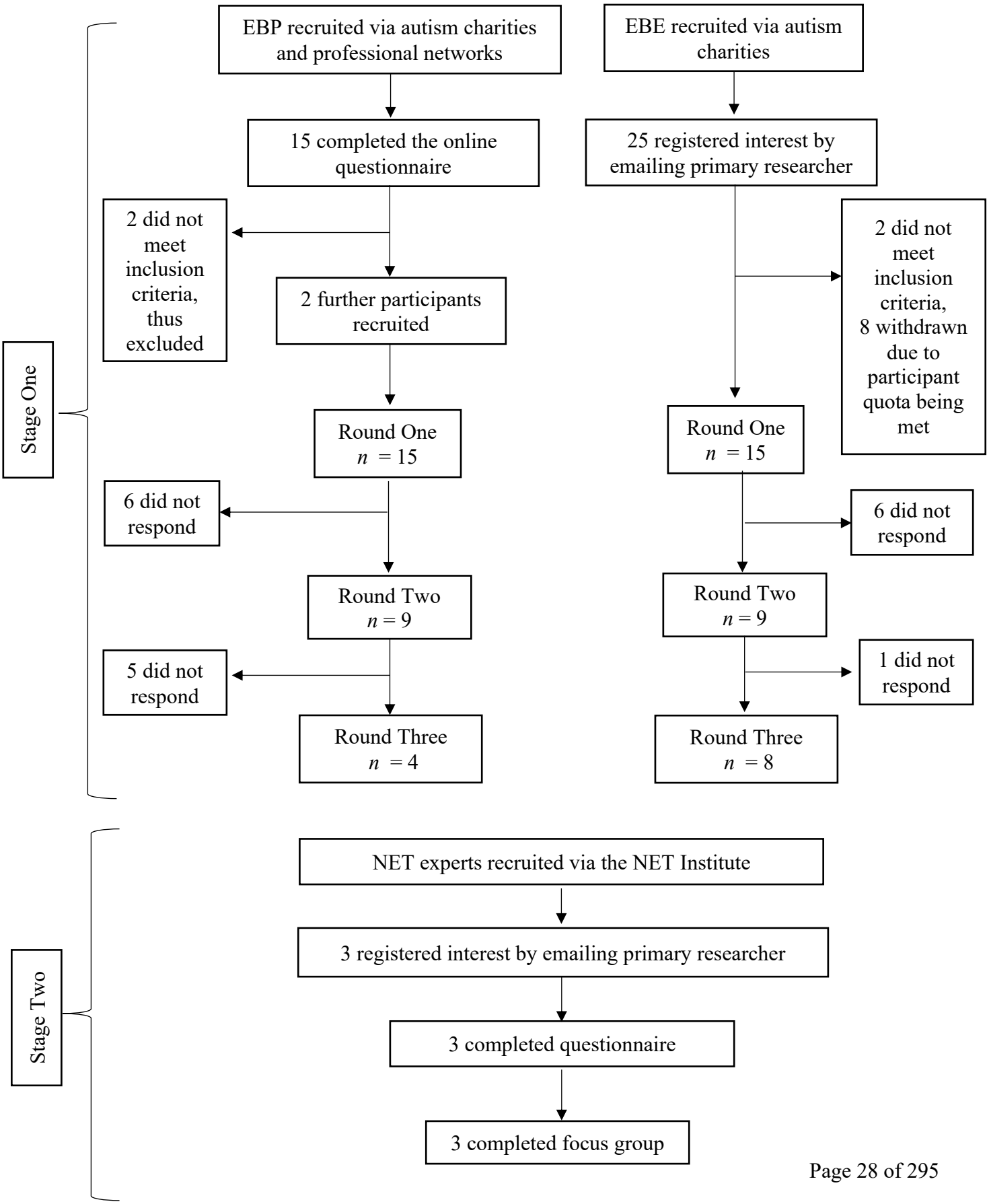
Focus Group. The focus group was video-recorded and transcribed by the primary researcher. Data were analysed using inductive, manifest qualitative content analysis and organised around the specific adaptations under investigation (Appendix U).

Results

The study process is outlined in Figure 1, detailing participant recruitment and contribution across each stage of the study.

Figure 1

Study Process and Participant Contribution



Participant Demographics

Stage One

EBP. Fifteen EBP participated. They were predominantly White British (*n* = 12), female (*n* = 13) and aged between 25 and over 65 years. The majority were psychologists (*n* = 11). Most participants worked within the UK National Health Service (NHS) (*n* = 11) and had between two and over 50 years of experience working with autistic adults[31].

EBE. Fifteen EBE participated. They were predominantly White British (*n* = 12), male (*n* = 9) and aged between 18 and over 65. The time since receiving a formal autism diagnosis ranged from six months to over 16 years[32].

Stage Two

Three NET experts participated. They were predominantly male (*n* = 2). Two participants were clinical psychologists, and one was a professor of clinical psychology. They reported between five and 26 years of experience delivering NET[33]. To protect participant anonymity, limited demographic details are provided.

Stage One

Round One

Most EBP and EBE indicated that adaptations to NET would be helpful for autistic clients. Some participants provided reasons for why they thought adaptations would not be helpful.

[31] See extended paper 3.1
[32] See extended paper 3.2
[33] See extended paper 3.3

Most of these responses suggested that adaptations were not necessary, while one participant highlighted that, even with adaptations, challenges such as difficulty identifying traumatic events and emotion identification and labelling might still limit the accessibility of the therapy for autistic individuals[34]. For those who indicated that adaptations would be helpful, their suggestions were analysed and formed 76 EBP proposed adaptations (Table 1) and 54 EBE proposed adaptations (Table 2). Adaptations were organised according to the five core elements of NET (i.e., assessment and psychoeducation, the lifeline, narration, re-narration, and the duration/total number of sessions).

[34] See extended paper 3.4

Table 1

Proposed Adaptations Generated from EBP Responses in Round One

Element of NET	Proposed Adaptation	Adaptation Reference
Assessment and Psychoeducation	The therapist should support the client with emotion identification and labelling	P1
	The therapist should ensure they and the client have a shared understanding of emotions	P2
	Clients should be provided with a diagram of the brain model and fear network	P3
	The therapist should incorporate the client's special interests when explaining the psychoeducation content	P4
	The therapist should incorporate the client's special interests to support engagement and motivation	P5
	The therapist should use pictures, written prompts, and diagrams	P6
	The therapist should clarify items on the PCL-5 and LEC-5 that relate to body sensations	P7
	The NICE CG142 (2021) guidelines should be incorporated via session contracting relating to sensory considerations and communication needs	P8
	Autism health passports* should be used to support session contracting *Further information on autism health passports: https://www.autism.org.uk/advice-and-guidance/topics/physical-health/my-health-passport	P9
	The client's sensory needs and preferences should be incorporated into the sessions; e.g. sensory toys should be available	P10
	The therapist should concretely show the client how the therapy is likely to be helpful and exactly what is expected of them	P11
	The therapist should assess for strategies to emotionally regulate	P12
	The client should be joined by a family member/carer/friend for support, if they want	P13

	The therapist should discuss the different types of trauma experienced by the autistic population	P14
	The therapist should understand the impact of potential co-occurring alexithymia (i.e., ability to identify and name emotions) and interoceptive abilities (i.e., ability to identify internal bodily sensations) on the client's ability to complete standardised measures (i.e., the PCL-5 and the LEC-5)	P15
	The therapist should explore the client's interoceptive ability (i.e., their ability to identify internal bodily sensations)	P16
	The therapist should explore the client's sensory experiences, needs, and preferences	P17
	The therapist should check that the pacing of the session is appropriate	P18
	The therapist should consider monotropic language (i.e., a tendency of some autistic people to pay attention to small specific details in a granular fashion rather than processing the larger context)	P19
	Abstract terms should be made concrete and the client's understanding checked, e.g. when talking about "trauma symptoms", examples should be given that are relevant to the client... when talking about "hot" and "cold" memories, ensuring the client does not infer this literally	P20
	Clients should be provided a clear plan, structure, and 'rules' to help them predict what will happen throughout therapy	P21
	The client should be shown the lifeline materials (i.e., the ribbon, stones, and flowers) at this stage so that they can see what will be asked of them during the lifeline exercise	P22
	Ahead of sessions, the therapist should describe the clinic room	P23
	Stabilisation/regulation support should be provided	P24
	Based on the individual's needs, there should be additional sessions at the start of therapy to allow the client to familiarise with the therapist	P25
The Lifeline	The client should be as active as they wish in placing the stones and flowers on the lifeline	P26
	The client should be able to choose their own symbols/representations of traumatic events and positive events as opposed to the default use of stones and flowers	P27
	The therapist should consider the client's ability to articulate the metaphorical use of stones and flowers	P28
	Stones and flowers should be physically labelled as a traumatic or positive event	P29
	Special interests should be incorporated where possible	P30

	The therapist should give an example of a traumatic event (i.e., a stone) and a positive event (i.e., a flower) to ensure the client understands the difference	P31
	It should be made clear how much detail clients should share at this stage (i.e., "up to five words")	P32
	The therapist should consider whether the lifeline materials cause distress or fixation	P33
	The lifeline session should take place over several shorter sessions	P34
	The therapist should write/draw out the lifeline one period of life at a time across multiple sessions, before bringing each period together to form the lifeline in one session	P35
	Clients should be made aware of/be prepared for the lifeline exercise prior to its completion	P36
	The therapist should be aware they may need to provide particular support in helping the client to identify positive events	P37
	To support emotional regulation, the client should have the option to draw	P38
	"Lifeline" should be re-phrased to a "river" or "stream" of life	P39
	"Birds-eye view" should be re-phrased as "summary of life events"	P40
Narration	The therapist should support the client to identify and label emotions	P41
	The client should be provided with a written and diagrammatic list of emotions	P42
	The therapist should normalise any difficulties with interoceptive awareness	P43
	The therapist should check in with the client regarding whether this method is accessible to them	P44
	If the client struggles to articulate elements of their experience (i.e., cognitions, sensory experiences, emotions etc) the therapist should provide options/examples of what they imagine the person felt	P45
	Clients should be provided with a visual map of the body	P46
	The client should be provided a stepped plan of the process of narration	P47
	The client should be provided visual representations of sensory experiences, emotions, cognitions etc that are laid out on the floor with "hold" and "cold" headings provided	P48
	The client should be offered a number of sensory exercises to complete as they narrate, if they want	P49
	The therapist should expect stimming and understand this as a mechanism to manage anxiety, and not necessarily an indicator of risk or acute distress	P50

	The therapist should be aware of how the client expresses distress, and monitor this throughout the session	P51
	It should be explained to the client that the narration is different to the lifeline exercise e.g., that they are now to provide 'up to a few pages' of detail	P52
Re-narration	The therapist should reassure the client as they guide them on how to think through their memories	P53
	The therapist should provide the client with a copy of the written narrative so that they can read it as the therapist reads aloud	P54
	The therapist should consider the clients preferred method of communication when producing the narrative	P55
	The therapist should explore the client's ability to imagine	P56
	The therapist and client should negotiate alternatives to communication if the client becomes non-speaking/'selectively mute'	P57
	The therapist should allow for sensory regulation if the client finds this helpful	P58
	The therapist should give explicit and specific consent to be interrupted/corrected	P59
	The therapist should read the narrative slowly to encourage corrections	P60
	The therapist and client should agree on when corrections should be made (i.e, as the therapist reads the narrative, after, or both)	P61
	The therapist should emphasise that the process of the narrative is about connecting with emotions and memories, rather than making the narrative perfect	P62
	The client should be provided with a copy of the narrative to read and correct outside of sessions	P63
	The therapist should incorporate visual information into the narrative wherever possible	P64
Duration and total number of sessions	The client should be offered regular breaks	P65
	Sensory breaks should be incorporated into sessions	P66
	Sessions should be shorter	P67
	The time, duration and total number of sessions should be agreed	P68
	If a client becomes distressed, the session should be lengthened until they feel safe to leave	P69
	The total number of sessions should be increased	P70
	The therapist should be flexible	P71

	The therapist should be prepared to accommodate accordingly	P72
	When agreeing the time/duration/total number of sessions, the therapist should inform the client that a 'new plan' can be agreed if anything changes	P73
	The care plan/plan for therapy should be communicated as per the clients preferences (e.g. written, typed, drawn, emailed, printed)	P74
	The therapist should not assume for how long the client can manage a session; they should explore this with the client	P75
	Rather than providing a total number of sessions, the therapist and client should agree that the therapy will be complete when all of the stones and flowers have been narrated	P76

Table 2

Proposed Adaptations Generated from EBE Responses in Round One

Element of NET	Proposed Adaptation	Adaptation Reference
Assessment and Psychoeducation	To allow the client to familiarise themselves with the therapist and understand the purpose of NET, the assessment and psychoeducation sessions should be spread across 3-5, one-hour long sessions	E1
	The therapist should support the client in explaining their emotions	E2
	The therapist should use prompts to support the client in sharing their experiences	E3
	Family/carers should be present if the client chooses	E4
	Written explanations of the psychoeducation should be provided	E5
	Visual diagrams of the psychoeducation should be provided	E6
	Time should be taken to consider how the client self-soothes	E7
	The clinic room should be quiet, with soft furnishings and natural light	E8
	The therapist should explain the process in detail, and reiterate where helpful	E9
	The therapist should allow the client additional processing time, and time to respond	E10
	Time should be taken to consider how the client processes information	E11
	The therapist should have empathy and understanding towards the autistic experience	E12
	The therapist should have prior knowledge of autism; how autistic people may experience trauma and how this may differ to neurotypical people	E13
The Lifeline	The client should be able to choose their own symbols to represent positive events and traumatic events	E14
	If the client wants to focus their lifeline on their experiences of being autistic, they should be able to	E15
	Family/carers should be present if the client chooses	E16

	The therapist should explain the process in detail, and reiterate where helpful	E17
	The therapist should allow the client additional processing time, and time to respond	E18
	Further clarification is needed on what a "significant or important event" is	E19
	Clients should be told about this exercise in advance so that they can think about what events they might want to include	E20
	There should be an option to revisit the lifeline later in therapy, e.g. to make changes if needed	E21
	There should be an option for the exercise to be completed via a computer (i.e., online/remotely)	E22
Narration	Visual aids should be used to help clients identify emotions (i.e., written emotion cards, the 'emotions wheel')	E23
	Clients should be offered a break if they become too overwhelmed	E24
	The therapist should follow a structured approach	E25
	If the client becomes overwhelmed, the session should not end until they feel better	E26
	Family/carers should be present if the client chooses	E27
	The therapist should explain the process in detail, and reiterate where helpful	E28
	The therapist should allow the client additional processing time, and time to respond	E29
	Clients should be able to write down their feelings, if they want	E30
	The therapist should explain that the conversations the client has with the therapist are 'different' to the ones they might have with people outside of therapy, i.e., typically, it would not be expected for somebody to tell a stranger or a friend all about their trauma, but it is typical for somebody to tell a therapist all about their trauma. The therapist should explain why.	E31
	Alternative options for emotional expression should be available e.g. pointing to words or pictures, drawing, or creating sounds	E32
	The narration should be stopped if the client becomes very upset	E33
	The focus should be on the client’s physical body sensations, rather than their emotions	E34
	The therapist should use onomatopoeia to help the client express their emotions (i.e., words that suggest how they sound; for instance, 'feeling fizzy', 'feeling cloudy')	E35
Re-narration	The client should be provided the written narrative to read before the session	E36
	The narrative should be written in words that make sense to the client	E37

	The client should be able to sit or lie on the floor, if they want	E38
	The client should have a fidget/fiddle toy, if they want	E39
	Family/carers should be present if the client chooses	E40
	The therapist should explain the process in detail, and reiterate where helpful	E41
	The therapist should allow the client additional processing time, and time to respond	E42
	The client should have a copy of the narrative to read as the therapist reads the narrative aloud	E43
	Instead of the therapist reading the narrative aloud, the client should be given a copy of the narrative to read themselves	E44
	The narrative should not be repeatedly read (i.e., each session)	E45
Duration and total number of sessions	If the client wants a break, they should be able to	E46
	There should not be a maximum number of sessions available to the client	E47
	Sessions should be shorter, with some longer sessions in between e.g. an hour-long session one week, an hour and a half-long session the next, an hour-long session the week after, and so on...	E48
	During each session, the therapist should remind the client how long they have left (i.e., letting the client know there is 5 minutes remaining)	E49
	Therapy should be offered via an online format	E50
	Clients should be offered 6-13 sessions	E51
	Each session should last for 75 - 110 minutes	E52
	The therapist should reassure the client that 'relapses' may occur i.e., that this is normal	E53
	Sessions should be shorter	E54

Round Two

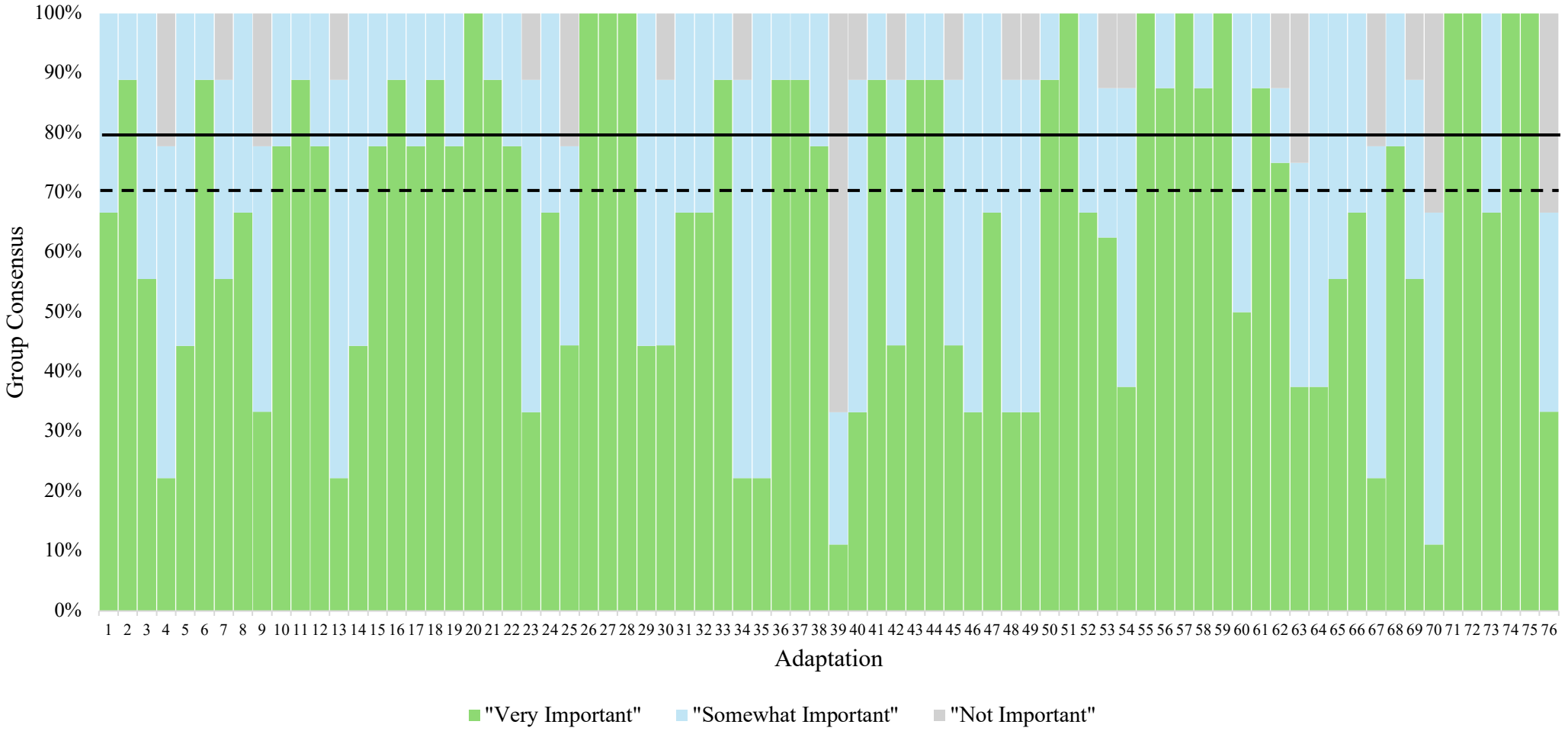
Participants rated the importance of the adaptations proposed by their own group in Round One.

EBP. As shown in Figure 3, 28 adaptations were rated as 'very important' by ≥ 80% of participants and were accepted at this stage. Of the remaining adaptations, 9 were rated as 'very important' by 70-79% of participants and were carried forward to Round Three, while the 39 rated as 'very important' by ≤69% of participants were excluded.

EBE. As shown in Figure 4, 21 adaptations were rated as 'very important' by ≥80% of participants and were accepted at this stage. Of the remaining adaptations, 13 were rated as 'very important' by 70-79% of participants and were carried forward to Round Three, while the 20 adaptations rated as 'very important' by ≤69% of participants were excluded.

Figure 2

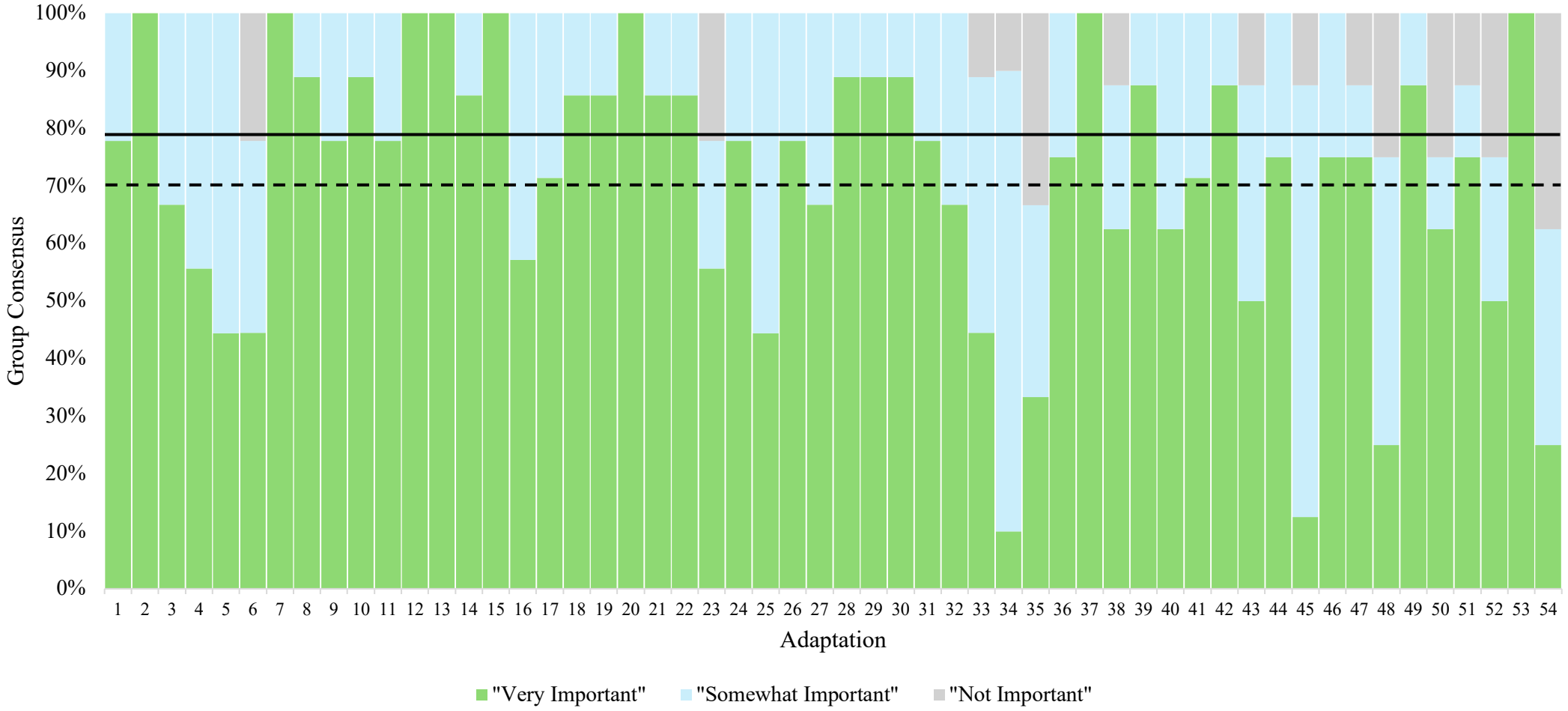
EBP Ratings in Round Two



Note. The solid black line represents the consensus threshold (≥80%). The dashed line indicates the near-consensus range (70-79%).

Figure 3

EBE Ratings in Round Two



Note. The solid black line represents the consensus threshold (≥80%). The dashed line indicates the near-consensus range (70-79%).

Round Three

Participants re-rated the adaptations proposed by their own group that were just below the 80% consensus threshold (i.e., 70-79%) in the previous round. They also rated the adaptations proposed by the other expert group that had achieved 70-100% consensus in that group. Duplicate adaptations were removed prior to presentation (Appendix V). Participants were also asked to clarify adaptations that the research team identified as subjective or ambiguous[35]. The clarified adaptations were cross-referenced with all previously proposed adaptions, including those excluded in earlier rounds, to ensure no previously excluded adaptation reappeared in the clarified list.

EBP. EBP rated a total of 39 adaptations in Round Three. Of these, 9 were EBP-proposed adaptations that were just below the consensus threshold in the previous round. After re-rating, two achieved ≥80% consensus as 'very important' adaptations and were accepted, while the remaining seven were excluded at this stage (Appendix W). The remaining 30 adaptations were proposed by the EBE group; of these, 11 were rated as 'very important' by ≥ 80% of EBP participants and accepted, while the remaining 19 were excluded at this stage[36].

EBE. EBE rated a total of 48 adaptations in Round Three. Of these, 13 were EBE-proposed adaptations that were just below the consensus threshold in the previous round. After re-rating, five achieved ≥80% consensus as 'very important' adaptations and were accepted, while the remaining eight were excluded at this stage (Appendix X). The remaining 35 adaptations were proposed by the EBP group; of these, 21 were rated as 'very important'

[35] See extended paper 3.5
[36] See extended paper 3.6

by ≥ 80% of EBE participants and accepted, while the remaining 14 were excluded at this stage[37].

Sensitivity Analysis. A sensitivity analysis was conducted to explore whether treating unpresented adaptations as 'not important' by default would affect the final consensus. This alternative approach resulted in six fewer adaptations meeting the ≥80% consensus criterion in the EBP group and 19 fewer in the EBE group (Appendix Y). As this approach risked being overly conservative – particularly given the stringent ≥80% threshold – the research team decided it was more appropriate to treat these responses as missing data.

Overall Consensus Between Groups. The expert group's responses in Round Three were compared. A total of 28 adaptations were rated as 'very important' by ≥80% of participants in both groups[38]. These adaptations were accepted for inclusion as important adaptations in the adapted protocol. A further 27 adaptations were rated as 'very important' by ≥80% of participants in one expert group, but not the other[39] and were included in the adapted protocol under the sub-heading 'potentially important adaptations for some autistic adults'. The remaining 12 adaptations did not meet consensus in either group and were therefore excluded from the adapted protocol.

[37] See extended paper 3.7
[38] See extended paper 3.8
[39] See extended paper 3.9

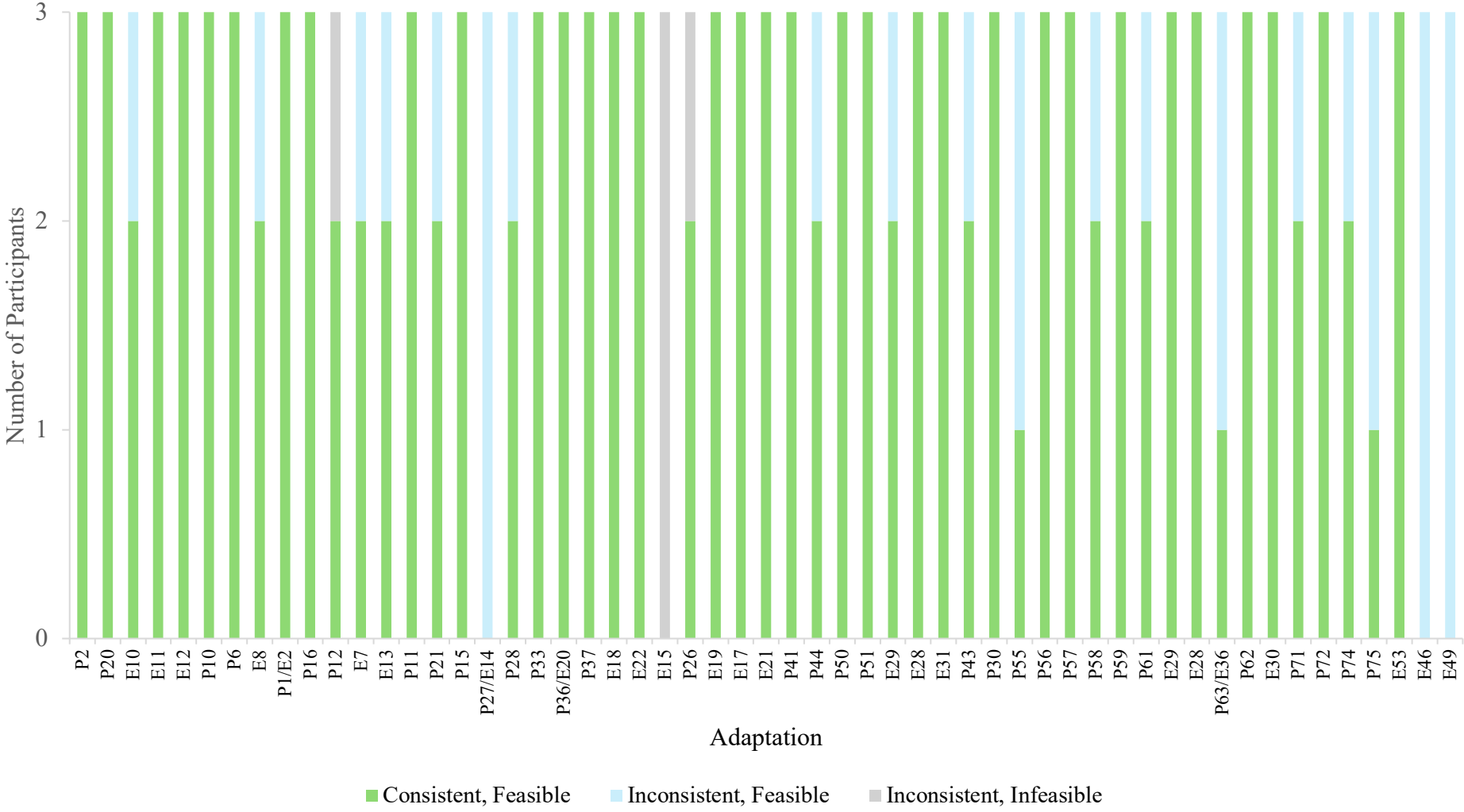
Stage Two

Pre-Focus Group Questionnaire

The NET experts rated the 55 adaptations that had reached consensus in Stage One. They evaluated each adaptation in terms of its consistency with the principles of NET and its feasibility in practice (Figure 4). Of these, 33 adaptations were unanimously rated as both consistent with NET and feasible and were accepted. A total of 19 were rated as not entirely consistent but feasible by at least one participant, and three were rated as inconsistent and infeasible by at least one participant.

Figure 4

NET Expert Ratings of the Proposed Adaptations



Focus Group

All three NET experts participated in the focus group. The discussion, informed by the findings of the pre-focus group questionnaire, centred on adaptations rated as inconsistent and infeasible or not entirely consistent but feasible. Participants were invited to discuss the reasoning behind why these adaptations might conflict with the principles of NET, and to consider whether they could be amended to align more closely with NET and improve feasibility, or whether they should be excluded.

Adaptations Rated as Inconsistent and Infeasible. Three adaptations were reviewed in this category. Participants agreed that one was fundamentally incompatible with NET and should be excluded (P12), while the remaining two were amended to improve alignment with NET principles and retained in the protocol (E15 and P26).

"The therapist should assess for strategies to emotionally regulate" (adaptation reference: P12). Participants spoke about how emotion regulation is not a core part of NET or the NET therapist's role. They explained that NET enables clients to experience and contextualise their emotions within the traumatic memory, rather than attempted to regulate or suppress them directly. Two participants described how NET inherently promotes regulation by reorganising memories, not through explicit techniques:

Participant 1:"Emotions are response dispositions that develop out of experience and the current context of the situation… your experiences in the past determine what your response will be or response disposition will be… [NET is about] regulating your memories… the emotions are automatically adjusted"

Participant 3: "I'm not really there trying to regulate the emotional response… I'm there to try to help them have a direct processing and experience of the emotion…to clear a space so that the person can have the appropriate emotional experience, rather than having it be… [an] overwhelming experience… and that in itself might add to the kind of regulatory process…"

Another participant noted that whilst assessing and teaching techniques for emotion regulation can be helpful, it is not always necessary, and delaying trauma processing for this purpose risks invalidating clients' emotional experiences:

Participant 2: "The patient has come to you and is telling you that they want to process the past trauma. They're going to feel… frustrated by you waiting and waiting and trying more skills… they know what's coming, they just want to face it…These are often people that… their emotions have been dismissed. [They] may not feel important… so they get an opportunity through NET to really feel them, express them, and feel validated. You might run the risk if you continue to throw strategies at them… [you would be] re-enacting a similar kind of narrative…sometimes it's not what the client actually needs… sometimes I would argue that it's more the therapist that needs [it]".

Participants also expressed doubts about the effectiveness of traditional regulation techniques, such as the use of imagery to reduce emotional suppression:

Participant 1: "The strategies you know, 'keep cool', 'keep calm', 'don't think of a polar bear right now'… it doesn't work for negative emotions… that's the problem and that's

actually what you want to regulate. You don't want to regulate the positive emotions. You want to adjust the negative emotions… it simply doesn't work"

Participants concluded that the adaptation could not be amended to improve consistency and feasibility and should therefore be excluded from the protocol.

"If the client wants to focus their lifeline on their experiences of being autistic, they should be able to" (adaptation reference: E15) . Participants discussed the complexity of understanding autistic experiences as traumatic within the NET framework. They noted that while autism shapes how trauma is experienced, focusing the lifeline solely on autistic experiences risks overwhelming the process and diluting its focus on discrete traumatic events:

Participant 3: "The use of the word 'traumatic' is potentially… difficult… [because] experiences of being autistic… it's not necessarily traumatic in the sense that we're talking about in terms of what we're trying to address in NET… it's like intense experience… [This could result in] an almost endless range of potential experiences… that we might want to jot down on the lifeline…and I suppose… practically it might get like really quite busy"

Participant 1: "The problem for us non-autistic people, it seems to sometimes be really difficult to understand why that person is so stressed…"

Participant 2: "I guess it would be experienced by them as traumatic, but…if we start going on to noises and sensory things… the lifeline will be full of… minor events…[and] if you think about the protocol of NET where you're having to go into details about one specific

event, if it's just the sound…and then that applies to any sounds, how do you pick which event across the lifeline has been the most traumatic…I don't know whether NET is the right approach to do that."

One participant expressed that autism and trauma are intertwined, and should not be viewed in isolation of each other, suggesting the therapist should remain mindful of how autism influences the narrative without shifting the focus away from specific events:

Participant 2: "Each experience will be tainted by them being autistic… let's say their grandmother died and the funeral itself was a very traumatic experience… the fact they were autistic and maybe they couldn't understand what was going on or why people were crying…inevitably that will be part of the conversation that will become part of the narrative."

Participants agreed that the adaptation should be amended to enhance its consistency with the principles of NET and improve feasibility. They noted that this consideration is more appropriately framed as guidance for the therapist's awareness, rather than as an explicit procedural step in NET (e.g., explicitly offering the client the option to focus the lifeline on their experiences of being autistic). They agreed on the following revision:

"The therapist should be aware that the events on the client's lifeline will likely have been shaped by the client's experience of autism, and that the client may wish to explore discussion around this."

This amended adaptation was retained in the protocol.

"The client should be as active as they wish in placing the stones and flowers on the lifeline" (adaptation reference: P26). One participant noted that this adaptation lacked clarity and prompted discussion about what it would look like in practice – for example, whether the therapist might place the stones and flowers for the client, perhaps due to sensory-related needs. The participant agreed that flexibility in how clients engage with this aspect of the lifeline is already consistent with NET, particularly when accommodating a disability or client preference:

Participant 2: "I mean, you would do that for a client that had come with a disability. I've got some clients that can't really get up and down…I wouldn't ask them to like, 'yes, bend, do it yourself'…. I think it's a bit common sense, isn't it"

Participants concluded that this adaptation was consistent with the principles of NET and was feasible, and it was therefore retained in the protocol.

Adaptations Rated as Inconsistent with NET, but Feasible. Of the 19 adaptations rated as not entirely consistent with the principles of NET but feasible in practice, six were amended accordingly and retained in the protocol alongside the remaining 13. Given that these adaptations were rated as not entirely consistent but feasible, it was anticipated that they would require less detailed deliberation than those rated as inconsistent and infeasible. Additionally, many of these adaptations were conceptually similar. To support a focused and efficient discussion, the primary researcher therefore organised them into thematic categories prior to the focus group (i.e., structure and pacing, communication style and clarity, symbolism and metaphor, therapist stance and approach, regulation, and environment and accessibility) (Table 3).

Table 3

Adaptations Rated as Inconsistent but Feasible by NET Experts

Adaptation Thematic Category	Adaptation	Adaptation Reference	Analysis of the Discussion	Amended Adaptation
Structure and Pacing	"The therapist should not assume for how long the client can manage a session; they should explore this with the client"	P75	Participants spoke about the importance of discussing this with the client, specifically with regards to setting expectations for the time it may take to narrate a stone.	"The therapist should not assume for how long the client can manage a session; they should explore this with the client, with a consideration of how long it will take to narrate the stone ahead of the session."
	"If the client wants a break, they should be able to"	E46	Participants felt this was dependent on the task at hand; for instance, it may be counterinitiative during the narration. Participants expressed the importance of resuming the session after the break. Participants reflected how clients requesting a break during NET is uncommon during practice.	"If the client wants a break, they should be able to. They should however be told of the importance of continuing with the narration, and that the session should resume until the processing is complete."

	"During each session, the therapist should remind the client how long they have left i.e., letting the client know there is 5 minutes remaining"	E49	Participants felt this was dependent on the task at hand; for instance, it may be unhelpful during the narration.	"After the narration is completed for a stone and the therapist and client are re-grounding themselves, the therapist should remind the client how long they have left i.e., letting the client know there is 5 minutes remaining"
	"The therapist should allow the client additional processing time, and time to respond" (present in assessment and psychoeducation, and narration)	E10/E29	Participants agreed that this adaptation was consistent with the principles of NET and feasible.	N/A
Communication Style and Clarity	"The care plan/plan for therapy should be communicated as per the client's preferences e.g., written, typed, drawn, emailed, printed"	P74	Participants expressed that this could be problematic for the narrative, which should be a written document. They agreed that alternatives to communication should not be explicitly offered but explored at the client's request.	"If the client requests alternatives to how the care plan/plan for therapy is communicated, alternatives should be offered, e.g., written, typed, drawn, emailed, printed"
	"The therapist should check in with the client regarding whether this method is accessible to them"	P44	Participants agreed that this adaptation was consistent with the principles of NET and feasible.	N/A
	"Clients should be provided a clear plan, structure, and 'rules' to help them predict	P21	Participants agreed that this adaptation was consistent with the principles of NET and feasible.	N/A

	what will happen throughout therapy”			
	“The therapist should consider the client’s preferred method of communication when producing the narrative”	P55	Participants agreed that this adaptation was consistent with the principles of NET and feasible.	N/A
	“The therapist and client should agree on when corrections should be made i.e., as the therapist reads the narrative, after, or both”	P61	Participants agreed that this adaptation was consistent with the principles of NET and feasible.	N/A
	“The client should be provided with a copy of the narrative to read and correct outside of sessions”	P63/E36	Participants discussed how prior research has shown that reading the narrative outside of sessions is neither helpful nor harmful. They agreed that the reading of the narrative outside of sessions should not be explicitly offered but explored at the client’s request.	“The client should be provided with a copy of the narrative to read and correct outside of sessions, if they request it”
Symbolism and Metaphor	“The client should be able to choose their own symbols/ representations of traumatic events and positive events as opposed to the default use of stones and flowers”	P27/E14	Participants expressed the importance of the therapist and client having a shared understanding of what the symbols represent. They expressed concerns that including alternative symbols may complicate the process.	“The client should be able to choose their own symbols/ representations of traumatic events and positive events as opposed to the default use of stones and flowers, if they request it”

			They agreed that personalised symbolisation should not be explicitly offered but explored at the client's request.	
	"The therapist should consider the client's ability to articulate the metaphorical use of stones and flowers"	P28	Participants agreed that this adaptation was consistent with the principles of NET and feasible.	N/A
Therapist Stance and Approach	"The therapist should be flexible"	P71	Participants agreed that this adaptation was consistent with the principles of NET and feasible.	N/A
	"The therapist should normalise any difficulties with interoceptive awareness"	P43	Participants agreed that this adaptation was consistent with the principles of NET and feasible.	N/A
	"The therapist should have prior knowledge about autism, how autistic people may experience trauma and how this may differ to neurotypical people"	E13	Participants agreed that this adaptation was consistent with the principles of NET and feasible.	N/A
Regulation	"Time should be taken to consider how the client self-soothes"	E7	Participants agreed that this adaptation was consistent with the principles of NET and feasible.	N/A
	"The therapist should allow for sensory regulation if the client finds this helpful"	P58	Participants agreed that this adaptation was consistent with the principles of NET and feasible.	N/A
Environment and Accessibility	"The clinic room should be quiet, with soft furnishings and natural light"	E8	Participants agreed that this adaptation was consistent with the principles of NET and feasible.	N/A

The Adapted Protocol

After incorporating the findings from both Stages One and Two, the adapted protocol was finalised with 54 adaptations (Table 4).

Table 4

NET for Autistic Adults Experiencing Traumatic Stress – The Adapted Protocol

Element of NET	Adaptation
Assessment & Psychoeducation	*Important adaptations*
	The therapist should ensure they and the client have a shared understanding of emotions, for instance: they should explicitly discuss and clarify emotional language; validate and listen to the client; use tools (e.g., body maps); and examples (e.g., typical responses to emotions) to facilitate shared understanding.
	Abstract terms should be made concrete and the client's understanding checked, e.g. when talking about "trauma symptoms", examples should be given that are relevant to the client... when talking about "hot" and "cold" memories, ensuring the client does not infer this literally.
	The therapist should allow the client additional processing time, and time to respond.
	Time should be taken to consider how the client processes information, for instance: they should assess processing style collaboratively and pace accordingly; allow additional time and repetitions as needed; use clear, unambiguous language and check understanding; and allow clients to "circle back" and revisit points.
	The therapist should have empathy and understanding towards the autistic experience.
	Potentially important adaptations for some autistic adults
	The client's sensory needs and preferences should be incorporated into the sessions, for instance: sensory toys should be available; sensory needs and preferences should be assessed collaboratively; the environment should be adapted and the session set-up accordingly; the client should be offered tools and validated for their choices; and adaptations should be balanced with the therapeutic aims.
	The therapist should use pictures, written prompts, and diagrams, for instance: materials should be adapted to client preferences; and varied and collaborative formats should be used.
	The clinic room should be quiet, with soft furnishings and natural light
	The therapist should support the client with emotion identification and labelling

	The therapist should explore the client's interoceptive ability (i.e., their ability to identify internal bodily sensations), for instance: the therapist should facilitate an awareness of bodily sensations; use tools (e.g., body maps) to externalise experiences; provide psychoeducation and examples; and recognise challenges and variability in interoceptive awareness.
	Time should be taken to consider how the client self-soothes, for instance: the therapist should assess and discuss self-soothing strategies explicitly; observe and validate behaviours; encourage client insight into their own soothing cues; and provide time and space for self-soothing without judgement.
	The therapist should have prior knowledge of autism, how autistic people may experience trauma and how this may differ to neurotypical people
	The therapist should concretely show the client how the therapy is likely to be helpful and exactly what is expected of them, for instance: the therapist should provide a clear and step-by-step explanation; clarify benefits, limitations, and expectations; and be flexible and collaborative.
	Clients should be provided a clear plan, structure, and 'rules' to help them predict what will happen throughout therapy.
	The therapist should understand the impact of potential co-occurring alexithymia (i.e., ability to identify and name emotions) and interoceptive abilities (i.e., ability to identify internal bodily sensations) on the client's ability to complete standardised measures (i.e., the PCL-5 and the LEC-5).
The Lifeline	*Important adaptations*
	The client should be able to choose their own symbols/ representations of traumatic events and positive events as opposed to the default use of stones and flowers, if they request it.
	The therapist should consider the client's ability to articulate the metaphorical use of stones and flowers, for instance: the therapist should explore whether metaphors are meaningful to the client; explain metaphors with concrete examples; offer alternative representations if metaphors are confusing; and adapt metaphor based on the client's needs and preferences.
	The therapist should consider whether the lifeline materials cause distress or fixation, for instance: the therapist should monitor for fixation or distress during use of materials; discuss preferences and adapt materials if problematic; use observation and ongoing dialogue to gauge response; and be flexible and validate the client's experience.
	Clients should be made aware of/be prepared for the lifeline exercise prior to its completion
	The therapist should be aware they may need to provide particular support in helping the client to identify positive events, for instance: the therapist should explicitly talk about positive events and provide examples; validate smaller or nontraditional "positive" experiences; recognise barriers (e.g., shame, negative bias) and address gently; and support the client without imposing assumptions.
	The therapist should allow the client additional processing time, and time to respond.

	Potentially important adaptations for some autistic adults
	There should be an option for the exercise to be completed via a computer (i.e., online/remotely).
	The therapist should be aware that the events on the client's lifeline will likely have been shaped by the client's experience of autism, and that the client may wish to explore discussion around this.
	The client should be as active as they wish in placing the stones and flowers on the lifeline.
	Further clarification is needed on what a "significant or important event" is, for instance: the therapist should discuss the criteria for significance with the client; provide examples but allow the client to define what is important; recognise that significance is subjective and may evolve; and explore early but revisit as needed.
	The therapist should explain the process in detail and reiterate where helpful.
	There should be an option to revisit the lifeline later in therapy, e.g. to make changes if needed.
Narration	*Important adaptations*
	The therapist should support the client to identify and label emotions.
	The therapist should check in with the client regarding whether this method is accessible to them, for instance: the therapist should assess understanding and accessibility explicitly; provide space for feedback and adjustments; offer multiple ways (e.g., verbal and non-verbal) to express concerns; and balance "checking-in" with respecting autonomy.
	The therapist should expect stimming and understand this as a mechanism to manage anxiety, and not necessarily an indicator of risk or acute distress.
	The therapist should be aware of how the client expresses distress and monitor this throughout the session.
	The therapist should allow the client additional processing time, and time to respond.
	Potentially important adaptations for some autistic adults
	The therapist should explain the process in detail and reiterate where helpful.
	The therapist should explain that the conversations the client has with the therapist are 'different' to the ones they might have with people outside of therapy; (i.e., typically, it would not be expected for somebody to tell a stranger or a friend all about their trauma, but it is typical for somebody to tell a therapist all about their trauma). The therapist should explain why.

	The therapist should normalise any difficulties with interoceptive awareness, for instance: the therapist should explain that difficulties with interoception are common; provide reassurance and psychoeducation; validate difficulties and reduce shame; and use simple, respectful language.
	Clients should be able to write down their feelings, if they want.
Re-narration	*Important adaptations*
	The therapist should consider the clients preferred method of communication when producing the narrative, for instance: the therapist should offer multiple communication formats; explicitly discuss and respect the client's preferences; "check-in" regularly and adapt as needed; and use prior information known about the client to guide choices.
	The therapist should explore the client's ability to imagine, for instance: the therapist should assess imagination ability explicitly and collaboratively; and offer alternatives if imagination is difficult.
	The therapist and client should negotiate alternatives to communication if the client becomes non-speaking/'selectively mute'; for instance, the therapist and client should plan potential scenarios beforehand; co-create and practice strategies; offer diverse alternative communication methods; and model calmness and validate difficulties.
	The therapist should allow for sensory regulation if the client finds this helpful, for instance: the therapist should allow the use of sensory tools and behaviours; provide options for sensory regulation; and minimise sensory overload and create a safe environment.
	The therapist should give explicit and specific consent to be interrupted/corrected.
	The therapist and client should agree on when corrections should be made (i.e, as the therapist reads the narrative, after, or both.
	The therapist should allow the client additional processing time, and time to respond.
	Potentially important adaptations for some autistic adults
	The therapist should explain the process in detail and reiterate where helpful.
	The client should be provided with a copy of the narrative to read and correct outside of sessions, if they request it.
	The therapist should emphasise that the process of the narrative is about connecting with emotions and memories, rather than making the narrative perfect.
	Clients should be able to write down their feelings, if they want.

Duration/Total Number of Sessions	*Important adaptations*
	The therapist should be flexible.
	The therapist should be prepared to accommodate accordingly.
	If the client requests alternatives to how the care plan/plan for therapy is communicated, alternatives should be offered (e.g., written, typed, drawn, emailed, printed).
	The therapist should not assume for how long the client can manage a session; they should explore this with the client, with a consideration of how long it will take to narrate the stone ahead of the session.
	The therapist should reassure the client that 'relapses' may occur (i.e., that this is ‘normal’).
	Potentially important adaptations for some autistic adults
	If the client wants a break, they should be able to. They should however be told of the importance of continuing with the narration, and that the session should resume until the processing is complete.
	After the narration is completed for a stone and the therapist and client are re-grounding themselves, the therapist should remind the client how long they have left (i.e., letting the client know there is 5 minutes remaining).

Discussion

This study addressed a gap in the literature by systematically adapting NET for autistic adults through a collaborative process that incorporated the views of both EBP and EBE, while preserving fidelity to the core principles of NET. A total of 54 adaptations were included in the final adapted protocol.

Expert Views on Adapting NET

The first stage of the study aimed to explore the views of EBP (RQ^1) and EBE (RQ^2) on how NET should be adapted. Following Round One, the majority of participants in both groups agreed that adaptations would be beneficial, consistent with existing literature highlighting the value of adapting psychological therapies for autistic clients (Cooper et al., 2018; Riches et al., 2023). However, a greater proportion of EBP supported adaptations across all elements of NET, whereas EBE responses were more variable. Some EBE expressed uncertainty, which may reflect a reluctance to over-generalise autistic needs, echoing the findings of Pappagianopoulos et al. (2025) that autistic individuals may value a more nuanced, individualised approach to therapy adaptation. This underscores the value of the adapted protocol as a foundational resource to be used as a flexible guide to support collaborative discussion and individual tailoring, rather than a prescriptive checklist.

Following Round One, EBP responses generated 76 proposed adaptations while EBE responses generated 54. Of these, only five overlapped directly, suggesting distinct priorities between the groups. This finding underscores the importance of including both EBP and EBE in adaptation processes – whether through research involvement or within clinical practice,

for example, by therapists inviting clients to share how the therapeutic approach could be tailored to their needs.

The adaptations proposed by EBP reflected a comprehensive and clinically informed perspective on adapting NET for autistic adults. The largest proportion of adaptations (*n* = 25) focused on the 'assessment and psychoeducation' element, suggesting a strong emphasis on preparation – specifically, creating a predictable, supportive, and containing environment. This emphasis on the early phase of treatment may reflect EBP's awareness that autistic individuals often experience heightened anxiety in unfamiliar or ambiguous situations (Jenkinson et al., 2020), highlighting the importance of building trust and clarity at the outset (Hume, 2022). Alternatively, this emphasis may reflect that EBP had greater confidence in adapting early-stage, transdiagnostic components of therapy – such as psychoeducation and contracting. Across the remaining elements of NET, many of the proposed adaptations centred on incorporating visual supports, addressing sensory needs, and scaffolding emotion identification and expression. These recommendations align with existing guidelines for adapting psychological therapies more broadly for autistic clients (NICE, 2021; National Autistic Society, 2021).

The adaptations proposed by EBE provided a lived-experience perspective on what autistic clients might find helpful during NET. Their suggestions emphasised emotional safety, autonomy, and clear, accessible communication, potentially stemming from lived experiences of being misunderstood or disempowered in healthcare interactions, which autistic adults consistently describe (Mazurek et al., 2022; Weir et al., 2022). EBE key priorities included creating a quiet and comfortable environment, allowing additional time for processing and responding, and offering alternative communication methods (e.g., written or drawn

responses). EBE also highlighted the value of therapist empathy and understanding of autism-specific experiences, reinforcing the importance of therapy feeling respectful, collaborative, and attuned to individual preferences. Thus, many of the proposed adaptations appeared to reflect common barriers to therapy reported by autistic adults (Jubenville-Wood et al., 2023).

Following Rounds Two and Three, EBP and EBE rated the adaptations proposed by the other group (RQ^3). The groups demonstrated agreement in several key areas. Notably, there was strong consensus on the importance of session pacing (e.g., E10, E11, E18, E29, E42, E46, P18), therapist awareness of autistic experiences including 'stimming' (i.e., self-stimulatory behaviour to regulate emotions), interoception, and alexithymia (e.g., P50, E12, E13), and the need for clarity and predictability in sessions (e.g., P20, P21, P36/E20, P59, P61, P62, E17). Both groups also agreed that sessions did not need to be shortened (e.g., P34, P67, E48, E54), which may reflect a shared understanding that the length of sessions should not be assumed but tailored collaboratively according to individual tolerance and need (e.g., P75).

Notable differences emerged around adaptations relating to sensory needs (e.g., E8, E39, P10, P17). EBP generally rated sensory-related adaptations as less important than EBE. This is surprising given that sensory sensitivities and heightened sensory interests are core features of autism (American Psychiatric Association, 2013; World Health Organisation, 2022) and are often highly salient in autistic adults' experiences (MacLennan et al., 2022). This discrepancy may reflect the 'double empathy problem' (Milton, 2012; Milton et al., 2022), where autistic and non-autistic individuals often misunderstand one another's perspectives – here, EBP may underestimate the relevance of sensory experiences to therapy. Additionally, sensory considerations are not outlined in the National Institute for Health and Care Excellence (2021) guidance on adapting psychological therapy for autistic adults, potentially

explaining this oversight. Sensory sensitivities are experienced by many autistic adults (Crane et al., 2009; Hwang et al., 2020) and can become heightened under stress (Chamak et al., 2008; Robertson & Simmons, 2015). The processing of distressing material often induces stress, so it is plausible that sensory sensitivities may increase during NET. This finding highlights the nuances involved in interpreting consensus – particularly where an adaptation meets consensus in one group but not the other.

Some of the findings diverged from clinical guidance and previous research. For example, EBP did not rate adaptations involving the incorporation of special interests (e.g., P4, P5, P30) as important. This contrasts with recommendations by the National Institute for Health and Care Excellence (2021) and the National Autistic Society (2021), as well as studies with autistic adults (Lizon et al., 2024; Patten Koenig & Hough Williams, 2017) and clinicians (Ainsworth et al., 2020; Cooper et al., 2018; Petty et al., 2023), which suggest that integrating special interests into therapy can enhance engagement and outcomes. This discrepancy may reflect misconceptions about the relevance of special interests to autistic adults or practical concerns about integrating them into a trauma-focused therapy context. Although research has demonstrated that autistic individuals often value their special interests (Grove et al., 2018), these interests are sometimes pathologised or misunderstood by others (Long, 2025). This misunderstanding may extend to professionals, though no research to date has explored how professionals perceive special interests in therapy – whether as obstacles or as potential therapeutic assets. Notably, these adaptations were excluded after Round Two, so the EBE group did not have the opportunity to rate them. However, the absence of any adaptations relating to special interests in the EBE's initial proposals may indicate this was not a priority for this group within the context of this study, again highlighting the heterogeneity of autistic experiences and preferences.

Similarly diverging from clinical guidance and previous research, adaptations relating to visual supports – such as diagrams and written materials (e.g., P46, P48, P64, E23, E32) were rated as less important by both groups. One explanation is that NET's existing use of visual tools, particularly the lifeline, may sufficiently address these needs. Adaptations involving the inclusion of a trusted other, such as a family member or carer (P13, E4, E16, E27, E40) were also rated as less important. This may reflect some autistic adults' preference for independence and autonomy in therapy, as highlighted in the literature (McVey et al., 2023), or it may relate to variability in the availability or appropriateness of support networks, particularly within the context of trauma-focused therapy, which is often a highly personal and individual process. Moreover, consensus for importance was reached by both groups on 28 adaptations, with a further 27 adaptations endorsed by one group only.

The Adapted Protocol's Fidelity to NET

The proposed adaptations were reviewed by a panel of NET experts to explore their consistency with the principles of NET and feasibility in practice (RQ^4). Of the 55 adaptations reviewed by the NET experts, one was excluded and six were amended to improve their consistency with the theoretical and procedural foundations of NET, resulting in a final protocol of 54 adaptations. The exclusion and amendment of adaptations demonstrate the importance of preserving the fidelity of an evidence-based therapy while also making it accessible to a specific population. This reflects the tension between fidelity to the model and adaptation to the population (McHugh et al., 2009; von Thiele Schwarz et al., 2021), where excessive adaptation risks diluting the therapeutic mechanisms, and too little adaptation risks compromising engagement.

The adaptation excluded for conflicting with the principles of NET and being infeasible in practice related to the assessment of emotion regulation strategies, which is not a core component of NET. Instead, NET emphasises exposure to, and contextualisation of, traumatic memories (Schauer et al., 2011) rather than emotional avoidance or suppression through excessive emotional regulation. Moreover, the experts noted that some of the proposed adaptations were already implicit in good clinical practice – for example, adjusting physical tasks to accommodate client needs or creating a comfortable therapeutic environment – reflecting the inherent flexibility within NET's structured framework (Elbert et al., 2015). Other adaptations required reframing to improve consistency and feasibility, preserving the valuable insights provided by EBP and EBE whilst maintaining fidelity to NET. This iterative review with NET experts strengthened the validity of the adapted protocol by ensuring it remained grounded in the core principles of NET while enhancing its suitability for autistic clients.

Limitations[40]

The findings of the present study should be considered in light of several limitations. One notable challenge was participant attrition during Stage One. Despite efforts to mitigate this risk – including recruiting a larger sample size at baseline, issuing personalised email reminders, and extending the response windows for later rounds – only 60% of participants from Round One continued into Round Two across both groups, meaning 40% of participants withdrew by default of not responding. By Round Three, retention had reduced to 26.6% of the original EBP sample and 53.3% of the EBE sample. While attrition is not uncommon in Delphi studies (Gargon et al., 2019) – with reported rates ranging from 0% to 92% (Keeney et al., 2011) – it raises important considerations around response bias (Humphrey-Murto et

[40] See extended paper

al., 2017). For example, participants who perceived the proposed adaptations as less important or were less invested in the topic may have been more likely to disengage. This selective dropout may have contributed to an overestimation of consensus and amplified the influence of individual responses, potentially reducing the representativeness and stability of the final findings.

However, the consensus threshold adopted in the present study was set at 80%, which is at the higher end of reported thresholds in Delphi literature, where studies report thresholds ranging from 50-96%, with a commonly reported median of 75% (Diamond et al., 2014; Foth et al., 2016). The use of a more stringent threshold was intended to increase confidence in the robustness of retained items and may have served to offset some of the limitations introduced by participant attrition. However, this decision may also have resulted in the exclusion of potentially meaningful items that did not meet consensus in later rounds, particularly given the reduced sample size. As such, it is possible that some nuanced or minority views were lost, limiting the scope of insights captured in the final set of agreed adaptations.

A further limitation is the sample size of NET experts, where only three participated in the focus group component of Stage Two of the study. While the initial aim was to recruit a sample of up to five participants to facilitate a more dynamic discussion, logistical challenges and difficulties with recruitment constrained the size of the final sample. The smaller group may have limited the depth of the interaction. However, the participating experts represented a range of professional backgrounds and experience, which contributed to the diversity and relevance of the perspectives offered during the discussion.

Furthermore, EBE were not required to have prior experience of a traumatic event, traumatic stress, or psychological therapy. It was not recorded whether participants had these experiences or not. It is possible that EBE with these experiences may have provided different insights into what may be helpful when adapting therapy. Similarly, NET experts were not required to have prior experience of working with autistic clients, which may have influenced their responses.

Future Research[41]

It is of note that Delphi studies should be viewed as a 'starting point', and not a means to producing a final product (Nasa et al., 2021). As such, further research is required to integrate the findings of this study into a more formalised protocol. Piloting the adapted protocol in clinical practice is a critical next step, ideally through detailed case studies with autistic adults experiencing traumatic stress. Future research should also address the lack of validated and normed outcome measures for traumatic stress in autistic populations.

Conclusions

This study systematically adapted an evidence-based, trauma-focused therapy for autistic adults, using an inclusive process that integrated the perspectives of autistic individuals and autism professionals. The resulting protocol remains grounded in the core principles of NET while incorporating targeted adjustments to guide clinicians in delivering NET in ways that are sensitive to the needs and preferences of autistic clients. This work represents an important step toward addressing the unmet need for trauma treatment in this population, contributing to the development of trauma-informed care that is accessible, person-centred,

[41] See extended paper

and empirically supported. Future research and clinical practice should build on this foundation to further refine, implement, and evaluate the adapted protocol.

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Extended Paper

1.0 Extended Background

1.1 Autism Terminology

This study adopts identity-first language (i.e., 'autistic person') rather than person-first language (i.e., 'person with autism') in line with the preferences expressed by many autistic individuals, who tend to view autism as an integral and positive aspect of their identity rather than a separable deficit (Kenny et al., 2016). Person-first language, often used by professionals to emphasise the person rather than their condition, can inadvertently reflect a medicalised and deficit-based narrative (Taboas et al., 2023), as is the case for the official diagnostic term 'autism spectrum disorder', with the term 'disorder' perpetuating the medicalised narrative that being autistic means there is something inherently wrong or in need of curing (Bury et al., 2023). Instead, the term 'autism' is often preferred as a more affirming alternative (Monk et al., 2022). Nonetheless, individual preferences vary, underscoring the need to respect and honour personal preferences.

1.2 Definitions of Autism

Autism is conceptualised by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) and the International Classification of Diseases (ICD-11; World Health Organization, 2022) as a neurodevelopmental condition characterised by features that emerge during early development and persist across multiple contexts throughout the lifespan. Both diagnostic systems outline two core domains, albeit with slightly different wording. The DSM-5 defines autism as "persistent deficits in social communication and social interaction" and "restricted, repetitive patterns of behaviour, interests, or activities" (American Psychiatric Association, 2013, p. 56-57). Similarly, the ICD-11 describes "persistent deficits in initiating and sustaining social communication and

reciprocal social interactions" and "persistent restricted, repetitive and inflexible patterns of behaviour, interests, or activities" (World Health Organisation, 2022, p. 124).

In recent years, the social model of disability has gained prominence amongst the autistic population, offering an alternative to the traditional medicalised framing of autism as a 'disorder' (Kamp-Becker, 2024). From this perspective, autism is understood as a difference rather than a disability. Any impairments that arise are seen as the result of an interaction between the autistic individual's characteristics and the demands of an environment designed primarily to meet the needs of non-autistic individuals (Pellicano & den Houting, 2022). As such, it is the lack of accommodation and environmental fit, rather than autism itself, that gives rise to functional difficulties. However, acceptance of the social model is not yet universal across services and research (Woods, 2017).

1.2.1 Autism Prevalence

It is widely cited that autism is prevalent in approximately one in 100 individuals (Zeidan et al., 2022). However, emerging evidence suggests that actual prevalence rates may be significantly higher. Recent studies have reported rates of one in 34 among children in the United Kingdom (O'Nions et al., 2023) and one in 36 among children in the United States (Maenner et al., 2023). The ratio of male-to-female diagnoses has been cited as 3:1 (Loomes et al., 2017) meaning males are more likely to receive a diagnosis than females. It has been proposed that autistic females are more able to conceal their autistic traits, meaning they are less likely to be recognised as autistic (Wood-Downie et al., 2021).

Prevalence rates among adults remain less clear, due to limited data availability (Huang et al., 2020). In a UK population-based cohort study using primary care data from 2000 to 2018,

O'Nions et al. (2023) examined the rate of confirmed autism diagnoses and compared these with estimates from community-based research to estimate levels of underdiagnosis. The study estimated that between 0.77% and 2.12% of the English population may be autistic but undiagnosed. Importantly, the study found that children and young people were significantly more likely to have received an autism diagnosis than adults, particularly older adults.

One potential explanation for this disparity lies in changes to diagnostic frameworks over time. Following the publication of the DSM-5 in 2013 (American Psychiatric Association, 2013), which introduced a more narrowly defined conceptualisation of autism, some individuals – particularly older adults – who may have met diagnostic criteria under the broader framework outlined in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994), may now find it more difficult to obtain an autism diagnosis (Mazefsky et al., 2013; Oberman & Kaufmann, 2020). This shift in diagnostic criteria may have contributed to an artificial suppression of adult diagnosis rates. However, increasing awareness, improved understanding, and a growing number of adults seeking assessments (Russell et al., 2022) may help to mitigate this effect.

1.2.2 Heterogeneity in Autism

Whilst diagnostic criteria offer a useful framework for understanding autism, they often obscure the considerable heterogeneity observed within the autistic population (Lombardo et al., 2019). This heterogeneity is evident in the expression and severity of the core and associated features of autism, including the extent to which autistic traits impact daily living (Sterrett et al., 2024). Importantly, this variability is not linear; rather, it is often described using the colloquial term "spiky profile", where an individual demonstrates pronounced strengths in some domains and significant challenges in others (Wilson, 2024). Difference

also exists between individuals – while one autistic person may require minimal to no support, another may require high levels of care and support (Peterson et al., 2019). As such, an autism diagnosis alone provides limited insight into a person's abilities, challenges, and support needs.

Previous attempts to conceptualise diversity within autism, including diagnostic subtypes such as Asperger's and informal terms such as 'high-functioning' and 'low-functioning' (Ousley & Cermak, 2014; Bal et al., 2017), have been widely criticised for being reductive and potentially stigmatising (Sterrett et al., 2024; Prizant, 2012). The publication of the DSM-5 introduced 'severity levels' ranging from 'Level One' ('requires support') to 'Level Three' ('requires very substantial support') to account for variation in levels of support needs (American Psychiatric Association, 2013). However, the concept of a singular, static 'severity' level does not align with the dynamic and domain-specific nature of individual functioning.

Moreover, various theoretical models have attempted to explain autism's heterogeneity. For instance, the Multiple Cognitive Deficit Model (Pennington, 2006) proposes that rather than arising from a singular underlying cause, autism arises from different combinations of cognitive difficulties, including deficits in theory of mind, weak central coherence, and executive functioning. Similarly, the 'Autisms' framework (Geschwind & Levitt, 2007) conceptualises autism as a collection of related conditions with related aetiologies, further underscoring the need for personalised and context-sensitive approaches in both research and practice.

1.3 Autism in Adulthood

From being initially characterised as a form of psychosis in the early 20th century (Bleuler, 1911/1950) to the eventual standardisation of diagnostic criteria in the 1980s (American Psychiatric Association, 1980), the conceptualisation of autism has evolved significantly. However, the understanding of autism in adulthood has not progressed at the same pace as it has for children and young people (Howlin & Taylor, 2015). The majority of existing literature has been completed with child and adolescent populations, likely contributing to the disparities in access to resources and support for adults (Gerhardt & Lainer, 2011; Howlin, 2008; Shattuck et al., 2012). Notably, a review of the United Kingdom's autism research funding landscape found that only 3% of funding in 2016 supported projects recruiting adults over the age of 50 (Warner et al., 2019). While research with child populations remains crucial – particularly given the benefits of early identification and intervention (Okoye et al., 2023) –autism is a lifelong condition requiring continued attention across the lifespan.

Historical misconceptions framing autism as a condition of childhood (Rutter, 1978), coupled with limited awareness of neurodiversity and institutionalisation practices in the previous century (Chow & Priebe, 2013), mean that many of today's autistic adults were either misdiagnosed or not diagnosed at all (Aylott, 2000). For instance, a recent study examining underdiagnosis found diagnostic rates were considerably higher in children than in adults, estimating that approximately 59-72% of autistic adults remain undiagnosed (O'Nions et al., 2023). In recognition of these disparities, adult populations have been described as a 'lost generation' in autism research and services (Lai & Baron-Cohen, 2015). This is changing, however, as increasing rates of adults are now seeking a diagnosis of autism (Gellini & Marczak, 2024; Kiehl et al., 2024; Nayyar et al., 2025; Wilson et al., 2023).

Despite increases in adult diagnosis, identifying autism in adulthood presents a range of challenges. These difficulties include access to reliable developmental histories, due to gaps in early medical records and limitations of retrospective recall (Lai & Baron-Cohen, 2015; Rutherford et al., 2016). Moreover, some of the most widely used and recommended diagnostic tools – such as the Autism Diagnostic Interview-Revised (ADI-R; Rutter et al., 2003) and the Diagnostic Observation Scale for Autistic Disorders, second edition (ADOS-2; Lord et al., 2012) – have limited empirical support for their use with adult populations (Kamp-Becker et al., 2021; Sappok et al., 2013). As such, adult diagnosis is often complex.

Additionally, the understanding of adult autism and the availability of support appear to decline with age (Roestorf et al., 2022). This stands in contrast to other neurodevelopmental conditions, such as intellectual disability, where support is typically sustained throughout life transitions (Howlin & Taylor, 2015). Research has shown that autistic adults are also less likely to access needed services (Turcotte et al., 2016), suggesting that autistic adults are an underserved and often overlooked population.

1.4 Co-Occurring Mental Health Conditions in Autistic Adults

A high proportion of autistic individuals experience co-occurring mental health conditions at significantly elevated rates compared to non-autistic populations (Howlin & Magiati, 2017; Joshi et al., 2013; Lai et al., 2019). Research indicates that approximately 79% of autistic individuals will meet the diagnostic criteria for at least one mental health condition over their lifetime, with anxiety and depression being the most prevalent (Lever & Geurts, 2016). The impact of this is substantial, with autistic individuals experiencing notably higher levels of suicidality than non-autistic individuals (Conner et al., 2020; Hand et al., 2020; Hedley & Uljarević, 2018), as well as higher rates of completed suicide (Kõlves et al., 2021). Despite

this, autistic individuals are at a reduced likelihood of receiving appropriate and effective support (Mandy, 2022).

The recognition, assessment, and treatment of co-occurring mental health conditions in autistic individuals is particularly complex due to symptom overlap, diagnostic overshadowing, and the heterogeneous nature of autism itself (Rosen et al., 2018). In addition, many autistic adults without intellectual disabilities report exclusion from mainstream mental health services due to their diagnosis, while also being ineligible for specialist intellectual disability services (Camm-Crosbie et al., 2019; Hallet & Crompton, 2018). Consequently, autistic adults are less likely to access community-based services and more likely to access tertiary care (Gilmore et al., 2022), with the rate of inpatient admissions being elevated in this population (Gray et al., 2025).

Where primary care mental health services are accessed, autistic adults may experience less clinical gain than non-autistic adults, as demonstrated by the findings of El Baou et al. (2023), who completed a retrospective, matched, observational study of health-care records to compare therapy outcomes between autistic and non-autistic adults in a secondary care service. The study also reported a novel finding that factors which tend to be associated with better outcomes in non-autistic adults – such as employment and low socioeconomic deprivation – may not have the same protective effect for autistic adults. However, it should be noted that the cohort evaluated were individuals accessing NHS secondary care services from 2012 – 2019, with little historical data available. As such, this sample is unlikely to be representative of the wider autistic population, many of whom may not access such services. It is also plausible that certain autistic characteristics influence help-seeking and service access – for example, individuals with greater verbal communication difficulties may be

underrepresented in clinical samples. As such, the climate for mental health support for autistic adults may be poorer than typically thought.

Historically, interventions for autistic individuals have often focused on the reduction or modification of autistic traits, such as through applied behaviour analysis or social cognition training (Bishop-Fitzpatrick et al., 2014). As a result, the evidence base for therapeutic approaches that specifically target co-occurring mental health conditions is limited in this population, highlighting a need for the development of tailored, evidence-based interventions (Camm-Crosbie et al., 2019; Lord et al., 2022). This lack of access to suitable services, compounded by the paucity of effective treatments and often non-adapted or inadequately adapted treatment (Trimmer et al., 2024), contributes to the chronicity of mental health difficulties across the lifespan for many autistic individuals (Adams & Young, 2021; Roestorf et al., 2022).

1.5 Diagnostic Criteria for Post-traumatic Stress Disorder (PTSD)

The DSM-5 (American Psychiatric Association, 2013) outlines that for a PTSD diagnosis, 'Criterion A' must be met through the experience of "death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence" whether it be through direct exposure, witnessing first-hand, or witnessing second-hand, such as through hearing of individuals' experiences. Alongside this, is the presence of intrusion symptoms associated with the event, such as the recurrent, involuntary, and intrusive recall of distressing memories of the event (Criterion B), persistent avoidance of associated stimuli (Criterion C), negative alterations in cognitions and mood (Criterion D), and marked alterations in arousal and reactivity (Criterion E). The symptoms must be present for more than one month (Criterion

F) and cause clinically significant distress or impairment in various areas of functioning (Criterion G) and not be attributable to the physiological effects of a substance (Criterion H).

Similarly, the ICD-11 (World Health Organization, 2022) outlines that for a diagnosis to be made, the individual must have been exposed to an extremely threatening, horrific event, such as natural or human-made disasters, combat, serious accidents, torture, sexual violence, terrorism, assault or acute life-threatening illness, or alternatively, witnessing the threatened or actual injury or death in others in a sudden, unexpected, and violent manner, or learning of this. Similar to the DSM-5, a host of symptoms follow, including re-experiencing the event in the present, deliberate avoidance of stimuli likely to trigger such re-experiencing of the event, and persistent perceptions of heightened threat. These symptoms must result in significant impairment in various areas of functioning or require significant additional effort to maintain functioning.

1.6 Adverse Life Events and Autism

Autistic individuals are at an increased risk of experiencing adverse life events (Peterson et al., 2019; Rumball, 2019; Stack & Lucyshyn, 2019). Much of the existing research exploring adverse events have focused on adverse childhood events (ACEs). An event can be described as an ACE when it is highly stressful, potentially traumatic, and occurring prior to adulthood (Tzouvara et al., 2023). ACEs typically include abuse (e.g., physical, emotional, and sexual), neglect, domestic violence, parental mental illness, substance misuse, and familial disruption (Felitti et al., 1998). Autistic individuals are not only more likely to experience the above, but also events beyond this that may be adverse and specific to the autistic experience, such as sensory trauma, unmet support needs, and experiences of exclusion (Crane et al., 2009; Kerns et al., 2022).

In a recent meta-analysis exploring the occurrence of ACEs in autistic individuals, Hartley et al. (2024) found autistic individuals to be more than twice as likely as non-autistic individuals to experience an ACE. Notably, the study reported elevated exposure to bullying and peer violence, parental mental health difficulties, and abuse, violence or neglect. While these findings provide an important contribution to the understanding of the autistic experience, much of the data derives from retrospective self-report studies, which may be impacted by recall bias and social desirability bias, thereby reducing the reliability and generalisability of the findings. However, despite these methodological limitations, the consistent pattern of elevated adversity in autistic populations reported across studies (Maïano et al., 2016; McDonnell et al., 2019; Nowell et al., 2014; Sreckovic et al., 2014) raises significant concerns regarding its psychological impact.

Indeed, the experience of adverse events – particularly when cumulative – is associated with the development of traumatic stress (Scott, 2007; Breslau et al., 1999; Brewin et al., 2000). In autistic populations, prevalence estimates range from 17.4% in autistic children and young people (Mehtar & Mukaddes, 2011) to 61% (Rumball et al., 2020) in adults, suggesting an increasing incidence of traumatic stress across the lifespan. There is limited research exploring why autistic individuals may be more susceptible to experiencing traumatic events and subsequent traumatic stress (Lobregt-van Buuren et al., 2021); however, one important factor that may heighten vulnerability is reduced access to effective social support following adverse events (Beck, 2024).

Research has consistently demonstrated that a lack of social support following exposure to a traumatic event is associated with an increased risk of developing PTSD (Johansen et al.,

2022; Simon et al., 2019; Wang et al., 2021). Autistic individuals may be less likely to receive social support for several reasons. For example, social communication and interaction differences inherent to autism, including a reduced intuition for social norms and difficulties interpreting social cues (Roy & Strate, 2023), can lead to greater social isolation (Grace et al., 2022). Furthermore, when an event that has been appraised as traumatic is shaped by autism-specific factors, such as sensory sensitivity, non-autistic individuals may find it difficult to understand or validate this experience – a dynamic explained by the 'double empathy' problem (Milton, 2012; Milton et al., 2022), where autistic and non-autistic individuals experience difficulties in understanding each other's worldview – which may further hinder the availability of emotional support from others.

1.7 Identification of Traumatic Stress in Autistic Adults

Although autistic individuals are understood to experience elevated rates of adverse life events and associated traumatic stress (Peterson et al., 2019; Rumball, 2019; Stack & Lucyshyn, 2019), their distress may be less likely to be recognised as PTSD within research and clinical contexts (Rumball et al., 2020). One significant barrier is the narrow definition of what constitutes a traumatic event in the DSM-5 (American Psychiatric Association, 2013) and ICD-11 (World Health Organization, 2022). In a study exploring trauma in autistic adults (n = 63), Rumball et al., (2020) found that over half of participants reported traumatic events that would not be recognised as traumatic by the DSM-5. These included experiences such as bereavement, bullying, mental health crises, social difficulties, and familial separation. This research suggests that autistic individuals may not only face higher rates of conventionally defined trauma, but are also vulnerable to a broader, more heterogeneous range of events that can be experienced as traumatic due to autism-specific vulnerabilities (e.g., sensory sensitivity, social exclusion, reduced predictability). This misalignment between lived

experience and diagnostic criteria has clinical implications, as clinicians may be less likely to recognise the importance of such events in this population, thereby resulting in reduced recognition and access to trauma-specific interventions.

The under-identification of trauma in autistic individuals is further compounded by a lack of validated, autism-informed assessment tools (Quinton et al., 2024). Existing measures of traumatic stress, such as the PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 1993), typically correspond with DSM-5 diagnostic criteria, thereby reinforcing the limitations outlined above. Additionally, outcome measures such as the PCL-5 are often reported to be difficult for autistic individuals to complete (National Autistic Society, 2021), perhaps due to differences with interoceptive ability and alexithymia, both of which can make it difficult to quantify the experience of physical sensations and emotions. This presents a significant barrier for clinical screening and access to services, which may rely on cut-off scores from tools not designed for use with this population. The consequence of this is that autistic individuals may be experiencing clinically significant levels of traumatic stress that may be more likely to be undetected and untreated due to current conceptual and diagnostic frameworks not accommodating the realities of the autistic experience.

1.8 National Institute for Health and Care Excellence (NICE) Guidelines for PTSD

The National Institute for Health and Care Excellence provide evidence-based guidance to healthcare services in England and Wales on the appropriate care of individuals with various physical and/or mental health conditions. Although these guidelines are advisory rather than mandatory, their implementation in practice is often constrained by limited resources and varying levels of clinician engagement (Lowson et al., 2015). More broadly, barriers to implementing evidence-based practice in mental health services have been well documented.

For example, Steel (2021) found that mental health clinicians cited insufficient time and resources as key obstacles to adopting evidence-based practice. Departures from evidence-based approaches, such as those recommended in the NICE guidelines, risk contributing to therapist drift – a phenomenon whereby clinicians deviate from optimal treatment protocols despite having the necessary skills and knowledge (Waller & Turner, 2016). Such drift can result in therapists defaulting to less effective modalities or practices not tailored to the specific needs of the client or condition (Waller, 2009). This highlights the critical role of evidence-based guidelines in supporting the delivery of effective, high-quality care.

For the treatment of PTSD in adults, the National Institute for Health and Care Excellence (2018) recommends individual trauma-focused CBT, which may include cognitive processing therapy, cognitive therapy, narrative exposure therapy, or prolonged exposure therapy. The intervention should be based on a validated manual and provided by a trained and supervised clinician over the course of eight to 12 sessions, with further sessions if clinically indicated. Sessions may be offered remote, if the client does not present with severe symptoms, particularly dissociative symptoms, and are not at significant risk of harm to themselves or others. If the client expresses a preference for eye movement desensitisation and reprocessing (EMDR) therapy, EMDR may be offered, providing the client presents with a diagnosis of PTSD or clinically significant symptoms of PTSD more than three months after a non-combat-related trauma.

Within trauma-focused CBT, psychoeducation should be provided to support the client's understanding on their response to trauma, as well as management strategies to navigate heightened arousal and flashbacks to the event. Trauma memories should be elaborated on and processed, allowing for trauma-related emotions (i.e., anger, shame, guilt) to be

processed and the cognitive restructuring of the trauma-related meanings held by the client. The client should be supported to overcome avoidance and improve their adaptive functioning. Importantly, safety planning should be encompassed into the treatment and the therapeutic ending planned, with 'booster sessions' offered if this is helpful for the client.

1.8.1 Guidelines for Adapting CBT for Autistic Clients

Despite the difference in neurotype between autistic and non-autistic clients, the guidance outlined by the National Institute for Health and Care Excellence (2018) for treating PTSD is the same for autistic and non-autistic clients. This uniform approach may be suboptimal, given that autistic individuals are more likely to encounter barriers to therapy (Dückert et al., 2023; Jubenville-Wood et al., 2023) and have higher rates of unmet healthcare needs compared to non-autistic individuals (Menezes et al., 2021). Recognising this, the National Institute for Health and Care Excellence (2021) issued supplementary guidelines specific to autism, which outline general adaptations to cognitive behavioural therapy that clinicians may consider when treating co-occurring mental health conditions. Recommended adaptations include adopting a concrete and structured approach, incorporating written and visual information, focusing more on behavioural change than cognitive change, making rules explicit and explaining their context, using clear and unambiguous language, involving a family members or carers where appropriate, offering regular breaks, and incorporating special interests where possible.

The National Autistic Society (2021) provide additional transdiagnostic guidance that was developed collaboratively with autistic individuals, their families, and professionals. The guidelines propose both in-session and service-level adaptations. In-session recommendations include ensuring a sensory-considerate therapeutic environment, using clear and

unambiguous communication, allowing additional processing time, exploring whether the presence of a trusted other would be helpful, supporting emotional identification, integrating the individual's interests if helpful, and offering written summaries of sessions. At the service-level, suggested adaptations include improving autism-specific training for staff, modifying therapy and waiting rooms to reduce sensory overwhelm, ensuring service information is accessible, supporting staff to identify and develop autism-friendly practices, and offering autistic clients a clear explanation of different therapeutic approaches to support informed choice.

1.9 The Evidence Base for Adapting Psychological Therapy for Autistic Individuals with Co-existing Conditions

In 2016, Autistica, an autism research and advocacy charity, conducted a James Lind Alliance Priority Setting Partnership alongside several organisations – including the National Autistic Society, Autism Research Trust, and Autism Alliance - to identify the key research priorities for autism. This initiative incorporated the views of experts by experience, including autistic individuals, their families, and autism professionals and identified ten priorities, the highest of which called for the development and evaluation of effective mental health treatments for autistic individuals, and for these to be appropriately adapted to their needs (Autistica, 2016). Nearly a decade later, Cage et al. (2024) reported that this priority remained highly endorsed among autistic adults (n = 225), raising questions about how effectively these priorities have been acted upon by researchers and clinicians.

Cognitive Behavioural Therapy (CBT) is an evidence-based treatment recommended for many mental health conditions (Fenn & Byrne, 2013). Accordingly, the majority of the literature on therapy adaptation for autistic individuals has focused on CBT (Cooper et al.,

2018; Riches et al., 2023; Petty et al., 2023b). Suggested adaptations commonly emphasise the use of clear and concrete language, enhanced structure and predictability, incorporation of written and visual supports, integration of clients' special interests, and a greater focus on behavioural techniques rather than cognitive techniques (Stark et al., 2021; Russell et al., 2019; Trimmer et al., 2024).

However, the evidence base for adapted CBT for autistic adults has several limitations. Much of the research has focused on children or adolescents (Weston et al., 2016; Spain et al., 2015), limiting its generalisability to older populations. Furthermore, Weston et al., 2016 completed a systematic review and meta-analysis of the research available on CBT for autistic individuals across the lifespan. Whilst there was some evidence of effectiveness for affective conditions such as anxiety and depression, this was dependent on the outcome measure, where self-report measures were associated with small and non-significant effect sizes, and informant or clinician reports were associated with a significant small or medium effect size. This discrepancy is in line with previous research (Sandercock et al., 2020), potentially indicating difficulties in the ability of autistic individuals to quantify their experiences (National Autistic Society, 2021).

A further challenge is the gap between guideline-recommended adaptations and actual clinical practice. Following a systematic review, Walters et al. (2016) noted that studies tend to report a greater number of modifications than those outlined by the National Institute for Health and Care Excellence (2018), suggesting that guidance may be insufficient to meet the needs of autistic clients. This leaves clinicians with the responsibility of determining additional, appropriate adaptations. While individualising therapy is a hallmark of good practice (Mayer et al., 2023), many clinicians report lacking the expertise, training, and

confidence to adapt therapy effectively for this population (Cooper et al., 2018; Petty et al., 2023a; Dückert et al., 2023; Riches et al., 2023), raising concerns about implementation quality, and potentially explaining reports from the autistic population that mental health services are frequently inappropriately or inadequately adapted to meet their needs (Au-Yeung et al., 2019; Camm-Crosbie et al., 2019).

Moreover, some studies have sought to systematically identify and formalise necessary adaptations. Spain and Happé (2020) used the Delphi method to achieve consensus among specialist autism clinicians and researchers, identifying 155 recommended adaptations to CBT. Consensus methods are particularly valuable in this context, as they provide a systematic and transparent way to synthesise expertise in order to develop pragmatic guidance where the evidence base is limited (Jorm, 2015). However, this study relied exclusively on the perspectives of autism professionals, which, while valuable, cannot fully substitute for lived experience. indeed, autistic individuals frequently report that their needs and preferences are overlooked or misunderstood by non-autistic professionals (National Autistic Society, 2021), meaning co-production with autistic individuals is essential.

Riches et al. (2023) addressed this limitation by involving a researcher with lived experience of autism throughout the project. The research identified eight key adaptations: 1) increased emphasis on collaboration, 2) supporting emotional literacy to aid emotional understanding, 3) inclusion of special interests, 4) use of visual prompts to improve communication and understanding and reduce difficulties, 5) enhanced consistency to build trust and reduce anxiety, 6) accommodation of sensory needs to reduce anxiety and build engagement, 7) avoidance of metaphors to reduce communication difficulties, and 8) use of role-play to build and enhance social skills. Such findings illustrate the richness of insight that emerges when

autistic voices are included in research. Nonetheless, further research is needed to include more diverse autistic perspectives and to establish how these adaptations influence clinical outcomes.

1.10 The Process of NET

NET is a structured, short-term treatment, typically delivered over 4-12 sessions of approximately 90 minutes each (Schauer et al., 2011). The main components are as follows:

Diagnostic Interview and Psychoeducation

In the initial session, the therapist completes a diagnostic assessment of the individual's difficulties using a clinical interview. The individual completes outcome measures, such as the Life Events Checklist (LEC-5; Gray et al., 2004). They provide psychoeducation, which includes discussion of the brain model, the fear network, the process of therapy, and challenges that may arise including difficulties with avoidance. Importantly, they gain informed consent from the client for the treatment.

The Lifeline

During the lifeline activity, the therapist and client create a timeline of the client's life. The therapist lays out a piece of rope – or ribbon if rope holds unhelpful associations to the client – and explains that one end of the rope represents the time the client was born, and the other end of the rope represents the life yet to come. Often, the therapist will explain to the client that "we are taking a birds-eye view of your life". The client and therapist then construct a chronologically elaborated timeline of the significant events that have taken place in the client's life, symbolised with a 'stone' for a traumatic event or a 'flower' for a positive event. The client provides each event with a label or a name. At this stage, the therapist does not

seek details about any events and instead focuses upon gaining an overview of the client's life. The therapist then may take a photograph, or draw the lifeline, so that they can re-construct a visual representation of the lifeline each session. At the end of the session, the therapist asks the client, "how should we pack this up for today".

It is outlined in the NET manual that the lifeline activity is optional, as there is evidence for the efficacy of NET both with and without this component (Neuner et al., 2004; Hijazi, 2012). However, the lifeline is recommended where possible.

Narration

This phase forms the core of NET. The client narrates the 'flowers' and 'stones' in chronological order, focusing on the 'stones' (i.e., the traumatic events) that are causing symptoms of traumatic stress. For each event, the therapist explores contextual details and supports the client to recount their experience, primarily in the past tense, but occasionally in the present tense if needed to reduce avoidance. The therapist encourages the client to make contrasts between the past and present, for instance, by asking the client "how are you feeling now?" Between sessions, the therapist constructs a coherent narrative of the client's account and reads this aloud at the start of the next session to facilitate habituation, emotional processing, and coherence. The narrative is always written in the past tense.

Final Session

After the narrative is completed, the therapist reads the final narrative aloud during the final session. Both the therapist and client 'sign' the narrative, and they discuss the client's hopes for the future.

1.10.1 NET – The Institute Fundamentals Training

The NET Institute, an organisation founded by the developers of NET, offers a two-day training course for clinicians wishing to incorporate the therapy into their practice. The training offers an understanding of the fundamental theoretical and practical underpinnings of the therapy and includes lectures and demonstrations. A solid understanding of the therapy is essential to evaluate and contextualise potential adaptations, ensuring that any modifications remain consistent with the core principles of NET. Accordingly, the primary researcher completed the NET fundamentals training at an early stage of the project to enable them to design and conduct the study, and to engage meaningfully with the expert feedback on proposed adaptations.

1.11 Testimonial Therapy

Testimonial therapy was developed by Lira and Weinstein to support survivors of the Pinochet regime in Chile (Cienfuegos & Monelli, 1983). Between 1977 and 1980, approximately 600 individuals received psychological assistance, which primarily involved group sessions termed ‘exile orientation groups’ where participants would speak about how torture and persecution had impacted their lives. It was noted from professionals working in Human Rights organisations that demanding justice through filing denunciations and court proceedings supported moral and psychological recovery. This then led to the incorporation of denunciations into the therapeutic process, which were often tape recorded to allow for a permanent archive and validation of their experiences. The tape recording was transcribed and became the focus of subsequent sessions, where the factual and emotional details were revisited (Becker et al., 1990; Lira, 2009). The process of developing this narrative served to be not only therapeutic but also allowed for the documentation of human rights violations (Bichescu et al., 2007). NET can be understood to be an evolution of testimonial therapy, by

adding therapeutic structure and emotional exposure to directly treat symptoms of traumatic stress, rather than solely focusing on documentation and validation (Schauer et al., 2011).

1.12 Behavioural Exposure and Habituation

Behavioural exposure is rooted in behavioural theories of classical conditioning and extinction (Marks, 1978; Pavlov, 1927). In classical conditioning, a neutral stimulus is paired with an unconditioned stimulus that elicits a response. Through repeated pairings, the neutral stimulus begins to elicit a similar response alone, (i.e., the conditioned response). In the context of traumatic stress, the traumatic event itself acts as the unconditioned stimulus and any stimuli present during the time of trauma (i.e., sights, sounds, smells, etc) form the neutral stimuli. The resulting conditioned response is traumatic stress symptoms. Given that traumatic events often involve intense emotional arousal, repeated pairings between the unconditioned stimulus and neutral stimulus are not always necessary for the neutral stimulus to become a conditioned stimulus and result in a conditioned response (i.e., 'one-trial learning') (Haesen et al., 2017).

In exposure therapy, the individual repeatedly faces a stimulus that causes them anxiety or fear, allowing for neural adaptation to 'filter out' irrelevant stimuli thus reducing its perceived importance – a process known as habituation, in which the individual's response to the stimulus gradually diminishes or disappears (Kepler et al., 2020; Harris, 1943; Jennings, 1931). In NET, the client repeatedly talks about the traumatic event in detail and re-lives the experience in the moment (exposure), over time, the individual's response to the stimulus (i.e., traumatic stress) gradually reduces (habituation) (Schauer et al., 2011).

1.13 Autobiographical Integration

Autobiographical memory refers to the memory system responsible for an individual's recollection of personally experienced events, integrated into their sense of self and life narrative (Baddeley, 1992). Traumatic experiences are considered to significantly disrupt this system, resulting in memories that are fragmented, sensory-driven, and without coherence (Brewin et al., 2010). According to Autobiographical Memory Theory (Moore & Zoellner, 2007; Rubin et al., 2008), traumatic experiences significantly impair the self-referential and temporal organisation of memory, making it difficult for the individual to situate the event in a time and place within their broader life story. Such disruption may function as a protective mechanism to shield the individual from the extreme psychological pain associated with the event (Ehlers & Clark, 2000; Van der Kolk & Fisher, 1995; Bedard-Gilligan & Zoellner, 2012).

Autobiographical integration – a proposed change mechanism of NET (Schauer et al., 2011) – refers to the process of integrating memories of traumatic experiences into a coherent autobiographical narrative (Neuner et al., 2008). Through detailed narration of traumatic and positive life events, NET aims to 'anchor' the disrupted trauma memory within the client's autobiographical memory system, leading to a reduction in the involuntary intrusion of such memories and their distressing nature (Schauer et al., 2011). However, empirical evidence for this mechanism remains limited, as illustrated by Lord (2021), who explored autobiographical integration in a mixed-methods single-case A-B design study and found that while participants reported an increase in the vividness and sensory detail of their traumatic memories, their contextual coherence did not consistently improve. This finding raises questions about the role of autobiographical integration in NET and suggests that other processes, such as exposure and habituation, may be more central to therapeutic change.

Alternatively, given that Lord's (2021) findings were based on a very small sample, the findings cannot be generalised and may instead reflect individual variability rather than a definitive reflection of the mechanisms involved in NET. Nonetheless, further research with larger samples is warranted to clarify the role of autobiographical integration in NET outcomes.

1.14 Dual Representation Theory (Brewin et al., 1996)

Brewin et al. (1996) proposed the Dual Representation Theory, which suggests that post-traumatic stress symptoms arise from a disconnect between two of the memory systems involved in the encoding of traumatic memories (Brewin & Burgess, 2014). The verbally accessible memory (VAM) system and the situationally accessible memory (SAM) system operate in parallel. Verbally accessible memories include information that was consciously processed at the time of the event; these memories can be voluntarily recalled and described verbally. In contrast, situationally accessible memories store information that was not consciously processed and can only be retrieved involuntarily through situational cues (Rubin et al., 2008). When an individual is driven into their defense response – such as during exposure to a traumatic event – their conscious attention is narrowly focused on the immediate threat. This heightened arousal impacts the functioning of the hippocampus, which is responsible for the 'date stamping' memories and situating them into autobiographical context (van Rooij et al., 2018). Consequently, the ability of the VAM system to collect and encode autobiographical context – such as the event's position in time – is impaired. Meanwhile, the SAM system encodes the sensory and emotional aspects of the event, which are later involuntarily reactivated through exposure to triggers. This results in a memory that is highly emotionally charged, poorly contextualised, and fragmented (Halligan et al., 2003).

1.15 Emotion Processing Theory (Foa & Kozak, 1986)

Foa and Kozak (1986) proposed the Emotional Processing Theory, which posits that emotional memories are stored within a network containing cognitive, emotional, physiological, and sensory representations of the traumatic event. With repeated or multiple traumatic experiences, this network broadens, forming a fear network that can be activated by exposure to any of the cues contained within it (Wilker & Kolassa, 2013). The avoidance of trauma-related cues serves to reinforce the fear network, as avoidance does not allow the network to be updated with corrective information (Foa & Kozak, 1986). From this perspective, psychological treatment should promote autobiographical integration of the traumatic memory and facilitate exposure to and habituation within the fear network, thereby reducing its power and accessibility (Brewin & Holmes, 2003).

1.16 Evidence Base

The evidence base for NET is growing, although still emerging. In a meta-analysis of randomised controlled trials (RCT), Wei and Chen (2021) reported medium effect sizes for NET in reducing symptoms of traumatic stress, suggesting it is an effective therapy. Notably, individuals receiving NET were more than twice as likely to no longer meet diagnostic criteria for PTSD compared to those in inactive control conditions (e.g., waitlist or no treatment). However, when adjusting for potential publication bias, these between-group differences were no longer statistically significant, raising questions about the robustness of the evidence. Furthermore, the meta-analysis identified high heterogeneity among included studies, which could not be fully explained by subgroup analysis, suggesting that NET's effectiveness may depend on contextual or population-specific factors. This highlights the need for further research to clarify which components of NET are most beneficial and for whom.

In a meta-analysis and meta-regression, Lely et al. (2019) evaluated the methodological quality of NET trials and concluded that external validity was generally high, and methodological quality was equivalent to other trauma-focused interventions. The analysis also suggested that older age was associated with better outcomes and that treatment effects are sustained over time. This finding was corroborated by Siehl et al. (2021), who examined the long-term efficacy of NET compared to active controls. The meta-analysis found small-to-medium effect sizes at short-term follow-up and large effect sizes at longer-term follow-up, suggesting that treatment benefits not only ensure but may increase over time, potentially as autobiographical integration and habituation continue following the therapy.

Whilst NET has not yet been empirically compared to other guideline-recommended trauma-focused therapies, preliminary evidence suggests NET may have the lowest drop-out rates among studied trauma-focused therapies, including exposure therapy and prolonged exposure (Varker et al., 2021). This could reflect NET's narrative and person-centred approach that allows for flexibility in accommodating to different contexts, potentially improving engagement. However, it should be noted that dropout was inconsistently defined and reported, with only 7% of studies explicitly operationalising it. Additionally, dropout was not necessarily associated with poorer outcomes, as some individuals who discontinued treatment still experienced clinical benefit.

1.17 NET for Children (KIDNET)

KIDNET was developed by Neuner et al. (2008) and typically consists of between four and 10 sessions, each lasting between 90 and 120 minutes. It was developed for use with children from the age of seven. During KIDNET, the child and caregiver attend a structured diagnostic

interview during which they complete the Life Events Checklist (LEC-5; Gray et al., 2004). This is followed by up to two brief psychoeducation sessions, each lasting approximately 90 minutes. The therapy then proceeds according to the standard NET protocol, with the addition of the child's parent or caregiver being present during the sessions – provided the caregiver is not the perpetrator of the traumatic event.

1.18 NET for Intellectual Disability (IDNET)

NET in its standard form may be challenging for individuals with an intellectual disability, primarily due to its reliance on verbal communication and the understanding of abstract concepts. To address these barriers, IDNET was developed by Marlow et al. (2022), incorporating a collection of 'easy read' therapy materials that use simpler language and visual representations. The adaptation also extends the lifeline exercise to allow for a slower pace and includes caregivers to support emotional containment and facilitate communication. The feasibility of IDNET is yet to be evaluated, including how it should be implemented in practice and its potential impact on symptoms of traumatic stress.

1.19 NET for Forensic Offender Rehabilitation (FORNET)

FORNET was developed by Hecker et al. (2015) as an adaptation of NET for use in forensic settings. In FORNET, clients are encouraged to verbalise the experience of positive emotions and experiences they associated with past violence and aggression. Such feelings may include a sense of power, control, and belonging, all of which can reinforce further offending. These feelings are then contrasted with those experienced during the narration of their traumatic experiences, often feelings of suffering, loss, and emptiness. Further elements are introduced to symbolise different types of experiences; for instance, a 'stick' is used to symbolise violence perpetrated by the client and a 'candle' is used to mark the bereavement of

significant figures in the client's life. Over the course of FORNET, the client is supported to transition from identifying as a 'violent offender' to a 'citizen' who is able to live a non-violent life.

1.20 NET for Autistic Adults

It is plausible that several components of NET are particularly well-suited for autistic adults. First, research has shown that autistic individuals are more likely to experience multiple traumatic events rather than a single, isolated event (Rumball et al., 2021). This can result in cumulative and complex traumatic stress (Kube et al., 2023) which NET is designed to address through its focus on the lifespan (Schauer et al., 2011). This broader temporal focus offers space to explore chronic or repeated stressors (e.g., bullying, sensory trauma, and misdiagnosis) which might otherwise be overlooked in traditional trauma therapies that prioritise "big T" events (e.g., physical assault, witnessing death) (Shapiro, 2001; Straussner & Calnan, 2014). Secondly, NET offers a highly structured, session-by-session format (Schauer et al., 2011). Many autistic individuals benefit from predictability and routine, particularly where differences in executive functioning are present, as increased structure can reduce cognitive load and thus support engagement and treatment outcomes (Gomot & Wicker, 2012; Goris et al., 2020).

Furthermore, the concrete and visual nature of NET – such as the use of tangible objects to symbolise the lifespan and significant events (Schauer et al., 2011) – may provide helpful containment for autistic clients who find it difficult to access traditional talk therapy due to differences in emotional processing, introspection, and abstract reasoning. Additionally, NET does not rely on explicit cognitive restructuring, making it potentially more accessible for individuals who tend to think more literally or have difficulties with abstract reasoning, as is the case for some autistic adults (Spain et al., 2023). This could potentially foster a more

psychologically safe environment, which is an important consideration for a population who frequently report negative, invalidating, and distressing encounters with healthcare services (Weir et al., 2022).

Despite this theoretical compatibility, NET has not been widely described in the context of autism. Given findings that autistic adults are less likely to have their healthcare needs met (Doherty et al., 2023; Mazurek et al., 2022; Weir et al., 2022), it is important that research and clinical efforts are made to address this gap. Indeed, the United Kingdom's National Health Service highlight an urgent need to develop and provide appropriate, trauma-informed services for autistic adults (NHS England, 2023). Adapting existing evidence-based interventions offers a more efficient and scalable approach than creating new treatments (Moore et al., 2021). As such, the present study sought to adapt NET for use with this population.

1.20.1 Narrative Therapy and Autism

Whilst NET has only been briefly described for use with autistic adults in a single research article (Fazel et al., 2020), narrative therapy, originally developed by White and Epston (1990), has been more widely applied with autistic populations (Cashin et al., 2013; Romney & Jones, 2020; Monteiro, 2021; Stancer, 2022; McGuinty et al., 2012; Falahi & Karimisani, 2016). Narrative therapy, rooted in social constructionism and postmodernism, has been used with a broad range of mental health difficulties (Ghavibazou et al., 2022). It offers a strengths-based approach aimed at supporting clients to re-author the stories they tell about themselves (Rice, 2015).

Cashin (2008) highlighted the consonance between the features of autism and the techniques of narrative therapy, noting that its visual and structured approach – such as the concept of 'spying' on the problem and co-authoring written and illustrated life stories – align with the cognitive and communication styles of autistic individuals. In a pilot study, Cashin et al. (2013) reported significant reductions in psychological distress among a sample of ten autistic children following five, one-hour sessions of narrative therapy. The intervention included the techniques central to narrative therapy, including externalisation, where the problem is separated from the person to support the individual in no longer viewing the problem as an inherent part of their identity, and thus feeling empowered to gain a sense of control over it.

Although not an explicit form of narrative therapy, social stories are commonly used with autistic individuals (Como et al., 2024). Social stories were developed by Grey (2000, 2010) to support autistic individuals with understanding and participating in social situations by providing expectations and examples of appropriate behaviours. It often forms a written narrative, using clear and literal language, with visual information if this is helpful. Thus, while narrative therapy, social stories, and NET differ in their theoretical foundations, approach, goals, and delivery, they converge in their use of storytelling. This suggests that narrative-based approaches may have particular relevance and acceptability for autistic individuals, offering a meaningful way to make sense of experiences and support psychological well-being.

1.20.2 Potential Challenges

There is some evidence to suggest that autistic individuals are more likely to experience difficulties with autobiographical memory, which may impact their ability to construct a

coherent personal narrative (Westby, 2022). In a study exploring the autobiographical memory of a sample of autistic adults, Crane and Goddard (2008) found that autistic adults demonstrated significantly weaker episodic memory than non-autistic controls, meaning they recalled significantly fewer specific personal events. However, no differences were observed in semantic memory, meaning participants retained general self-knowledge similarly to non-autistic controls. These findings were corroborated by Gaigg et al. (2014), who asked a sample of autistic adults to name a number of historical figures either in chronological order (i.e., to probe semantic memory) or in a randomly generated order (i.e., to probe episodic memory). The findings revealed that participants performed significantly less well than a matched control group only on the episodic task. Given that autobiographical integration is considered to be a key change mechanism in NET (Schauer et al., 2011), autistic individuals may find it difficult to recall traumatic events in sufficient detail to build a coherent, chronological narrative, potentially resulting in a more fragmented narrative. This difficulty may have implications for engagement and outcomes.

In addition, many autistic individuals experience difficulties in interoception, which is the ability to identify, name, and interpret internal bodily sensations (Loureiro et al., 2024; Folz et al., 2024), and alexithymia, which refers to difficulties in identifying and naming emotions (Kinnaird et al., 2019; Poquérusse et al., 2018). Since NET requires clients to describe their sensory and emotional experiences both at the time of the traumatic event and during the narration, these aspects of the process may feel inaccessible, overwhelming, or even distressing for some autistic individuals.

Despite these potential challenges, some of which may persist beyond adaptation, dismissing NET as unsuitable for the autistic adults risks unnecessarily excluding this population from

an evidence-based treatment that may be impactful if appropriately adapted. While the difficulties outlined above may make NET more challenging for autistic adults to access, these challenges should not preclude its use and rather, underscores the importance of meaningful adaptation to accommodate to these differences.

1.21 ADAPT Guidance

It is generally recommended that rather than producing new therapies, it could be more efficient to adapt current evidence-based therapies. To guide this process, the ADAPT guidance was produced following a need to improve the conduct and reporting of adapted interventions (Moore et al., 2021). The guidance was generated using various methods including systematic (Movsisyan et al., 2019) and scoping (Movsisyan et al., 2021) review methods, qualitative interviews and consultation with stakeholders (Copeland et al., 2021) and a three-round Delphi study (Campbell et al., 2020). The guidance presents a framework (Appendix Z) for researchers to follow, advise they consider: 1) the involvement of stakeholders in generating adaptations, 2) identifying a suitably evidence-based intervention to adapt, 3) planning and undertaking the adaptations, 4) evaluating the adaptations, 5) implementing the adaptations into routine clinical practice, and 6) reporting the process of identifying the adaptations and their outcomes. A checklist of key considerations is provided to support researchers in this process (Table 5). The guidance also outlines several recommendations for the transparent reporting of adaptations (Appendix AA). These recommendations were adhered to throughout the write-up of the present study.

Table 5

ADAPT Guidance Checklist (Moore et al., 2021)

ADAPT Guidance	The Present Study
Forming an adaptation team	
Have you involved an appropriate range of stakeholders, including those with expertise in the intervention and its evidence base, and those with knowledge of the new context?	Experts by experience (i.e., autistic adults) and experts by profession (i.e., autism professionals) were recruited to identify the potential adaptations. Experts by experience have lived experience of autism and so are able to provide valuable insights into what may be helpful for this population. Experts by profession have a working knowledge of autism, and a practical insight into implementation in clinical settings. Clinicians experienced in NET were also recruited to explore whether the proposed adaptations were consistent with the principles of NET and feasible in practice.
Is your team clear on roles, including who will make decisions on adaptations, when, and how?	The research team explicitly identified that experts by experience and experts by profession would be responsible for generating and reviewing adaptation decisions. They were responsible alongside the NET experts for finalising adaptation decisions. The research team pre-determined the consensus threshold to be 80%.
Will you work with the developers of the intervention? If so, how will you manage any conflicts of interest arising from this?	One member of the NET expert panel was involved in the original development of NET. Their contribution was limited to providing

	feedback, and they were not involved in decision-making, mitigating potential conflicts of interest.
How might the membership of your adaptation team need to evolve as adaptation progresses?	If the adaptations were to be piloted in a feasibility or implementation trial, it may be helpful for additional stakeholders to become involved. Though, piloting is out of scope for this formative phase of study.
Assessing the rationale for intervention, and considering intervention-context fit	
What is the problem that an intervention seeks to improve in the target population?	Autistic adults are disproportionately affected by traumatic life events and are at an elevated risk of experiencing traumatic stress (Rumball et al., 2020; Peterson et al., 2019). Despite this, autistic individuals have limited access to evidence-based trauma therapies that are adapted to meet their needs (Rumball, 2019). The present study addressed this gap by adapting NET for use with this population.
Is there more than one potential evidence informed intervention? If so, are there reasons one might be more suitable than others, such as the relevance of its programme theory and change mechanisms?	While other trauma-focused therapies exist, NET was selected due to its suitability for use with individuals who have experienced multiple traumatic experiences, as is often the case for autistic adults (Rumball et al., 2020). NET is also a structured, approach that incorporates visual elements and storytelling (Schauer et al., 2011), all of which align well with the preferences and strengths of many autistic individuals (Gomot & Wicker, 2012; Goris et al., 2020).

What is known about the selected intervention(s) in terms of programme theory, process, effectiveness, cost effectiveness and implementation in other contexts?	NET is an evidence-based, short-term trauma-focused therapy that supports clients to create a coherent, chronological life narrative that integrates their experiences of trauma (Schauer et al., 2011). It has demonstrated efficacy in reducing symptoms of traumatic stress (Wei & Chen, 2021; Lely et al., 2019; Siehl et al., 2021). NET has demonstrated efficacy in resource-limited settings (Neuner et al., 2004). It is typically delivered in four to 12 sessions.
How robust are any claims that the intervention(s) has worked elsewhere?	NET has been evaluated in various randomised controlled trials, with evidence for its short-term and long-term effectiveness (Wei & Chen, 2021; Siehl et al., 2021). However, the evidence is limited due to publication bias (Lely et al., 2019). The use of NET with autistic individuals remains unexplored, with only a single published case study (Fazel et al., 2020).
How similar and different are original and new contexts, in terms of issues likely to affect implementation and effectiveness?	NET was originally developed for use with populations impacted by war and torture (Schauer et al., 2011). It has since been adapted to various populations, including children (KIDNET; Neuner et al., 2008), individuals with intellectual disability (IDNET; Marlow et al., 2022), and forensic offender rehabilitation (FORNET; Hecker et al., 2015). The new context – autistic adults in mental health services – differs in neurotype, which may affect delivery.
Are there any intellectual property issues which limit use and adaptation of the intervention(s)?	NET is an open-access, manualised intervention. No intellectual property issues were anticipated.

Planning for and undertaking adaptations

What adaptations can you make to respond to constraints and facilitators, while maintaining consistency with intended intervention functions?	Proposed adaptations were developed to improve accessibility for autistic adults while preserving consistency with the principles of NET (i.e., autobiographical integration, exposure and habituation). These were assessed for consistency and feasibility by NET experts.
What adaptations need to be made to intervention materials, such as manuals, to capture changes made to the intervention?	The NET manual is to be adapted; specifically, how the assessment and psychoeducation, the lifeline, narration, re-narration, and duration/total number of sessions are outlined.
Might interactions with aspects of the new context lead to any new unintended consequences?	Not formally explored, but potential risks were considered (e.g., clients becoming overwhelmed with the demands of exposure, the approach being inaccessible due to difficulties with interoception and alexithymia).
What costs and resources are needed to deliver the adapted intervention?	Out of scope for this formative phase of study.
Who will deliver the adapted intervention, and how will you recruit them?	Out of scope for this formative phase of study.

Planning for and undertaking evaluation	
Given what is known about the intervention, and the likely transferability of previous evidence, what type and extent of re-evaluation is warranted?	Out of scope for this formative phase of study.
What will be the value of new information to policymakers, practitioners, and other stakeholders?	Out of scope for this formative phase of study.
What resources are available for re-evaluation?	Out of scope for this formative phase of study.
Does initial feasibility testing indicate that any further adaptations are needed?	Out of scope for this formative phase of study.
How will you capture responsive adaptations and decide whether the intervention remains consistent with intended functions and change mechanisms?	Out of scope for this formative phase of study.
How will you evaluate effectiveness, cost effectiveness, and process, if this is warranted by uncertainty about whether existing evidence will transfer?	Out of scope for this formative phase of study.
Implementing and maintaining the intervention at scale	
What long term partnerships and capacity will be needed for maintenance of the intervention?	Out of scope for this formative phase of study.

How will you monitor whether the intervention continues to be delivered, and maintains its effectiveness, over time in real world practice?	Out of scope for this formative phase of study.

2.0 Extended Methods

2.1 The Delphi Method

The Delphi method is a structured and systematic approach to gathering and refining expert opinion on a specific topic through a series of iterative rounds (Dalkey & Helmer, 1963). It is grounded in the principle of the 'wisdom of crowds', which suggests that the collective opinion of a group is superior to that of an individual (Surowiecki, 2005; Lyon & Pacuit, 2013). The Delphi is particularly well suited to situations where the evidence base is limited or underdeveloped (Shang, 2023), and typically begins with the recruitment of a panel of experts with relevant knowledge and experience in the topic area. These participants are presented with a stimulus – such as an interview schedule or a structured survey, typically containing open-ended questions – and are invited to provide their views. Responses from the initial round are then aggregated and analysed, often using qualitative analysis, to extract key themes or generate items for use in subsequent rounds (Nasa et al., 2021; Beiderbeck et al., 2021).

In some Delphi studies, a summary of individual and group-level feedback is provided in subsequent rounds, and participants are invited to reconsider or refine their responses in light of this information, thereby supporting the convergence of opinion (Chalmers & Armour, 2018). In other designs, participants are not asked to revise their earlier responses but are instead presented with an updated or amended version of the original stimulus (King et al., 2021). This process is repeated until a predefined stopping criterion is met, which is typically the achievement of consensus, the completion of a predetermined number of rounds, or a decline in participant engagement (Shang, 2023).

The Delphi method is highly flexible and has been adapted to suit a variety of research aims and contexts, leading to the development and recognition of several variants, including the Classic Delphi, Modified Delphi, Policy Delphi, and e-Delphi (Strasser, 2017).

Classic Delphi

As the original format of the Delphi method, the Classic Delphi is typically conducted over two-to-three rounds. It begins with an open-ended question on a specific topic, inviting participants to share their views. These initial responses are then analysed to generate stimuli that are to be rated in subsequent rounds (e.g., an initial set of items or themes) (Hassan et al., 2025). In later rounds, the stimuli are rated or ranked by participants, typically using quantitative response formats. Responses are analysed using measures of central tendency and dispersion to determine the level of consensus within the group. These aggregated findings are then re-presented in subsequent rounds, allowing participants to reconsider and refine their views considering the group feedback (Trevelyan & Robinson, 2015).

Modified Delphi

The Modified Delphi refers to any variation of the Classic Delphi method that diverges from the original process (Nasa, 2021). Common modifications include beginning the process with a pre-defined stimulus which may have been derived from a literature review or prior expert consultation, reducing the number of rounds, and incorporating face-to-face elements, such as a focus group (Woodcock et al., 2020). While the inclusion of in-person elements can compromise participant anonymity, it may facilitate a richer dialogue and increased engagement among participants (Baumann & Brütt, 2023).

Policy Delphi

The Policy Delphi is typically conducted over more than three rounds and is designed to explore a wide range of perspectives rather than to reach consensus (Turoff, 1970). It is particularly well-suited to complex or controversial topics, where limited information is available (Manley, 2013). The primary aim of the Policy Delphi is to structure dissensus by identifying areas of agreement and disagreement, while also examining the underlying rationale behind participants positions (de Loë et al., 2016).

e-Delphi

The e-Delphi was utilised in the present study. It is a modern adaptation of the Delphi method that maintains its core methodological principles – such as iterative rounds, controlled feedback, and participant anonymity – while being conducted entirely online (Thangaratinam & Redman, 2005). This format enables asynchronous participation, allowing participants to contribute at their own convenience (Mamaqi et al., 2010). The e-Delphi is particularly well suited to studies involving international or geographically dispersed panels, where logistical challenges might otherwise limit participation (Msibi et al., 2018).

2.1.1 Defining 'Consensus'

A key consideration when using the Delphi method is how consensus is defined and measured. In most studies, consensus is operationalised using a percentage agreement threshold, which can vary from 50-96%, with a commonly reported median of 75% (Diamond et al., 2014; Foth et al., 2016). It is generally recommended that this threshold is specified a priori to enhance methodological rigour and reduce the risk of post hoc bias (Nasa et al., 2021). However, the identification of a fixed threshold can be arbitrary, particularly if responses fall just below the defined threshold, which could result in meaningful items being

excluded (Barrios et al., 2021). As such, while a priori thresholds support transparency, it can be helpful if they are used flexibly.

2.1.2 Defining 'Experts'

Within the context of a Delphi study, an expert is defined as an individual with knowledge and experience relevant to the subject matter that is under investigation (Okoli & Pawlowski, 2004). Experts may include, but are not limited to, researchers, clinicians, policymakers, or individuals with lived experience. The key criterion is that participants have sufficient insight and knowledge regarding the subject matter in order to provide informed and meaningful judgements (Hasson et al., 2000). According to Surowiecki (2005), for the 'wisdom of crowds' effect to emerge, the group of experts must fulfil four key criteria: 1) heterogeneity of expertise (i.e., experts that diverge in their background allow for a wider breadth of experience to be accounted for); 2) independence (i.e., experts decisions should not be influenced by others); 3) decentralisation (i.e., experts should be autonomous and draw on their own specialised knowledge); 4) aggregation (i.e., there should be a structured means to coordinate and combine experts' responses into a collective outcome).

2.1.2.1 Sample Size. The sample size in Delphi studies can vary considerably and is largely dependent on the scope of the research question, the complexity of the topic, and the resources available (Fink et al., 1991; Delbecq et al., 1975). Most commonly, Delphi panels include between eight (Paul, 2008) and 20 participants (Jorm, 2015), with panels of 15 to 20 participants considered to be sufficient to capture a diverse range of opinion (Hasson et al., 200). Smaller sample sizes can be problematic, as each participant has proportionally greater influence on the results (Shang, 2023). This can increase the risk of response instability and reduce the likelihood that the panel reflects a sufficiently diverse or representative pool of

expertise. Conversely, while larger samples may dilute the influence of individual responses and potentially enhance representativeness, they may present practical challenges, such as lower response rates, greater attrition across rounds, and greater administrative burden on the research team. Additionally, larger samples may result in diminishing returns, where further participants do not significantly improve the quality or stability of the results (Vogel et al., 2019; Murphy et al., 1998). As such, it is important that methodological rigour is balanced with practical feasibility when selecting an appropriate sample size for a Delphi study.

2.1.3 Quantifying Consensus

In the present study, participants rated each stimulus using a criterion-based scale with three response options (i.e., 'very important', 'somewhat important', 'not important'). This format was selected to encourage clear and considered judgments, while also enhancing accessibility. Research has suggested that autistic individuals may experience difficulties with traditional numerical scales, particularly when asked to rate abstract concepts such as agreement or importance along a continuum (National Autistic Society, 2021; Stacey & Cage, 2023). The use of a criterion-based scale allowed for a verbal anchor for each response, helping to reduce ambiguity and cognitive load. Limiting the response options to three categories also supported simplicity and clarity. The same criterion-based approach was applied to EBE and EBP panels to ensure methodological consistency across groups. This approach aimed to optimise both the validity of participant responses and the usability of the data for analysing consensus.

2.1.4 Critical Consideration of the Delphi Method

The Delphi method is considered highly appropriate for addressing research questions that are not amenable to experimental methods (Jorm, 2015), particularly in areas where empirical

evidence is limited or emerging (Farrell & Scherer, 1983), as is the case for the use of NET with autistic adults. Despite the increasing use of the Delphi method in health and social care research (Nasa, 2021), a frequently cited limitation of the method is the lack of standardised guidance on its implementation (Hasson et al., 2025). This has contributed to significant methodological variability across studies in aspects such as sample size, number of rounds, definition of consensus, and methods of analysis (Shang, 2023). In addition, there are currently no universally accepted quality appraisal parameters for Delphi studies, which poses challenges for evaluating the credibility, replicability, and impact of studies utilising the method (Nasa, 2021).

To address these concerns, the present study utilised the framework outlined by King et al. (2021), which provides practical and systematic guidance on applying the Delphi method to the adaptation of psychological therapies for new populations and contexts. This framework informed several key aspects of the study's design, including the use of purposeful sampling, the 80% consensus criterion determined a priori, and use of three iterative rounds. However, the present study diverged from this guidance in one significant way: it did not include a face-to-face component. While King et al. (2021) incorporated this component to enhance engagement and clarify responses, it was deemed potentially unsuitable in the present study due to the increased likelihood that some EBE may find this to be challenging. While it would be an overgeneralisation to assume that all autistic individuals would experience discomfort during face-to-face social interactions with individuals unfamiliar to them, this difficulty reflects the known social and sensory differences associated with autism (American Psychiatric Association, 2013; World Health Organization, 2022). This adaptation highlights the flexibility of the Delphi method and the importance of aligning the technique in response to the practical and ethical considerations of the participant group. While the lack of

standardisation across Delphi studies is often cited as a limitation (Hasson et al., 2025; Shang, 2023), this very flexibility can also be viewed as a methodological strength of the approach, as it allows researchers to tailor the method to suit the research context, thereby enhancing both inclusivity and relevance.

The Delphi method was considered alongside alternative consensus-based methods, such as the Nominal Group Technique (NGT). The NGT typically consists of four stages: 1) idea generation, 2) round-robin feedback, 3) group discussion, and 4) ranking of priorities (McMillan et al., 2016). This structured, face-to-face format allows for equal contribution among participants and can result in more efficient idea-generation than less structured methods, such as brainstorming (Boddy, 2012). However, the NGT is most appropriate for generating and prioritising concrete ideas within small, in-person group contexts and may not necessarily be well-suited to a multi-stage, content-focused process such as adapting a therapeutic protocol. Given the highly structured and time-limited nature of the NGT, its use in the present study may have yielded vague or surface-level contributions, particularly in comparison to the Delphi method, which facilitates more reflective and in-depth responses over multiple rounds (Jorm, 2015). Although it would have been possible to conduct several NGT sessions, doing so would likely have increased participant burden and the risk of attrition, as this would have required multiple periods of sustained focus at fixed times. In contrast, the e-Delphi format utilised in the present study allowed for asynchronous participation, enabling participants to respond at times most convenient to them, thereby supporting greater accessibility and engagement.

Whilst the NGT has been successfully utilised with autistic participants (Nelson et al., 2023), its suitability for use with the EBE group in the present study was questioned. The requirement for in-person verbal communication may have risked excluding individuals less comfortable with these dynamics, potentially resulting in a biased sample composed of those more confident in navigating such contexts. Additionally, the lack of anonymity in NGT introduces the potential for power dynamics to influence responses. For example, EBE may have felt disempowered or reluctant to challenge ideas expressed by EBP, while EBP may have withheld views to avoid appearing dominant or insensitive. While it could have been possible to conduct two separate EBE and EBP NGT groups, this would have reduced time efficiency and potentially weakened the integration of perspectives across the groups. In contrast, the Delphi method preserved participant anonymity and allowed for remote participation, which was considered more inclusive and equitable, particularly for a neurodiverse sample. As such, the Delphi method provided a pragmatic balance between rigour, inclusivity, and rigour.

It is important to acknowledge that despite its strengths, the Delphi method is sometimes regarded as producing lower-quality evidence when compared to experimental designs such as randomised controlled trials (RCT), which are often positioned as ‘the gold standard’ in research (Hariton & Locascio, 2018). However, this critique overlooks the fact that the Delphi method was used to develop the criteria for assessing the quality of RCTs themselves (Verhagen et al., 1998). Moreover, RCTs are not amenable to all types of research questions, particularly in early-stage intervention development, where a foundation of expert consensus and qualitative understanding must be established. It is also important to recognise that expert input in Delphi studies may originate from findings in published literature, which experts

may draw upon in their responses. As such, the Delphi method offers a valuable starting point for further investigation.

2.2 Using the Delphi Method to Adapt Therapy

Although evidence-based treatments are often modified, the Delphi method has not been widely described for this purpose. King et al. (2021) subsequently described a framework for applying the Delphi method to adapting psychological treatments, which was utilised in the present study (Table 6).

Table 6

Applying the Delphi Method to Psychological Treatment Adaptation, adapted from King et al. (2021)

Delphi Procedure	The Present Study
Step 1. Identify Research Question/ Problem Statement	Aim: To adapt NET for use with autistic adults. Research Questions: What are the views of experts by profession on how NET should be adapted for autistic adults experiencing traumatic stress? What are the views of experts by experience on how NET should be adapted for autistic adults experiencing traumatic stress?
Step 2. Identify and Select SMEs (subject matter experts)	15 experts by profession (i.e., psychologist, nurse, occupational therapist, psychiatrist, social worker, speech and language therapist, or member of support staff, with a minimum of two years' experience working with autistic individuals). 15 experts by experience (i.e., autistic adults with a confirmed autism diagnosis).
Step 3. Establish Data Collection & Analytic Procedures	
Specify design (quantitative, qualitative, mixed)	Mixed.
Specify analytic paradigm	Qualitative: content analysis. Quantitative: descriptive statistics (i.e., percentages).

Operationally define consensus	≥ 80% (i.e., items rated as ‘very important’ by 80% or more of participants were included in the adapted protocol).
Establish communication medium	Remote, anonymous, via an online survey platform.
Create stimulus materials	Three rounds of questionnaires: Round 1: Participants were presented the five elements of NET (i.e., assessment and psychoeducation, the lifeline, narration, re-narration, and duration/total number of sessions). For each element of NET, participants were asked whether adaptations would be helpful. If responding ‘yes’, they were asked to suggest what adaptations may be helpful. If responding ‘no’, they were asked to explain their rationale. Round 2: Participants were presented the adaptations proposed by their own expert group and asked to rate the adaptation in terms of its importance. Round 3: Participants were re-presented the adaptations proposed by their own expert group that were close to the threshold (i.e., 70-79% consensus as ‘very important’). They were also presented the adaptations reaching 70-100% in the other expert group and asked to rate their importance. They were also asked to clarify a number of adaptations the research team deemed to be subjective or ambiguous.
Step 4. Collect & Analyse Data	
Multi-round feedback loop	Three rounds:

	Round 1 – 15 EBP and 15 EBE responded. Responses were analysed using content analysis, forming 76 adaptations from EBP responses and 54 from EBE responses. Round 2 – EBP rated 76 adaptations in terms of importance, and EBE, 54. Following this, 28 EBP adaptations met consensus, 9 to be re-rated, and 39 excluded. For EBE adaptations, 21 met consensus, 13 to be re-rated, and 20 excluded. Round 3 – EBP rated 39 adaptations and EBE, 48. Following this, 28 met consensus in both groups, 27 in one group but not the other group, and 12 in neither group. Adapted NET protocol produced.
Close feedback loop	
Step 5. Decision-Making	
Assessment of whether further study or implementation is required.	The research team determined that sufficient adaptations were generated and achieved consensus, and that implementation would be required to explore the adaptations in practice.

2.3 Focus Groups

Focus groups are a qualitative data collection method used to gather the insights and perspectives of a group of participants on a specific topic area (Morgan & Spanish, 1984; Morgan, 1997). They involve guided discussions facilitated by a moderator, allowing participants to present their views, respond to each other, and reflect on the discussion, resulting in the co-construction of meaning (Kitzinger, 1995). This process allows for the emergence of richer and more nuanced data than might be achieved through individual interviews, as it surfaces the convergence and divergence of opinion in real time (Barbour, 2007). The moderator plays a key role in promoting equal participation and directing the discussion using a flexible structure of open-ended, pre-determined questions and prompts (Neville, 2007; Krueger, 2002). Sample sizes in focus group research can vary, but in a study interviewing researchers experienced in conducting focus groups, participant sample sizes of between four and six were deemed to be optimal to allow participants sufficient time and space to contribute meaningfully (Tausch & Menold, 2016).

In the present study, the focus group method was utilised during the consultation with NET experts. This approach was selected to facilitate an interactive discussion among individuals with in-depth knowledge of the model of NET, enabling the exploration of whether the adapted protocol was consistent with the principles of NET and feasible in practice. The focus group method was particularly well-suited to this phase of the study, as it allowed NET experts to respond to and reflect on each other's experiences and insights, and for areas of convergence or divergence in opinion to be highlighted. The session was guided by a semi-structured schedule (Appendix Q).

2.3.1 Critical Consideration of Focus Groups

Focus groups offer several methodological advantages. They allow for the collection of multiple perspectives in a single session, making them both time and resource-efficient (Ochieng et al., 2018). The semi-structured format offers flexibility, enabling the moderator to pursue relevant tangents that arise organically during the discussion. Such content can result in valuable insights that might not have otherwise surfaced in structured, individual interviews (Kitzinger, 1995). However, focus groups also pose various limitations. One key challenge is the potential for unequal participation among group members, where some participants may dominate the conversation while others remain quiet, resulting in 'groupthink', where participants align with dominant voices without necessarily expressing their true views, thus resulting in the representation of only a subset of opinion (Janis, 1972). Although it is the role of the moderator to note unequal participation and encourage more balanced participation, this can be challenging in practice and requires a moderator who is both skilled and experienced in facilitating group discussions (Leung & Savithiri, 2009).

2.4 Experts by Profession Eligibility Criteria Justification

EBP were required to have a minimum of two years' experience working with autistic individuals. This was to ensure that participants had sufficient clinical knowledge and practical experience to make informed and meaningful contributions, whilst also allowing for a degree of variance in experience levels to result in a more heterogeneous sample that can capture a wide range of ideas and priorities. In addition, EBP were required to be working in a profession recognised within a specialist autism team (e.g., psychologist, nurse, occupational therapist, psychiatrist, social worker, speech and language therapist, or member of support staff), as defined by the National Institute for Health and Care Excellence (2021). This ensured that the panel captured multi-disciplinary perspectives to allow for a

comprehensive account of how NET may be adapted for this population and further supported heterogeneity of the sample.

2.5 Expert by Experience Eligibility Criteria Justification

EBE were required to have a confirmed clinical diagnosis of autism, rather than a suspected or self-identified diagnosis. This criterion was necessary to ensure that participants were representative of the specific population targeted by the study. While individuals with suspected autism may have similar experiences, including those with a confirmed diagnosis increased the validity and specificity of the findings by ensuring that all perspectives were grounded in the lived experience of autistic adults. Participants were not required to provide formal evidence of their diagnosis, in line with common practice in autism research and to respect the privacy of participants and minimise unnecessary barriers to participation.

EBE were defined as autistic adults, rather than family members or carers of autistic individuals. Although family members and carers can provide useful insights, they cannot speak directly to the subjective experience of being autistic themselves. Additionally, it has been noted in the literature that some autistic individuals report that they do not wish for family members to be involved in psychological therapy (McVey et al., 2023) and so involving family members or carers in the adaptation of therapy for the population would have felt incongruent with this preference. Furthermore, while some autistic individuals – particularly those with a co-occurring intellectual disability - may rely on familial support, this is not representative of the sample targeted in this study. Individuals with a co-occurring diagnosis of intellectual disability were excluded from participation due to the existence of an already adapted protocol of NET for this population (Marlow et al., 2022). Given the differences in presentation and therapeutic needs between autistic individuals with and

without an intellectual disability, and the aim of the present study to focus on autism-specific adaptation, it was important to maintain a clear boundary between the two populations.

2.6 NET Expert Eligibility Criteria Justification

To ensure the relevance and validity of the consultation process, NET experts were required to have a high level of familiarity with NET. Specifically, participants were required to have either contributed to the development or delivery of the NET Fundamentals training (e.g., as a founder or trainer) or have completed the NET Fundamentals training themselves. This criterion ensured that NET experts had a sound theoretical and practical grounding in the model, enabling them to evaluate whether the proposed adaptations retained fidelity to its core principles. Inviting individuals involved in the development and dissemination of NET allowed or the perspectives of those with advanced theoretical and clinical insight into NET. This was particularly important given that the present study sought to adapt NET to a new context while maintaining fidelity to the model.

2.7 Community Involvement in the Development of the Questionnaires

During the development stages of the research materials (i.e., participant information sheet, consent form, and the first round of questionnaires), an autism service advisory group was approached to ensure that the materials were appropriate and accessible to the autistic population. Two advisors were sought to advise on the study and were offered financial compensation in line with guidance provided by the National Institute for Health and Care Research (2024). A further four advisors voluntarily offered their views on the study. Overall, the feedback received indicated that advisors felt the study materials were largely clear and well-intentioned, and is briefly summarised below:

General Comments on the Research

One advisor commented on the topic in general, and their view that living as an autistic individual in a neurotypical world can cause chronic trauma which differs significantly to neurotypical experiences.

Clarity

One advisor queried the definition of 'expert by experience', specifically if family members of carers could participate, and advised for this decision to be made more explicit in the study materials. Additionally, one advisor queried the use of the term "gender identity" in the demographics section and queried whether the inclusion of "sex" may support those who do not accept the concept of gender fluidity, which the term 'gender identity' inherently adopts. Advisors suggested that certain phrases could be potentially confusing and should be clarified; for instance, "virtually signing" to "providing written consent online".

Language and Tone

Three advisors commented on the language use and tone of the study materials. This related to avoiding the use of deficit-based or clinical language such as "restricted interests" and "rigidity", which the advisors commented could be potentially perceived as pathologising. Additionally, advisors suggested the phrase "what adaptations would be *necessary*" to "what adaptations would be *helpful*", to reframe questions to sound supportive rather than burdensome, and avoiding participants feeling as though they must justify their needs. Furthermore, advisors suggested more consultative wording as opposed to directive wording, for instance 'talk to others…'.

Format

Four advisors flagged concerns around the format of the questionnaire, including their view that the questionnaire seemed overly long and repetitive, and that questions should be made to be more concise. A number of formatting suggestions were made, including unnecessary line breaks and underlined text.

Moreover, the study materials were adapted accordingly.

2.8 Ethical Considerations

Ethical considerations are central to the design and implementation of all research projects (British Psychological Society, 2021) and were carefully considered throughout all stages of the present study.

2.8.1 Initial Project

During the initial development stage, the present study differed considerably from its current form. It involved two phases, with the first phase relating to the adaptation of NET and the second phase relating to the implementation of the adapted protocol. During the first phase, it was planned that EBP would be recruited from NHS services to participate in a session using the Nominal Group Technique. This session was intended to generate consensus on proposed adaptations to NET for autistic adults. EBE were to be recruited from autism charities and invited to provide individual written feedback on the adaptations proposed by the EBP group. The adapted protocol was then to be presented to a panel of NET experts in a focus group. Phase two proposed piloting the adapted protocol using a sequential measurement single case series design, with participants recruited from an NHS service to assess potential feasibility of the adapted protocol. Ethical approval for both phases was sought as a single application

via the Integrated Research Application System (IRAS), following guidance from the university sponsor, and was submitted to the Health Research Authority (HRA) for review.

Following the review, the Research Ethics Committee (REC) issued an unfavourable opinion. Their concerns centred primarily around the involvement of EBEs; for instance, the committee considered it inappropriate to approach EBEs through autism charities, as there would be limited knowledge of participants' backgrounds. They felt that asking individuals to consider how a trauma-focused therapy could be adapted could place them at psychological risk, and that autistic adults may not be able to identify if the project could be potentially personally triggering. The REC also raised concerns about phase two. Specifically, they questioned aspects of NET's therapeutic process, which involves encouraging clients to continue engaging with traumatic memories even when encountering resistance or distress. While client safety is paramount, NET includes mechanisms – such as the 'one foot in the past, one foot in the present' approach – to maintain grounding during exposure and minimise risk. The REC expressed discomfort with this component of the therapy, despite NET's status as an evidence-based treatment endorsed by the National Institute for Health and Care Excellence (2018). The committee's position was that such procedures could be potentially harmful in a research context, even with safeguards in place.

Following this feedback, significant modifications were made to the project before re-submission for ethical approval.

2.8.2 The Present Study

The present study received ethical approval from the Mental Health and Clinical Neurosciences Research Ethics Sub-Committee at the University of Nottingham (Appendix

R). One amendment was made to the study after ethical approval, specifically to request NET experts review a list of all adaptations prior to the focus group, due to there being a high number of adaptations. This amendment received ethical approval (Appendix BB).

2.8.2.1 Consultation with the Service Advisory Group. While gaining feedback from a service advisory group on the study materials, ethical considerations remained a priority, even though the advisors were not formal research participants. It was important to clearly define the scope and nature of the consultation before advisors consented to participate. Incentives were offered in line with the guidance provided by the National Institute for Health and Care Research (2024) to ensure that advisors were appropriately compensated for their time. Due to resource limitations, incentives were only available to two advisors. However, additional advisors volunteered their time. This was navigated in consultation with the chair of the advisory panel, who agreed with advisors that incentives would be distributed on a 'first come, first served' basis.

Power dynamics were considered in this process. The use of remote and written formats for consultation may have helped mitigate some of these imbalances by allowing advisors to express their views more freely. A professional relationship was maintained throughout the advisory process.

2.8.2.2 Stage One and Stage Two. During each stage of the research, all potential participants were provided with the participant information sheet for their population group (Appendices E, I, and M) and virtually signed a consent form (Appendices F, J, and N). EBP were able to access the link containing the participant information sheet, consent form, and study materials via the online advertisements (Appendices C and D). Following consent, EBP

were automatically granted access to the study. This was also the case for NET experts. The EBE advertisement poster (Appendix H) requested that interested individuals contact the primary researcher to register their interest. This additional step for EBE aimed to offer an additional layer of safety, particularly for individuals who may have lived experience of traumatic events. This initial communication enabled potential participants to explore whether participation would be appropriate for them. Once contact had been made, participants received the study link, providing access to the participant information sheet, consent form, and study materials. This additional step was not deemed necessary for EBP or NET experts, given that professionals working in clinical roles are typically exposed to trauma-related content as part of their routine practice.

The participant information sheets and consent forms were based on templates provided by the Mental Health and Clinical Neurosciences Department at the University of Nottingham, which align with recommendations outlined by the British Psychological Society (2021). The participant information sheet explained the purpose of the study, what participation would involve, and the voluntary nature of participation. Participants were informed they could withdraw without giving a reason or facing negative consequences, up to five days after their participation. After this point, data would be analysed and aggregated with other responses and no longer identifiable.

Although no personal benefits were expected, participants were advised that it was unlikely the study would cause harm or distress. Nonetheless, given the study's focus on trauma, potential risks were carefully considered. Autistic individuals are known to experience higher rates of trauma compared to non-autistic populations (Rumball, 2019), and while the study did not ask participants to reflect on their own experiences, it was acknowledged that the

material could act as a potential trigger. Accordingly, participants were encouraged to reflect on their readiness to participate, particularly if they had prior experiences of trauma. A list of potential sources of support were attached to the end of all participant information sheets.

Before data collection began, a Data Management Plan was completed (Appendix CC). The data were securely stored and managed on the University of Nottingham password protected OneDrive platform, in compliance with the General Data Protection Regulations (GDPR; European Union, 2016) and the Data Protection Act (UK Government, 2018). Each participant was assigned a randomly generated code to ensure anonymity. Personal and research data were stored separately. Data related to racial/ethnic origin and sexual orientation were treated as special category data under GDPR due to its sensitivity. The collection and processing of this data were justified under Article 9(2) (j) of the GDPR, which permits processing for scientific research purposes, provided appropriate safeguards are in place. In line with these regulations, all special category data were stored securely, anonymised, and only accessed by the research team. This information was collected to support analysis of participant diversity and contextualise findings but not used to identify individuals.

EBP and EBE were invited to enter a random prize draw as a gesture of appreciation for their time and contributions to the research. Four £25 vouchers were available – two for the EBP group and two for the EBE group. Entry into the draw was optional. Participants who wished to enter were asked to provide their email address during the initial questionnaire. These contact details were stored securely and separately from research data to ensure confidentiality. The draw was conducted following the completion of data collection, and

four participants (i.e., two EBP and two EBE) were randomly selected to receive the vouchers.

An incentive was not offered to NET experts due to a combination of practical and resource-related considerations, including the short duration and advisory nature of their involvement. Nonetheless, they were thanked for their time and contributions.

2.8.3 Epistemological Position

The epistemological position underpinning the present study is pragmatism. Pragmatism prioritises the research under investigation, proposing that researchers should adapt their philosophical and methodological choices according to what best addresses the research question under investigation (Fishman, 1999). Pragmatism posits to bridge the gap between postpositivism and constructivism paradigms (Creswell & Poth, 2016); while it acknowledges the existence of an objective reality, it recognises that our understanding of it is mediated by individual interpretation and context (Kaushik & Walsh, 2019). In this way, pragmatism accepts that multiple, co-existing variations of the same truth can co-exist (Elder-Vass, 2022; Maxcy, 2003).

Pragmatism supports a plurality of methods (Tashakkori & Teddlie, 1998) and emphasises the importance of producing actionable knowledge that addresses real-world issues (Kelly & Cordeiro, 2020; Creswell & Plano Clark, 2017). It is therefore well suited to the present study, which employed Delphi and focus group methodologies to explore a complex, applied research question involving multiple expert stakeholder groups, with the aim of generating an actionable output – an adapted NET protocol for use with autistic adults experiencing traumatic stress.

2.9 Content Analysis

Content analysis is a systematic method for analysing textual data; it is applicable to both quantitative (Krippendorff, 2018; Neuendorf, 2017) and qualitative (Berg & Lune, 2014; Catanzaro, 1988) data. Quantitative content analysis involves converting data into numerical values – typically counts or percentages of identified categories – to answer questions such as "how many" (Berelson, 1952; Krippendorff, 2018). In contrast, qualitative content analysis analyses data in the form of words and themes to capture richness of meaning – to answer questions such as "what, how, or why" (Forman & Damschroder, 2007).

Content analysis can be conducted at a manifest or latent level (Bengtsson, 2016). Manifest content analysis focuses on the explicit content of the text, preserving participants' actual words and thus 'staying close' to the data (Kleinheksel et al., 2020). In contrast, latent content analysis seeks to interpret the underlying meaning of the text (Potter & Levine-Donnerstein, 1999). The present study employed a manifest approach throughout all stages, as the research aimed to explore 'what has been said' rather than interpreting the underlying meaning or intention behind participants' responses.

Content analysis can be completed using an inductive or deductive approach (Elo & Kyngäs, 2008). Inductive content analysis is often used when there is limited theoretical knowledge available on the topic – during inductive analysis, data is analysed without predefined categories or codes, and instead, categories or codes are identified from the data itself, thus adopting a 'bottom-up' approach (Vears & Gillam, 2022). In deductive content analysis – often used where prior theoretical knowledge exists – a 'top-down' approach is taken, where data is analysed according to a predefined framework (Kyngäs & Kaakinen, 2020). In the present study, an inductive approach was employed throughout. For instance, in stage one,

codes and categories (i.e., potential adaptations) were generated from participants responses, with data organised around the five elements of NET (i.e., assessment and psychoeducation, the lifeline, narration, re-narration, and duration/total number of sessions). In stage two, codes and categories were similarly generated from participants' responses, but were organised around the specific adaptations under investigation.

2.9.1 Data Management

The process of data management is outlined below.

Familiarisation. The primary researcher began by reading all data thoroughly and multiple times to become immersed in the content. This step allowed for a holistic understanding of the responses and the identification of preliminary patterns.

Coding. Coding schedules (Appendices S, T, and U) were developed inductively, meaning that codes and categories emerged from the data itself rather than being imposed a priori. Initial codes were generated line-by-line and reflected the manifest content of the data. These codes were then reviewed by the research team, refined, and grouped into broader categories.

Interpretation. Following coding, categories were interpreted in relation to the research aims. In stage one, the focus was on identifying potential adaptations to NET (round one) and further clarifications to the proposed adaptations (round three). In stage two, the focus was on participants views on whether the proposed adaptations were consistent with the principles of NET and thus feasible in practice.

Trustworthiness. Several strategies were employed throughout the analysis to ensure its trustworthiness. A clear audit trail was ensured throughout coding, with decisions documented to support transparency. The process of coding and emergence of categories were discussed during research supervision with experienced qualitative researchers to enhance credibility. The primary researcher maintained reflexivity throughout the process through ongoing reflection on personal assumptions and potential influences on interpretation.

3.0 Extended Results

3.1 Expert by Profession Participant Demographics

Participants provided demographic information in the first questionnaire (Table 7).

Table 7

Experts by Profession Demographics

Demographic	Round 1 (n = 15)	Round 2 (n = 9)	Round 3 (n = 4)
Gender			
Female	13	7	3
Male	1	1	1
Non-binary/genderqueer	1	1	0
Age (years)			
25-34	7	4	2
35-44	3	2	1
45-54	4	3	1
> 65	1	0	0
Ethnicity			
White	12	8	4
Mixed or Multiple Ethnicity	2	1	0
Not disclosed	1	0	0
Occupation			
Psychologist	11	7	4
Psychiatrist	1	0	0
Speech & Language Therapist	1	1	0
Nurse	1	0	0
Support Staff	1	1	0
Years of Experience			
2-4	4	2	1
5-9	5	4	2
10-14	3	2	1
> 15	3	1	0
Organisation (current)			
NHS	11	8	4
Private Practice	2	0	0
Charity/third-sector	2	1	0

3.2 Expert by Experience Participant Demographics

Participants provided demographic information in the first questionnaire (Table 8).

Table 8
Experts by Experience Demographics

Demographic	Round 1 (*n* = 15)	Round 2 (*n* = 9)	Round 3 (*n* = 8)
Sex at Birth			
Female	6	4	4
Male	9	5	4
Gender Identity			
Female	2	0	0
Male	9	5	4
Non-binary/genderqueer	2	2	2
Not disclosed	2	2	2
Age (years)			
18-24	4	2	2
25-34	3	2	2
35-44	2	1	1
45-54	1	0	0
55-64	4	3	3
> 65	1	1	0
Ethnicity			
White	12	7	6
Asian	1	1	1
Mixed or Multiple Ethnicity	1	1	1
Other	1	0	0
Years of Official Diagnosis			
< 6 months	1	1	0
7 months – 1 year	1	1	1
1– 2 years	2	1	1
3 – 4 years	3	3	3
5 – 10 years	3	2	2
11 – 15 years	2	1	1
> 16 years	3	0	0

3.3 NET Expert Demographics

The NET Expert group consisted of two clinical psychologists and one professor of clinical psychology. The two clinical psychologists had experience of delivering NET in a variety of NHS services, including a local mental health team, a perinatal team, and a tier four mental health team. The professor of clinical psychology was involved in the founding and development of NET and had experience of delivering NET in a wide variety of contexts and in supervising multiple doctoral projects relating to NET.

3.4 Perspectives Opposing Adaptation of NET

During the Round One, some participants indicated that adaptations to various elements of NET would not be helpful (Table 9) and were asked to provide reasons for their views. While not all participants elaborated, those who did shared their reasoning in relation to the following elements of NET: lifeline, re-narration, and duration/total number of sessions. Regarding the lifeline, one EBP and one EBE felt that the task was sufficiently straightforward and did not require further adaptation. Another EBE highlighted past difficulties with identifying what constitutes a traumatic event, as well as challenges with emotion identification and labelling. This response suggested that, even with adaptations, certain autistic traits might continue to pose barriers to accessing NET. In terms of the duration and total number of sessions, one EBE expressed that the standard length of NET was appropriate and did not believe additional sessions were necessary.

Table 9

Expert Ratings on the Helpfulness of Potential Adaptations (Round One)

Element of NET	EBP (*n* = 15)			EBE (*n* = 15)		
	'Yes'	'No'	'Unsure'	'Yes'	'No'	'Unsure'
Assessment and Psychoeducation	13	0	2	9	1	5
The Lifeline	11	2	2	7	4	4
Narration	13	0	2	8	1	6
Re-narration	8	3	4	9	2	4
Duration/total number of sessions	12	0	3	9	2	4

3.5 Improving the Objectivity of Proposed Adaptations

Following Round Two, it was noted by the research team that a proportion of the proposed adaptations were ambiguous or subjective in their wording, which may have limited their clarity or potential for implementation. To address this, further clarification was considered necessary to refine the wording and ensure greater objectivity and precision. Tables 10 and 11 present each adaptation alongside an indication of whether further clarification was required. A summary of the clarifications made is presented in Table 12.

Table 10

Expert by Profession Proposed Adaptations – Clarification Requirements

Element of NET	Proposed Adaptation	Adaptation Reference	Clarification Required? Why?
Assessment and Psycho-education	The therapist should support the client with emotion identification and labelling	P1	N/A – did not meet consensus in Q2
	The therapist should ensure they and the client have a shared understanding of emotions	P2	Yes
	Clients should be provided with a diagram of the brain model and fear network	P3	N/A – did not meet consensus in Q2
	The therapist should incorporate the client's special interests when explaining the psychoeducation content	P4	N/A – did not meet consensus in Q2
	The therapist should incorporate the client's special interests to support engagement and motivation	P5	N/A – did not meet consensus in Q2
	The therapist should use pictures, written prompts, and diagrams	P6	Yes
	The therapist should clarify items on the PCL-5 and LEC-5 that relate to body sensations	P7	N/A – did not meet consensus in Q2
	The NICE CG142 (2021) guidelines should be incorporated via session contracting relating to sensory considerations and communication needs	P8	N/A – did not meet consensus in Q2
	Autism health passports* should be used to support session contracting *Further information on autism health passports: https://www.autism.org.uk/advice-and-guidance/topics/physical-health/my-health-passport	P9	N/A – did not meet consensus in Q2
	The client's sensory needs and preferences should be incorporated into the sessions; e.g. sensory toys should be available	P10	Yes

	The therapist should concretely show the client how the therapy is likely to be helpful and exactly what is expected of them	P11	Yes
	The therapist should assess for strategies to emotionally regulate	P12	Yes
	The client should be joined by a family member/carer/friend for support, if they want	P13	N/A – did not meet consensus in Q2
	The therapist should discuss the different types of trauma experienced by the autistic population	P14	N/A – did not meet consensus in Q2
	The therapist should understand the impact of potential co-occurring alexithymia (i.e., ability to identify and name emotions) and interoceptive abilities (i.e., ability to identify internal bodily sensations) on the clients ability to complete standardised measures (i.e., the PCL-5 and the LEC-5)	P15	No – self-explanatory
	The therapist should explore the client's interoceptive ability (i.e., their ability to identify internal bodily sensations)	P16	Yes
	The therapist should explore the clients sensory experiences, needs, and preferences	P17	Yes (but removed after Q3)
	The therapist should check that the pacing of the session is appropriate	P18	No – self-explanatory
	The therapist should consider monotropic language (i.e., a tendency of some autistic people to pay attention to small specific details in a granular fashion rather than processing the larger context)	P19	No – self-explanatory
	Abstract terms should be made concrete and the client’s understanding checked, e.g. when talking about "trauma symptoms", examples should be given that are relevant to the client... when talking about "hot" and "cold" memories, ensuring the client does not infer this literally	P20	No – self-explanatory
	Clients should be provided a clear plan, structure, and 'rules' to help them predict what will happen throughout therapy	P21	No – self-explanatory
	The client should be shown the lifeline materials (i.e., the ribbon, stones, and flowers) at this stage so that they can see what will be asked of them during the lifeline exercise	P22	No – self-explanatory
	Ahead of sessions, the therapist should describe the clinic room	P23	N/A – did not meet consensus in Q2
	Stabilisation/regulation support should be provided	P24	N/A – did not meet consensus in Q2

	Based on the individual's needs, there should be additional sessions at the start of therapy to allow the client to familiarise with the therapist	P25	N/A – did not meet consensus in Q2
The Lifeline	The client should be as active as they wish in placing the stones and flowers on the lifeline	P26	Yes
	The client should be able to choose their own symbols/representations of traumatic events and positive events as opposed to the default use of stones and flowers	P27	No – self-explanatory
	The therapist should consider the client's ability to articulate the metaphorical use of stones and flowers	P28	Yes
	Stones and flowers should be physically labelled as a traumatic or positive event	P29	N/A – did not meet consensus in Q2
	Special interests should be incorporated where possible	P30	N/A – did not meet consensus in Q2
	The therapist should give an example of a traumatic event (i.e., a stone) and a positive event (i.e., a flower) to ensure the client understands the difference	P31	N/A – did not meet consensus in Q2
	It should be made clear how much detail clients should share at this stage (i.e., "up to five words")	P32	N/A – did not meet consensus in Q2
	The therapist should consider whether the lifeline materials cause distress or fixation	P33	Yes
	The lifeline session should take place over several shorter sessions	P34	N/A – did not meet consensus in Q2
	The therapist should write/draw out the lifeline one period of life at a time across multiple sessions, before bringing each period together to form the lifeline in one session	P35	N/A – did not meet consensus in Q2
	Clients should be made aware of/be prepared for the lifeline exercise prior to its completion	P36	No – self-explanatory
	The therapist should be aware they may need to provide particular support in helping the client to identify positive events	P37	Yes
	To support emotional regulation, the client should have the option to draw	P38	No – self-explanatory
	"Lifeline" should be re-phrased to a "river" or "stream" of life	P39	N/A – did not meet consensus in Q2
	"Birds-eye view" should be re-phrased as "summary of life events"	P40	N/A – did not meet consensus in Q2
Narration	The therapist should support the client to identify and label emotions	P41	Yes

	The client should be provided with a written and diagrammatic list of emotions	P42	N/A – did not meet consensus in Q2
	The therapist should normalise any difficulties with interoceptive awareness	P43	Yes
	The therapist should check in with the client regarding whether this method is accessible to them	P44	Yes
	If the client struggles to articulate elements of their experience (i.e., cognitions, sensory experiences, emotions etc) the therapist should provide options/examples of what they imagine the person felt	P45	N/A – did not meet consensus in Q2
	Clients should be provided with a visual map of the body	P46	N/A – did not meet consensus in Q2
	The client should be provided a stepped plan of the process of narration	P47	N/A – did not meet consensus in Q2
	The client should be provided visual representations of sensory experiences, emotions, cognitions etc that are laid out on the floor with "hold" and "cold" headings provided	P48	N/A – did not meet consensus in Q2
	The client should be offered a number of sensory exercises to complete as they narrate, if they want	P49	N/A – did not meet consensus in Q2
	The therapist should expect stimming and understand this as a mechanism to manage anxiety, and not necessarily an indicator of risk or acute distress	P50	No – self-explanatory
	The therapist should be aware of how the client expresses distress, and monitor this throughout the session	P51	No – self-explanatory
	It should be explained to the client that the narration is different to the lifeline exercise e.g., that they are now to provide 'up to a few pages' of detail	P52	N/A – did not meet consensus in Q2
Re-narration	The therapist should reassure the client as they guide them on how to think through their memories	P53	N/A – did not meet consensus in Q2
	The therapist should provide the client with a copy of the written narrative so that they can read it as the therapist reads aloud	P54	N/A – did not meet consensus in Q2
	The therapist should consider the clients preferred method of communication when producing the narrative	P55	Yes
	The therapist should explore the client's ability to imagine	P56	Yes

	The therapist and client should negotiate alternatives to communication if the client becomes non-speaking/'selectively mute'	P57	Yes
	The therapist should allow for sensory regulation if the client finds this helpful	P58	Yes
	The therapist should give explicit and specific consent to be interrupted/corrected	P59	No – self-explanatory
	The therapist should read the narrative slowly to encourage corrections	P60	N/A – did not meet consensus in Q2
	The therapist and client should agree on when corrections should be made (i.e, as the therapist reads the narrative, after, or both)	P61	No – self-explanatory
	The therapist should emphasise that the process of the narrative is about connecting with emotions and memories, rather than making the narrative perfect	P62	No – self-explanatory
	The client should be provided with a copy of the narrative to read and correct outside of sessions	P63	N/A – did not meet consensus in Q2
	The therapist should incorporate visual information into the narrative wherever possible	P64	N/A – did not meet consensus in Q2
Duration and total number of sessions	The client should be offered regular breaks	P65	N/A – did not meet consensus in Q2
	Sensory breaks should be incorporated into sessions	P66	N/A – did not meet consensus in Q2
	Sessions should be shorter	P67	N/A – did not meet consensus in Q2
	The time, duration and total number of sessions should be agreed	P68	No – self-explanatory
	If a client becomes distressed, the session should be lengthened until they feel safe to leave	P69	N/A – did not meet consensus in Q2
	The total number of sessions should be increased	P70	N/A – did not meet consensus in Q2
	The therapist should be flexible	P71	No – self-explanatory
	The therapist should be prepared to accommodate accordingly	P72	No – self-explanatory
	When agreeing the time/duration/total number of sessions, the therapist should inform the client that a 'new plan' can be agreed if anything changes	P73	N/A – did not meet consensus in Q2
	The care plan/plan for therapy should be communicated as per the clients preferences (e.g. written, typed, drawn, emailed, printed)	P74	No – self-explanatory

	The therapist should not assume for how long the client can manage a session; they should explore this with the client	P75	No – self-explanatory
	Rather than providing a total number of sessions, the therapist and client should agree that the therapy will be complete when all of the stones and flowers have been narrated	P76	N/A – did not meet consensus in Q2

Table 11

Expert by Experience Proposed Adaptations – Clarification Requirements

Element of NET	Proposed Adaptation	Adaptation Reference	Clarification Required? Why?
Assessment and Psycho-education	To allow the client to familiarise themselves with the therapist and understand the purpose of NET, the assessment and psychoeducation sessions should be spread across 3-5, one hour long sessions	E1	No – self-explanatory
	The therapist should support the client in explaining their emotions	E2	No – self-explanatory
	The therapist should use prompts to support the client in sharing their experiences	E3	N/A – did not meet consensus in Q2
	Family/carers should be present if the client chooses	E4	N/A – did not meet consensus in Q2
	Written explanations of the psychoeducation should be provided	E5	N/A – did not meet consensus in Q2
	Visual diagrams of the psychoeducation should be provided	E6	N/A – did not meet consensus in Q2
	Time should be taken to consider how the client self-soothes	E7	Yes
	The clinic room should be quiet, with soft furnishings and natural light	E8	No – self-explanatory
	The therapist should explain the process in detail, and reiterate where helpful	E9	No – self-explanatory
	The therapist should allow the client additional processing time, and time to respond	E10	No – self-explanatory
	Time should be taken to consider how the client processes information	E11	Yes

	The therapist should have empathy and understanding towards the autistic experience	E12	No – self-explanatory
	The therapist should have prior knowledge of autism, how autistic people may experience trauma and how this may differ to neurotypical people	E13	No – self-explanatory
The Lifeline	The client should be able to choose their own symbols to represent positive events and traumatic events	E14	No – self-explanatory
	If the client wants to focus their lifeline on their experiences of being autistic, they should be able to	E15	No – self-explanatory
	Family/carers should be present if the client chooses	E16	N/A – did not meet consensus in Q2
	The therapist should explain the process in detail, and reiterate where helpful	E17	No – self-explanatory
	The therapist should allow the client additional processing time, and time to respond	E18	No – self-explanatory
	Further clarification is needed on what a "significant or important event" is	E19	Yes
	Clients should be told about this exercise in advance so that they can think about what events they might want to include	E20	No – self-explanatory
	There should be an option to revisit the lifeline later in therapy, e.g. to make changes if needed	E21	No – self-explanatory
	There should be an option for the exercise to be completed via a computer (i.e., online/remotely)	E22	No – self-explanatory
Narration	Visual aids should be used to help clients identify emotions (i.e., written emotion cards, the 'emotions wheel')	E23	N/A – did not meet consensus in Q2
	Clients should be offered a break if they become too overwhelmed	E24	No – self-explanatory
	The therapist should follow a structured approach	E25	N/A – did not meet consensus in Q2
	If the client becomes overwhelmed, the session should not end until they feel better	E26	No – self-explanatory
	Family/carers should be present if the client chooses	E27	N/A – did not meet consensus in Q2
	The therapist should explain the process in detail, and reiterate where helpful	E28	No – self-explanatory

	The therapist should allow the client additional processing time, and time to respond	E29	No – self-explanatory
	Clients should be able to write down their feelings, if they want	E30	No – self-explanatory
	The therapist should explain that the conversations the client has with the therapist are 'different' to the ones they might have with people outside of therapy; i.e., typically, it would not be expected for somebody to tell a stranger or a friend all about their trauma, but it is typical for somebody to tell a therapist all about their trauma. The therapist should explain why.	E31	No – self-explanatory
	Alternative options for emotional expression should be available e.g. pointing to words or pictures, drawing, or creating sounds	E32	N/A – did not meet consensus in Q2
	The narration should be stopped if the client becomes very upset	E33	N/A – did not meet consensus in Q2
	The focus should be on the clients physical body sensations, rather than their emotions	E34	N/A – did not meet consensus in Q2
	The therapist should use onomatopeia to help the client express their emotions (i.e., words that suggest how they sound; for instance, 'feeling fizzy', 'feeling cloudy')	E35	N/A – did not meet consensus in Q2
Re-narration	The client should be provided the written narrative to read before the session	E36	No – self-explanatory
	The narrative should be written in words that make sense to the client	E37	No – self-explanatory
	The client should be able to sit or lie on the floor, if they want	E38	N/A – did not meet consensus in Q2
	The client should have a fidget/fiddle toy, if they want	E39	No – self-explanatory
	Family/carers should be present if the client chooses	E40	N/A – did not meet consensus in Q2
	The therapist should explain the process in detail, and reiterate where helpful	E41	No – self-explanatory
	The therapist should allow the client additional processing time, and time to respond	E42	No – self-explanatory
	The client should have a copy of the narrative to read as the therapist reads the narrative aloud	E43	N/A – did not meet consensus in Q2

	Instead of the therapist reading the narrative aloud, the client should be given a copy of the narrative to read themselves	E44	No – self-explanatory
	The narrative should not be repeatedly read (i.e., each session)	E45	N/A – did not meet consensus in Q2
Duration and total number of sessions	If the client wants a break, they should be able to	E46	No – self-explanatory
	There should not be a maximum number of sessions available to the client	E47	No – self-explanatory
	Sessions should be shorter, with some longer sessions in between e.g. an hour-long session one week, an hour and a half-long session the next, an hour-long session the week after, and so on...	E48	N/A – did not meet consensus in Q2
	During each session, the therapist should remind the client how long they have left (i.e., letting the client know there is 5 minutes remaining)	E49	No – self-explanatory
	Therapy should be offered via an online format	E50	N/A – did not meet consensus in Q2
	Clients should be offered 6-13 sessions	E51	No – self-explanatory
	Each session should last for 75 - 110 minutes	E52	N/A – did not meet consensus in Q2
	The therapist should reassure the client that 'relapses' may occur i.e., that this is normal	E53	No – self-explanatory
	Sessions should be shorter	E54	N/A – did not meet consensus in Q2

Table 12

Clarifications on Ambiguous or Subjective Adaptations

Adaptation (including reference)	Participant Responses (including frequency count)		Subsequent 'Clarification'
	EBP Responses	EBE Responses	
"The therapist should ensure they and the client have a shared understanding of emotions" (P2)	Discuss emotional language explicitly (4) Use client's language and offer therapists interpretation (4) Use physiological cues and tools, such as body maps (2) Facilitate emotion labelling (4) Ongoing emotion check-ins (1)	Validate the client's emotional experience (1) Ask the client what works (2) Clarify through discussion (2) Active listening (1) Explain emotions and typical reactions (1)	Explicitly discuss and clarify emotional language Validate and listen to the client Use tools (e.g., body maps) and examples (e.g., typical responses to emotions) to facilitate shared understanding
"The therapist should use pictures, written prompts, and diagrams" (P6)	Use pictures as timeline symbols (1) Use pictures for psychoeducation (2) Pictures as discussion prompts (2) Collaborative diagramming (2)	Use diagrams to explain emotions (e.g., emotion wheel) (1) Written prompts for goal tracking (1) Adapt according to the clients preference (1)	~~Visual aids to explain psychoeducation and emotion*~~ Adapt materials to client preferences Use varied and collaborative formats

		Use a variety of visual tools i.e., emotions wheel, flowcharts, cards (5)	
"The therapist should concretely show the client how the therapy is likely to be helpful and exactly what is expected of them" (P11)	Explain the process of NET step-by-step (2) Provide bullet point overviews (1) Share the evidence base (verbal and written) (1) Show the expected benefits (verbal and written) (1) Produce a collaborative therapeutic contract (1)	Simplify explanations (1) Clarify the limitations of NET (1) Include examples in explanations (1) Combine formats (e.g., verbal, written) (1) Flexibility and reassurance (2)	Clear and step-by-step explanation Clarify benefits, limitations, and expectations Be flexible and collaborative
"The therapist should explore the client's interoceptive ability (i.e., their ability to identify internal bodily sensations)" (P16)	Discuss bodily and emotional sensations (2) Focus on bodily sensations first Use body maps (3) Provide multiple ways to express (1) Externalise sensations (2)	Enhance self-awareness of triggers (2) Recognise learned disconnection (1) Psychoeducation about interoception (1) Explore context variability (1) Provide examples linking feelings and emotions (1)	Facilitate an awareness of bodily sensations Use tools (e.g., body maps) to externalise experience Provide psychoeducation and examples Recognise challenges and variability in interoceptive awareness
"The client's sensory needs and preferences should be	Adjust environment based on preference (3)	Minimise overstimulation (3)	Assess sensory needs and preference” collaboratively

incorporated into the sessions; e.g. sensory toys should be available" (P10)	Check comfort and adapt (3) Map sensory preferences (1) Ask open questions at the start (1) Balance needs with therapy goals (1)	Validate through adjustments to the environment (1) Allow personal items (5) Offer and discuss sensory aids (7) Discuss sensory needs early (1)	Adapt the environment and session set-up accordingly Offer tools and validate the client's choices Balance adaptations with therapeutic aims
"The therapist should assess for strategies to emotionally regulate" (P12)	Plan co-regulation strategies (2) Recognise unhelpful strategies (2) Teach grounding techniques (1) Observe in-session coping (1) Document strategies (1)	Ask the client's preferred strategies (3) Support autonomy in regulation (3) Plan ahead for regulation (1)	Explore and document regulation strategies collaboratively Recognise unhelpful patterns and redirect Teach adaptive strategies Support client autonomy and plan proactively
"The therapist should explore the client's sensory experiences, needs, and preferences" (P17)	Ask explicitly about sensory needs (2) Use tools to explore sensory needs (1) Adjust environment and session to preferences (1)	Support autonomy in sensory choices (4) Asking the client what their sensory needs are (7) Validate sensory preferences (1)	Assess sensory needs collaboratively (ask, observe, use tools) Adapt environment and session accordingly Validate client's choices

"Time should be taken to consider how the client self-soothes" (E7)	Plan co-regulation strategies (1) Recognise unhelpful soothing (1) Encourage adaptive strategies (2) Document self-soothing approaches (2)	Provide time and space (3) Explicitly explore preferred strategies (4) Validate self-soothing (2)	Assess and discuss self-soothing strategies explicitly Observe and validate behaviours Encourage client insight into their own soothing cues Provide time and space for self-soothing without judgement
"Time should be taken to consider how the client processes information" (E11)	Assess processing collaboratively (2) Allow extra time (1) Clarify and confirm understanding (2)	Allow to circle back (2) Break down information (1) Offer multiple explanations (1) Respect and validate processing pace (2) Allow additional time (2)	Assess processing style collaboratively, and pace accordingly Allow additional time and repetitions as needed Use clear, unambiguous language and check understanding Allow clients to “circle back” and revisit points
“The therapist should consider the client's ability to articulate the metaphorical use of stones and flowers" (P28)	Check client’s understanding of metaphor (4) Explain metaphor with examples (1) Provide alternatives (3)	Respect client’s interpretation (1) Recognise a preference against metaphor (1) Clarify metaphor meaning (2)	Explore whether metaphors are meaningful to the client Explain metaphors with concrete examples

	Adapt metaphor to preferences (3)	Explore alternative ways to describe things (3)	Offer alternative representations if metaphors are confusing Adapt metaphor based on the client's needs and preferences
"The therapist should consider whether the lifeline materials cause distress or fixation" (P33)	Observe fixation and distress (2) Discuss the client's experience of the materials (2) Adjust session pace accordingly (1)	Explore preferences (3) Observe non-verbal signs of distress (3) Validate feelings about materials (1) Be flexible with materials (2)	Monitor for fixation or distress during use of materials Discuss preferences and adapt materials if problematic Use observation and ongoing dialogue to gauge response Be flexible and validate the client's experience
"The therapist should be aware they may need to provide particular support in helping the client to identify positive events" (P37)	Prompt the client directly (2) Give concrete examples (2) Avoid assumptions (1) Explore barriers to recognising positive events (1)	Provide examples (3) Validate small or subtle positive events (1)	Explicitly talk about positive events and provide examples Validate smaller or nontraditional "positive" experiences Recognise barriers (e.g., shame, negative bias) and address gently Support the client without imposing assumptions

"Further clarification is needed on what a 'significant or important event' is" (E19)	Clarify the criteria for significance (3) Give examples (3) Recognise the client's perspective (1) Explore early in therapy (1)	Client-defined significance (1) Give examples (3) Recognise shifting meaning or significance of an event over time (1)	Discuss the criteria for significance with the client Provide examples but allow the client to define what is important Recognise that significance is subjective and may evolve Explore early but revisit as needed
"The therapist should support the client to identify and label emotions" (P41)	Explore early in therapy (2) Provide visual aids (1) Model emotional labelling (2) Agree shared vocabulary (2)	Validate the client's expression (2) Ask the client (3) Give examples (4) Prompt (1) Offer alternative modes (3) Allow extra time (2)	Use tools and examples to assist emotional labelling Agree on shared emotional language Validate difficulty and respect individual expression Pace appropriately
"The therapist should normalise any difficulties with interoceptive awareness" (P43)	Normalise interoceptive challenges (2) Acknowledge in the first session (1) Explain simply (1)	Validate difficulties (3) Give examples (1) Reduce shame (2)	Explain that difficulties with interoception are common Provide reassurance and psychoeducation

	Offer psychoeducation (3)	Education on connection to autism (1)	Validate difficulties and reduce shame Use simple, respectful language
"The therapist should check in with the client regarding whether this method is accessible to them" (P44)	Assess accessibility explicitly (2) Check understanding (3) Encourage openness (1) Balance checking with autonomy (1)	Offer formal feedback tools (1) Support accessibility (3) Offer alternatives (1) Regularly invite feedback (2) Observe non-verbal signals (1)	Assess understanding and accessibility explicitly Provide space for feedback and adjustments Offer multiple ways (e.g., verbal and non-verbal) to express concerns Balance “checking-in” with respecting autonomy
"The therapist should consider the clients preferred method of communication when producing the narrative" (P55)	Assess communication preference (2) Offer flexible formats (2) Use prior information (1) Offer choice and review regularly (1)	Respect preferences (2) Provide options (3) Ongoing checking in (2) Plan ahead (1)	Offer multiple communication formats Explicitly discuss and respect the client’s preferences “Check-in” regularly and adapt as needed Use prior information known about the client to guide choices

“The therapist should explore the client's ability to imagine" (P56)	Assess imagination explicitly (2) Offer alternatives (1) Test imaginative ability (1)	Recognise limits to imagination (1) Ask the client how they imagine (3) Use interests to engage (1)	Assess imagination ability explicitly and collaboratively Offer alternatives if imagination is difficult ~~Use client interests~~*
"The therapist and client should negotiate alternatives to communication if the client becomes non-speaking/'selectively mute'" (P57)	Plan ahead (2) Use prior information and ask explicitly (1) Co-create strategies (2) Practice alternatives beforehand (1)	Provide alternative methods (2) Asking the client beforehand (3) Model calmness and validate (1) Offer creative communication aids (2)	Plan potential scenarios beforehand Co-create and practice strategies Offer diverse alternative communication methods Model calmness and validate difficulties
"The therapist should allow for sensory regulation if the client finds this helpful" (P58)	Allow sensory toys (1) Monitor and encourage regulation (1)	Validate sensory behaviours (1) Provide options (2) Normalise stimming (1) Create a sensory-friendly space (2)	Allow the use of sensory tools and behaviours Provide options for sensory regulation Minimise sensory overload and create a safe environment

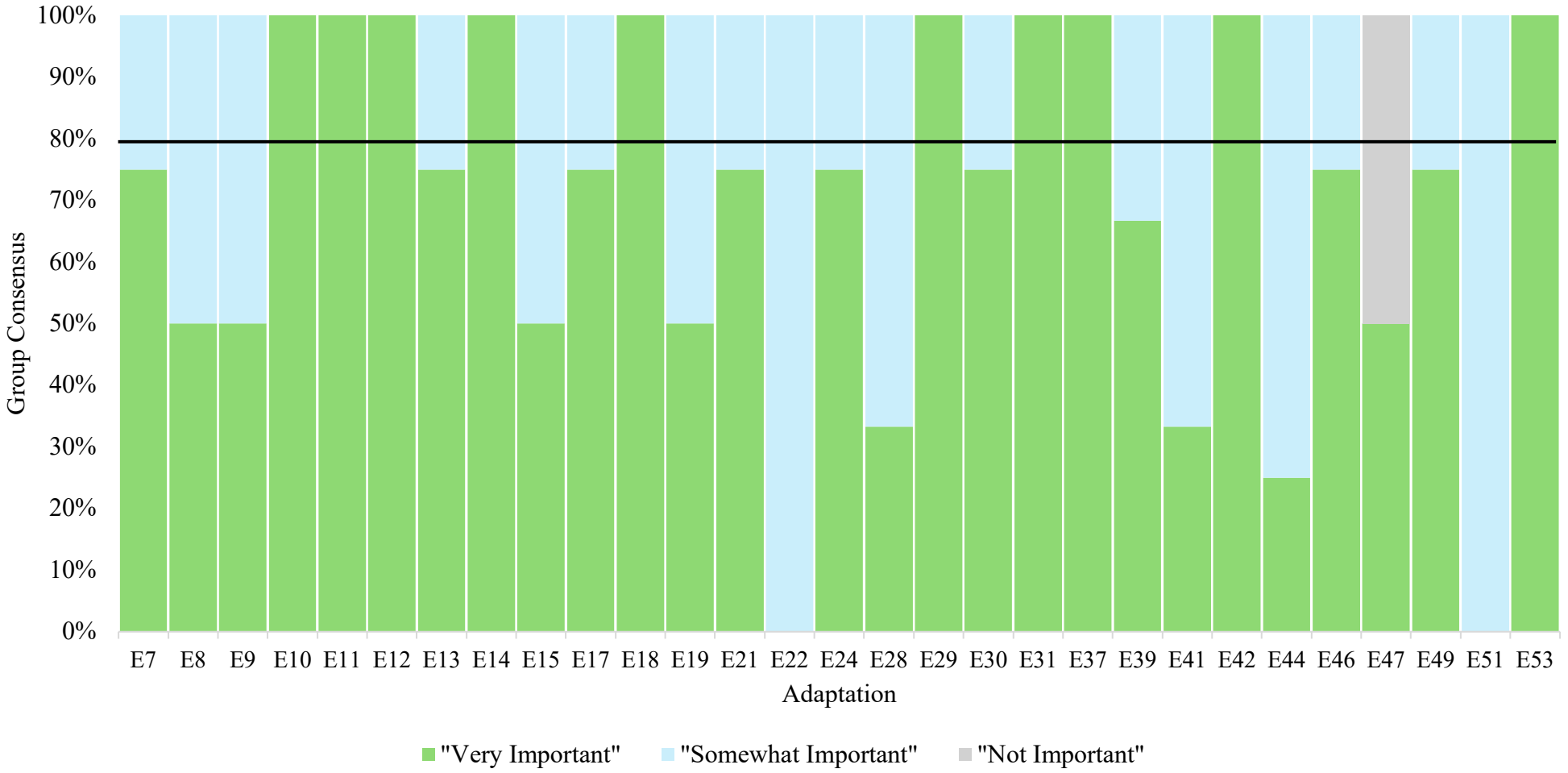
* *Note. Items with a strikethrough are items containing an adaptation removed elsewhere.*

3.6 Expert by Profession Ratings of Expert by Experience Proposed Adaptations

During Round Three, EBP rated the adaptations proposed by EBE that had reached between 70 and 100% consensus in the EBE group in Round Two (Figure 5).

Figure 5

EBP Ratings of EBE Proposed Adaptations



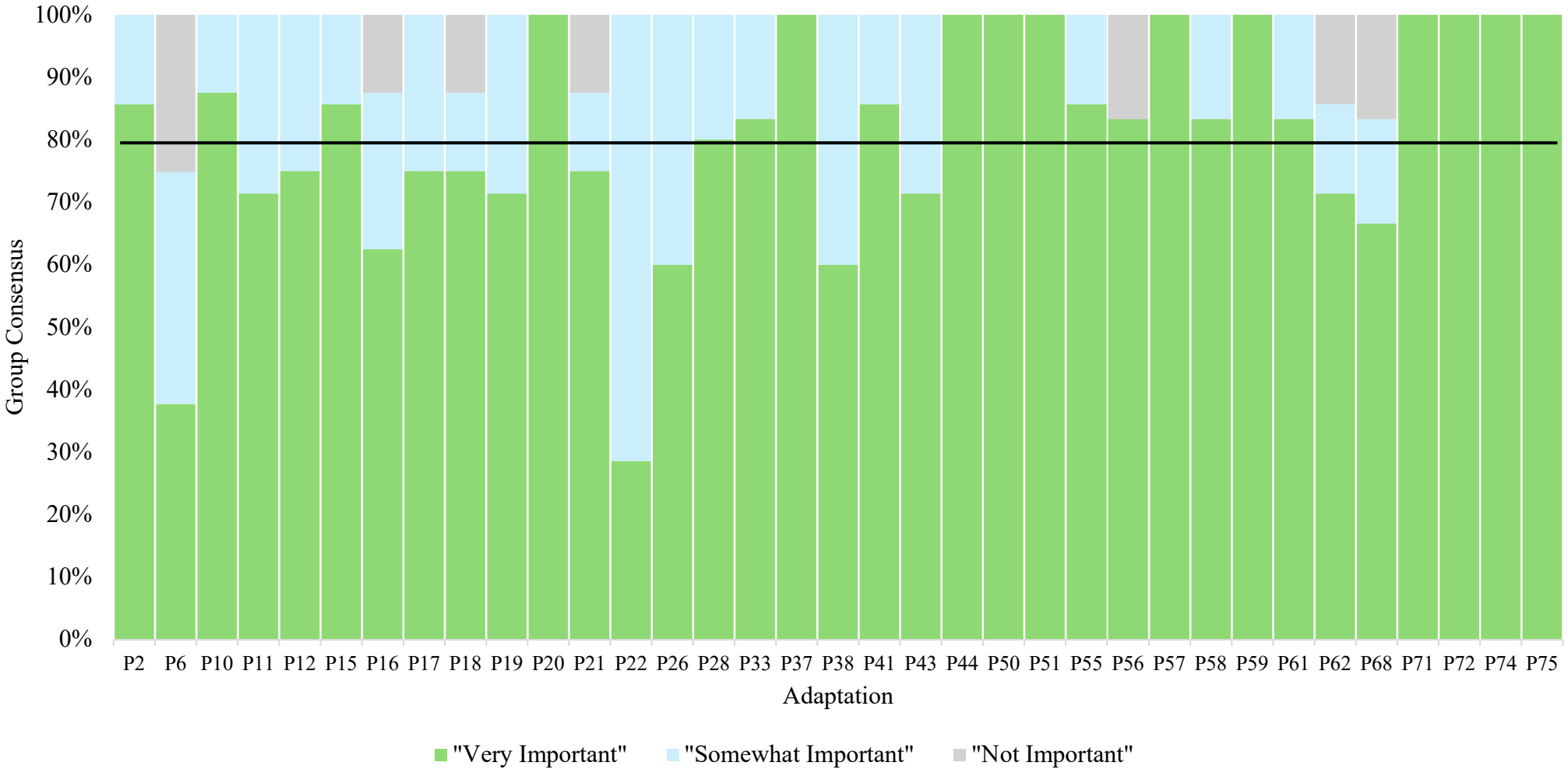
Note. The solid black line represents the consensus threshold (≥80%).

3.7 Expert by Experience Ratings of Expert by Profession Proposed Adaptations

During Round Three, EBE rated the adaptations proposed by EBP that had reached between 70 and 100% consensus in the EBP group in Round Two (Figure 6).

Figure 6

EBE Ratings of EBP Proposed Adaptations



Note. The solid black line represents the consensus threshold (≥80%).

3.8 Adaptations Reaching Consensus in Both Expert Groups

Following Round Three, a total of 28 adaptations met consensus as ‘very important’ adaptations in both expert groups (Table 13).

Table 13

Important Adaptations - Adaptations Reaching ≥80% Consensus in Both Expert Groups

Element of NET	Adaptation	Adaptation Code
Assessment & Psychoeducation	The therapist should ensure they and the client have a shared understanding of emotions*	P2
	Abstract terms should be made concrete and the client's understanding checked, e.g. when talking about "trauma symptoms", examples should be given that are relevant to the client... when talking about "hot" and "cold" memories, ensuring the client does not infer this literally	P20
	The therapist should allow the client additional processing time, and time to respond	E10
	Time should be taken to consider how the client processes information*	E11
	The therapist should have empathy and understanding towards the autistic experience	E12
The Lifeline	The client should be able to choose their own symbols/representations of traumatic events and positive events as opposed to the default use of stones and flowers	P27/E14
	The therapist should consider the client's ability to articulate the metaphorical use of stones and flowers*	P28
	The therapist should consider whether the lifeline materials cause distress or fixation*	P33
	Clients should be made aware of/be prepared for the lifeline exercise prior to its completion	P36/E20
	The therapist should be aware they may need to provide particular support in helping the client to identify positive events*	P37
	The therapist should allow the client additional processing time, and time to respond	E18
Narration	The therapist should support the client to identify and label emotions	P41
	The therapist should check in with the client regarding whether this method is accessible to them*	P44
	The therapist should expect stimming and understand this as a mechanism to manage anxiety, and not necessarily an indicator of risk or acute distress	P50
	The therapist should be aware of how the client expresses distress, and monitor this throughout the session	P51
	The therapist should allow the client additional processing time, and time to respond	E29
Re-narration	The therapist should consider the clients preferred method of communication when producing the narrative*	P55

	The therapist should explore the client's ability to imagine*	P56
	The therapist and client should negotiate alternatives to communication if the client becomes non-speaking/'selectively mute'*	P57
	The therapist should allow for sensory regulation if the client finds this helpful*	P58
	The therapist should give explicit and specific consent to be interrupted/corrected	P59
	The therapist and client should agree on when corrections should be made (i.e, as the therapist reads the narrative, after, or bot	P61
	The therapist should allow the client additional processing time, and time to respond	E29
Duration/Total Number of Sessions	The therapist should be flexible	P71
	The therapist should be prepared to accommodate accordingly	P72
	The care plan/plan for therapy should be communicated as per the client's preferences (e.g. written, typed, drawn, emailed, printed)	P74
	The therapist should not assume for how long the client can manage a session; they should explore this with the client	P75
	The therapist should reassure the client that 'relapses' may occur i.e., that this is normal	E53

Note. ***** denotes an adaptation deemed to require further clarification (See Table 3).

3.9 Adaptations Reaching Consensus in One Expert Group, but not the Other

Following Round Three, a total of 27 adaptations met consensus as ‘very important’ adaptations in one expert group, but not the other (Table 14).

Table 14

Potentially Important Adaptations for Some Autistic Adults - Adaptations Meeting Consensus in One Expert Group

Element of NET	Adaptation	Adaptation Code	Accepted By	Rejected By	Discrepancy in Agreement
Assessment & Psychoeducation	The client's sensory needs and preferences should be incorporated into the sessions; e.g. sensory toys should be available*	P10	EBE	EBP	87.5
	The therapist should use pictures, written prompts, and diagrams*	P6	EBP	EBE	51.4
	The clinic room should be quiet, with soft furnishings and natural light	E8	EBE	EBP	38.9
	The therapist should support the client with emotion identification and labelling	P1/E2	EBE	EBP	33.3
	The therapist should explore the client's interoceptive ability (i.e., their ability to identify internal bodily sensations)*	P16	EBP	EBE	26.4
	The therapist should assess for strategies to emotionally regulate*	P12	EBP	EBE	25
	Time should be taken to consider how the client self-soothes*	E7	EBE	EBP	25
	The therapist should have prior knowledge of autism, how autistic people may experience trauma and how this may differ to neurotypical people	E13	EBE	EBP	25
	The therapist should concretely show the client how the therapy is likely to be helpful and exactly what is expected of them*	P11	EBP	EBE	17.5

	Clients should be provided a clear plan, structure, and 'rules' to help them predict what will happen throughout therapy	P21	EBP	EBE	13.9
	The therapist should understand the impact of potential co-occurring alexithymia (i.e., ability to identify and name emotions) and interoceptive abilities (i.e., ability to identify internal bodily sensations) on the client's ability to complete standardised measures (i.e., the PCL-5 and the LEC-5)	P15	EBE	EBP	10.7
The Lifeline	There should be an option for the exercise to be completed via a computer (i.e., online/remotely)	E22	EBE	EBP	85.7
	If the client wants to focus their lifeline on their experiences of being autistic, they should be able to	E15	EBE	EBP	50
	The client should be as active as they wish in placing the stones and flowers on the lifeline	P26	EBP	EBE	40
	Further clarification is needed on what a "significant or important event" is*	E19	EBE	EBP	35.7
	The therapist should explain the process in detail, and reiterate where helpful	E17	EBE	EBP	25
	There should be an option to revisit the lifeline later in therapy, e.g. to make changes if needed	E21	EBE	EBP	10.7
Narration	The therapist should explain the process in detail, and reiterate where helpful	E28	EBE	EBP	55.6
	The therapist should explain that the conversations the client has with the therapist are 'different' to the ones they might have with people outside of therapy, i.e., typically, it would not be expected for somebody to tell a stranger or a friend all about their trauma, but it is typical for somebody to tell a therapist all about their trauma. The therapist should explain why	E31	EBP	EBE	42.9
	The therapist should normalise any difficulties with interoceptive awareness *	P43	EBP	EBE	17.5
	Clients should be able to write down their feelings, if they want	E30	EBE	EBP	13.9

Re-narration	The therapist should explain the process in detail, and reiterate where helpful	E28	EBE	EBP	55.6
	The client should be provided with a copy of the narrative to read and correct outside of sessions	P63/E36	EBE	EBP	45.8
	The therapist should emphasise that the process of the narrative is about connecting with emotions and memories, rather than making the narrative perfect	P62	EBP	EBE	28.6
	Clients should be able to write down their feelings, if they want	E30	EBE	EBP	13.9
Duration/total Number of Sessions	If the client wants a break, they should be able to	E46	EBE	EBP	12.5
	During each session, the therapist should remind the client how long they have left (i.e., letting the client know there is 5 minutes remaining)	E49	EBE	EBP	12.5

Note. ***** denotes an adaptation deemed to require further clarification (See Table **3**).

3.9.1 Divergence in Consensus

There was evidence of divergence in the priorities of EBP and EBE, with some adaptations reaching consensus as ‘very important’ in one group, but not in the other group. It was important to manage this carefully, given that the perspectives of both groups were considered equally valuable. While the literature offers limited guidance on how to address such discrepancies within Delphi studies, the research team adopted a pragmatic approach. Specifically, adaptations that reached consensus as ‘very important’ in one group but not the other were retained in the adapted protocol, under the descriptor ‘potentially helpful adaptations for some autistic adults’. This decision was made to ensure the contributions of both expert groups were respected, and to acknowledge that EBP and EBE draw on different forms of knowledge and lived experience. Excluding these adaptations could have risked diminishing the richness and relevance of the data, as well as overlooking adaptations that still may hold utility for specific individuals. Consequentially, the adaptations warrant further investigation and evaluation in clinical practice.

4.0 Extended Discussion

4.1 Limitations

In the present study, the research team made the deliberate decision not to present participants with individual and group-level responses in subsequent Delphi rounds of Stage One. This was intended to minimise participant burden and reduce the risk of attrition by keeping the questionnaires concise and manageable. Additionally, withholding group-level feedback helped to reduce the potential for conformity bias, whereby participants might feel pressured to adjust their views according to the perceived consensus. This concern was particularly salient given the involvement of EBP and EBE. While participants were not explicitly made aware of the composition of the other expert group, they were made aware in Round Three that another expert group had contributed to the study. It is therefore plausible that some participants inferred the nature of the other panel (i.e., that they were made up of EBE or EBP), potentially influencing their responses due to perceived power differentials between professionals and those with lived experience. At the same time, exposure to the aggregated views of others may have encouraged participants to reflect more deeply and potentially arrive at more considered judgements.

In line with inclusive research practices, and to respect participants' privacy and reduce barriers to participation, EBE were not asked to provide formal evidence of an autism diagnosis. While this decision supported ethical engagement, it introduces the possibility that some participants may not have held a confirmed diagnosis. This is particularly relevant given the study's use of a prize draw incentive, which may have inadvertently attracted individuals outside of the intended sampling frame. As such, this raises questions about the validity of the sample, though the risk is considered minimal given the nature of the

eligibility screening process, the specificity of the study topic, and the targeted recruitment strategy, which involved advertising through autism-specific charity websites than general online forums.

4.2 Future Research

To support the piloting and potential wider implementation of NET for autistic adults, further research is needed to build the evidence base for NET as a standalone intervention. While promising evidence exists for NET across various population groups, studies specifically evaluating its efficacy in comparison to other established trauma-focused interventions – such as EMDR or TF-CBT – are necessary to determine its relative benefits and clinical utility.

Additionally, the present study highlighted several structural and systemic barriers to autism-specific research, including difficulties obtaining ethical approval. To understand this disparity more systematically, future research could audit the number and types of research proposals involving autistic participants that are rejected by research governance or funding bodies and compare these with similar studies involving non-autistic participants. Such an audit could serve to identify any structural disparities and inform improvements in how neurodivergent-inclusive research is supported.

Following the findings of the present study – where many of the proposed adaptations went beyond those currently outlined in clinical guidelines – future research should explore how EBP engage with and apply clinical guidelines with autistic clients. Specifically, it would be valuable to examine whether existing guidelines sufficiently capture the adaptations considered necessary or helpful in practice, regardless of the treatment modality, and whether revisions may be warranted to more accurately reflect the needs of this population.

5.0 Reflections

Throughout the completion of the thesis project, a reflective diary was kept to document decisions as they were made and to reflect upon decisions after they had been made. From this point, the primary researcher will write in first-person.

Identifying a Project

The process of identifying a project to immerse myself in over the coming three years was at first quite daunting, especially due to this decision being invited shortly after accepting a place on the training programme and prior to starting.

Autism

Autism has been an interest of mine for many years, and part of what led me to the career of clinical psychology: a want to *understand* and *empower* difference and challenge any narrative that serves to misunderstand or marginalise this. Throughout my professional and personal experiences with autistic individuals, I have been continually inspired by the perspectives shared with me by those with lived experience – often described as a way of seeing beyond social conventions, and embracing clarity, honesty, and authenticity – qualities of which I experience as deeply grounding and refreshing, and have shaped how I think, relate, and practice as a clinician.

Traumatic Stress

My clinical interest in traumatic stress grew during the early years of my career, during which I worked in an alternative education provision for children and young people, many of which experienced a range of mental health difficulties and significant, multiple adverse childhood

experiences. It was during my first-year placement in a tier four mental health service, where I was again, met with the impact of others cruel actions – the number of referrals that referenced past abuse, amongst other traumatic events, was striking. To witness how humans can be so awful to each other is something I am yet to understand, and probably never will understand.

It was during this placement that I was first introduced to NET by my placement supervisor. Over the course of the placement, I had the opportunity to deliver NET to several clients who had experienced significant trauma. The experience highlighted the transformative potential of NET, helping individuals to begin to imagine a future beyond their traumatic past. I particularly recall working with a client who struggled to look at the colour red due to its powerful association with a traumatic event. Following NET, the colour red no longer felt like an anchor to her past trauma; the association lessened to a point where the colour no longer triggered the same distressing emotional response, allowing her to engage with her environment in a more liberated way.

Autism and NET

During supervision in my first-year placement, my supervisor and I began to reflect on how NET might work in the context of autism. My supervisor shared her experiences of delivering NET to several autistic clients, noting that adaptations – such as omitting the lifeline or re-narration components – were sometimes helpful to support engagement. Despite these key components being modified or removed, clients still experienced clinically significant reductions in traumatic stress. This raised important questions on how the intervention might be adapted to better align with neurodivergent needs. Given the striking absence of literature

on the use of NET with autistic individuals, it became clear to me that this was an area in need of focused exploration.

Design of the Research

After selecting my identified project (i.e., adapting NET for use with autistic adults), I soon realised that it would primarily involve qualitative methods – something which initially cause some apprehension. My previous research experience had been largely quantitative, which appealed to my preference for clear answers and structured interpretation. I vividly remember attending a teaching session on qualitative methods during the first year of training, where we were introduced to the Delphi method. At the time, I recall thinking "I would never use this design; it seems to complex and almost invites issues such as attrition".

Originally, I had planned to utilise the Nominal Groups Technique (NGT) for Stage One. However, I felt discomfort about whether a group-based method would be appropriate or accessible for EBE, given the nature of autism and the potential challenges experienced by some in navigating social dynamics. At the same time, was cautious about making generalised assumptions about what autistic individuals may or may not find difficult. Still, I recognised that a group format could risk attracting a more homogeneous sample – those more comfortable with group interaction – ultimately limiting the diversity of views. This led me to explore the Delphi method more seriously, as it offered a more accessible, flexible, and anonymous way for participants to contribute their views.

I had also originally planned to pilot the adapted NET protocol with an autistic client. At the time, this seemed feasible, especially as I knew from my placement experience that many autistic adults experiencing traumatic stress were awaiting therapy. in hindsight, this would

have effectively constituted a separate project entirely, and could have compromised depth and quality.

Service User Involvement

From the outset, I was certain that the voices of EBE needed to be involved in the project. I was particularly interested to involve autistic individuals not only as participants but also in the shaping of the study materials to ensure accessibility, relevance, and inclusivity. However, this process posed some challenges, primarily due to constraints on the research budget and limited resources. Despite these challenges, I was fortunate to collaborate with several individuals from a service advisory group based at a university, whose thoughtful input helped refine the design and language of the study materials. Their contributions were invaluable, and I remain deeply appreciative of their time.

In the future, I would hope to engage more fully in co-produced research, working alongside EBE across all stages of the project – from initial idea generation to analysis and dissemination.

Ethical Approval

Health Research Authority (HRA) and Research Ethics Committee (REC)

As outlined in the ethical considerations section of the extended paper, obtaining ethical approval through the HRA and REC proved to be a significant challenge, and remains an area of personal and professional discomfort. While the committee's concerns around approving an adapted therapeutic protocol without having the finalised content were understandable, it was the implicit attitudes towards autism that were more troubling.

Efforts were made to mitigate risk to participants, including signposting to relevant support organisations within the participant information sheet. The questionnaire itself was designed to avoid triggering content, focusing on structured and relevance of the intervention rather than traumatic experiences directly. Participants were also asked to carefully consider whether participation felt appropriate for them, particularly if they had previously experienced a traumatic event. Despite these safeguards, the REC expressed considerable concern regarding autistic participants' ability to consent to participation in the study. The implication that autistic adults might lack the capacity to make an informed decision about their involvement was uncomfortable and, in my view, misguided. Autism and decision-making capacity are not mutually exclusive; autistic individuals often possess a strong sense of autonomy and self-awareness, and it felt, and continues to feel, necessary to advocate for this understanding.

The REC further characterised autistic individuals as "extremely vulnerable" and "unpredictable". While it is true that autistic individuals may face specific vulnerabilities, this should not overshadow their strengths or autonomy. Such blanket statements can reinforce harmful stereotypes that equate autism with deficiency or risk, rather than recognising the diversity and capability within the population. This implication not only has ethical implications, but may also contribute to the delay in developing and improving research that addresses the therapeutic needs of this group.

The committee expressed discomfort with the requirement of NET to continue the narration during moments of distress – a core component of the intervention that is supported by empirical evidence and recommended in national clinical guidelines. Despite efforts to clarify this and to provide reassurance about safeguarding and support, these concerns retained a

barrier to approval. Of note, there was no mental health professional present on the panel, which may have understandably contributed to these misunderstandings.

This experience highlighted broader systemic issues in research governance. It raised important questions about how assumptions about autistic individuals are shaping which studies are approved, and how the development of trauma-focused therapies for this population might be hindered by outdated or inaccurate views.

University Ethics

Following the necessary amendments, approval was sought from the university ethics committee. Ethical approval was granted within two weeks of submission. This milestone marked a turning point in the project, and I felt optimistic about the research progressing.

Participant Recruitment

The interest received from EBE was substantial. The recruitment target was met quickly, and we were required to close the study to further participants. Even a year after recruitment closed, I continued to receive expressions of interest from EBE in response to archived advertisements. While this level of interest supported the practical aspects of recruitment, it also pointed towards a broader systemic issue: the unmet need for trauma-focused interventions within the autistic community, and the willingness of autistic individuals to contribute to improving services in this area. This served as a powerful reminder of the relevance and urgency of the research.

In contrast, recruiting EBP and NET experts was more challenging. Reflecting on this, I considered common barriers for clinicians engaging in research studies, including time

pressures, competing clinical demands, and burnout. Although not all EBP were required to be clinical psychologists, the professional tends to become less research-active post-qualification, and this may have also contributed to lower levels of engagement.

Data Collection and Analysis

The process of collecting and analysing data was both rewarding and overwhelming. Moving from a predominantly quantitative research background, I initially found the ambiguity and interpretive nature of qualitative work challenging. Despite this, the process of analysing the data deepened my understanding of the topic and the voices of participants. I came to value the richness and complexity of qualitative research, and how it enables nuanced perspectives to be captured.

Final Reflections

Throughout this project, it has been important to return to my core motivation: to contribute meaningfully to a population that is too often misunderstood. I sincerely hope that this project, the adaptations developed through it, and any subsequent developments towards a more formalised protocol, will one day be of value to an autistic individual who has been forced to heal from something they should have never had to experience.

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Appendices

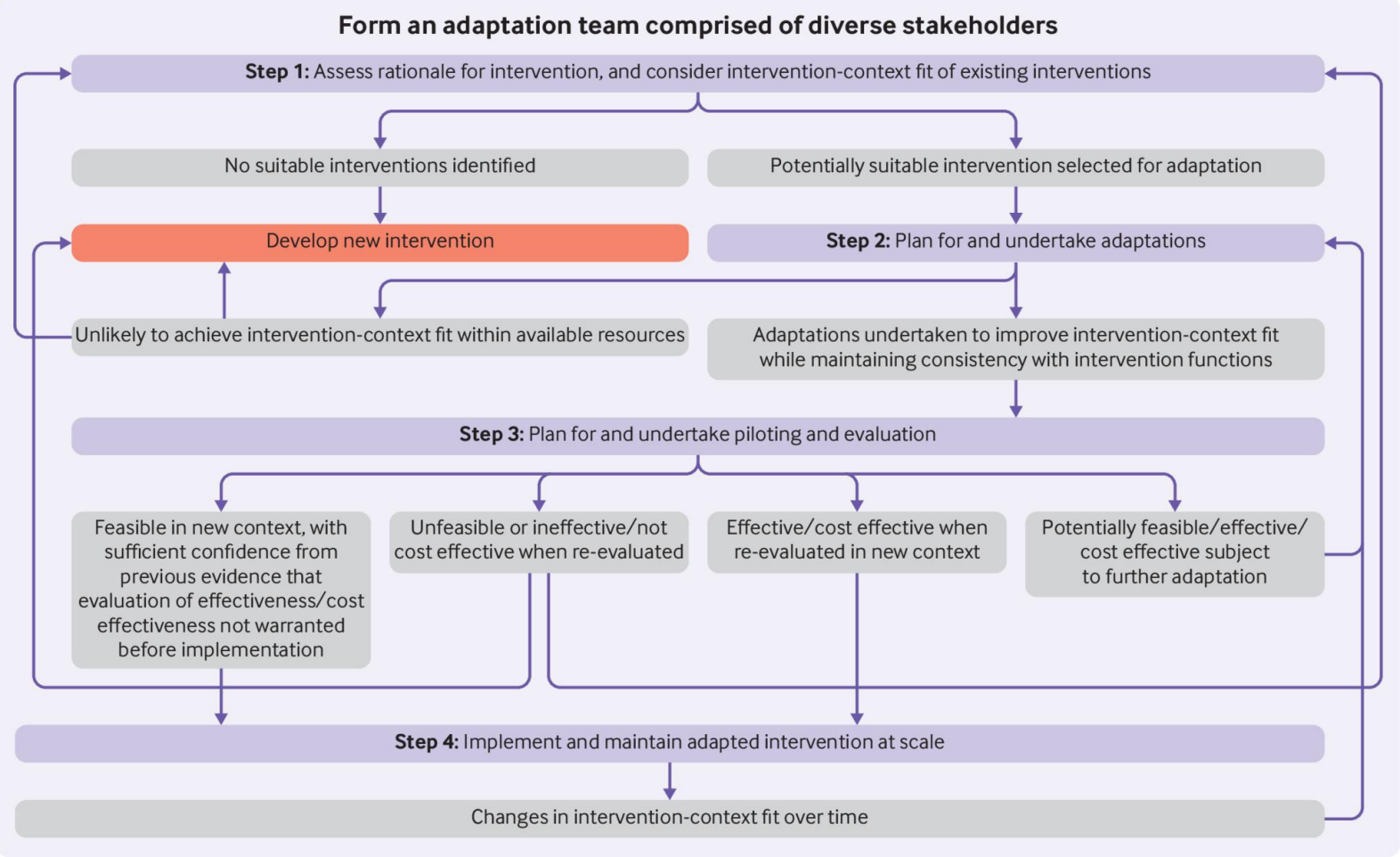
Appendix A

Submission Guidelines for 'Autism' in 'Frontiers in Psychiatry'

The guidelines for submission are accessible here: https://www.frontiersin.org/guidelines/author-guidelines

Appendix B

ADAPT Guidance (Moore et al., 2021)



Appendix C

Participant Advertisement Email: Experts by Profession

Dear XXX

My name is Sophie Dinsdale and I am a second-year Trainee Clinical Psychologist. I would like to invite you to take part in a study about Narrative Exposure Therapy, a trauma-focused psychological therapy, and how it may be adapted for use with autistic adults presenting with traumatic stress. The study will form as my thesis completed in partial fulfilment of the Trent Doctorate in Clinical Psychology. This study has received ethical approval from the Mental Health and Clinical Neurosciences Research Ethics Sub-Committee (ref: MHCN-2024-3145-1).

Participation in the study is entirely voluntary and involvement entails a series of up to three questionnaires. It is expected that the first questionnaire will take between 45 minutes to one hour of your time, and up to 30 – 45 minutes in subsequent rounds. I am offering a random draw of two £25 Amazon vouchers for those who participate.

If you are interested, please follow the link in the attached advertisement. I would be grateful if you could share this with your colleagues.

If you have any questions, please contact me.

Thank you.

Best wishes,

Sophie Dinsdale
sophie.dinsdale@nottingham.ac.uk

Appendix D

Participant Advertisement Poster: Experts by Profession



Appendix E

Participant Information Sheet: Experts by Profession

PARTICIPANT INFORMATION

STUDENT RESEARCH PROJECT ETHICS REVIEW
Mental Health and Clinical Neurosciences

Project Title: Adapting Narrative Exposure Therapy (NET) for Autistic Adults Experiencing Traumatic Stress

Student: Sophie Dinsdale, sophie.dinsdale@nottingham.ac.uk

Supervisor/Chief Investigator: Professor Thomas A Schröder,

thomas.schroder@nottingham.ac.uk

Ethics Reference Number: MHCN-2024-3145-1

We would like to invite you to take part in a research study about how Narrative Exposure Therapy, a type of trauma therapy, might be adapted for use with autistic adults with symptoms of traumatic stress. Before you begin, we would like you to understand why the research is being done and what it involves for you.

What is the purpose of this study?
This study aims to explore how Narrative Exposure Therapy (NET) can be adapted for autistic adults. NET is a type of psychological therapy that can be helpful for people who have experienced one or more traumatic experiences which they continue to find distressing. The findings of this study will be written up as part of a thesis completed in partial fulfilment of the Trent Doctorate in Clinical Psychology.

Why have I been invited?
You are being invited to take part because you have experience of working with the autistic population. We are inviting up to fifteen participants like you to take part.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part, we will ask you to provide consent on the following form. You may change your mind about being involved at any time or decline to discuss a particular question. You are free to withdraw at any point before or during the study without giving a reason. If you wish to withdraw please contact the student completing the project, Sophie Dinsdale, sophie.dinsdale@nottingham.ac.uk. If you withdraw during the study, we will no longer collect any information about you or from you, but we will keep the information about you that we have already obtained as this information may have already been used in some analyses and may still be used in the final study analyses. If you decide to withdraw after participating in the study you can withdraw your data within five days. After this time data may be anonymised and included in analyses, and it will no longer be technically possible to withdraw your data.

What will I be asked to do?
If you choose to take part, you will be asked to complete the questionnaire attached. The questionnaire includes an overview of Narrative Exposure Therapy. You will be asked to consider how Narrative Exposure Therapy could be adapted for use with autistic adults experiencing traumatic stress. You do not need to have previous experience or knowledge of Narrative Exposure Therapy to take part. It is expected that this will take between 45 minutes – one hour. Once responses have been received from all participants, you will be invited to complete up to two further questionnaires. In these subsequent questionnaires, you will be asked to review the adaptations suggested in the first questionnaire. It is expected that subsequent questionnaires will take between 20 – 30 minutes.

Will the research be of any personal benefit to me?
There is no direct benefit to you from taking part but the information we get from this study may help us to understand more about treating traumatic stress in the autism population. This information will contribute to the development of guidelines in using Narrative Exposure Therapy for this purpose.

Are there any possible disadvantages or risks in taking part?
We don't expect there to be any disadvantages or risks to taking part. However, the research relates to a type of trauma therapy. Some people can become upset when thinking about trauma. It is important that you consider if this may be triggering for you, particularly if you have experienced a traumatic event previously, and if so, if it is appropriate that you take part. If you find that the study evokes difficult feelings, please find information on sources of support attached to the bottom of this information sheet. The study involves some time spent looking at a computer screen. Some people may become fatigued when doing so for extended periods of time. We advise you to regularly look away from the screen if your eyes are tired, and to take regular breaks.

What will happen to the information I provide?
To ensure confidentiality, only the research team will have access to the questionnaire data. Participants will be identified by a participant number only. We would like to be able to quote what you say in reports or publications. We will make sure that your anonymity is protected, but if you do not wish us to quote you, please tell us.

The information that you provide will be used to write a thesis for the partial fulfilment of the Trent Doctorate in Clinical Psychology, and may also be used to write academic papers to be published in peer-reviewed journals and in presentations at conferences. If you would like a summary of the results, please email the supervisor Professor Thomas A Schröder, thomas.schroder@nottingham.ac.uk for a copy.

Anything you say during the study will be kept confidential, unless you reveal something of concern that may put yourself or anyone else at risk. It will then be necessary to report to the appropriate persons.

We will follow ethical and legal practice and all information will be handled in confidence. Under UK Data Protection laws, the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the

research to be reliable and accurate. To safeguard your rights, we will use the minimum personally–identifiable information possible. You can find out more about how we use your information and to read our privacy notice at: https://www.nottingham.ac.uk/utilities/privacy.aspx

We would like your permission to use anonymised data in future studies, and to share our research data (e.g. in online databases) with other researchers in other Universities and organisations both inside and outside the European Union. This would be used for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty. At the end of the project, all raw data will be kept securely by the University under the terms of its data protection policy after which it will be disposed of securely. The data will not be kept elsewhere.

If you have any questions or concerns, please don't hesitate to ask. We can be contacted before and after your participation at the email addresses above.

What if there is a problem?
If you have any queries or complaints, please contact the student's supervisor/chief investigator in the first instance. If this does not resolve your query, please write to the Administrator: MS-MHCNS-Ethics@exmail.nottingham.ac.uk and the Administrator will pass your query to the Chair of the Committee.

If you remain unhappy and wish to complain formally, you should then contact the Faculty of Medical and Health Sciences Ethics Committee Administrator, Faculty Hub, Medicine and Health Sciences, E41, E Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH or via E-mail: FMHS-ResearchEthics@nottingham.ac.uk

We believe there are no known risks associated with this research study; however, as with any online activity the risk of a breach is always possible. We will do everything possible to ensure your answers in this study will remain anonymous.

Sources of support

Anxiety UK
03444 775 774 (helpline)
07537 416 905 (text)
anxietyuk.org.uk
Advice and support for people living with anxiety.

ASSIST Trauma Care
assisttraumacare.org.uk
Information and specialist help for people who have experienced trauma or are supporting

someone who has.

Birth Trauma Association
birthtraumaassociation.org.uk
Support for anyone affected by birth trauma, including partners.

Combat Stress
0800 1381 619
combatstress.org.uk
Treatment and support for armed forces veterans who have mental health problems.

Disaster Action
disasteraction.org.uk
Information and support for people affected by major disasters in the UK and overseas.

EMDR Association UK
emdrassociation.org.uk
Professional association of EMDR clinicians and researchers in the UK and Ireland. Provides lots of information about EMDR. Includes a search tool to find EMDR-accredited therapists.

Freedom from Torture
freedomfromtorture.org
Supports survivors of torture.

Help for Adult Victims of Child Abuse (HAVOCA)
havoca.org
Information and support for adults who have experienced any type of childhood abuse, run by survivors.

The National Association for People Abused in Childhood (NAPAC)
0808 801 0331
support@napac.org.uk
napac.org.uk
Supports adult survivors of any form of childhood abuse. Offers a helpline, email support and local services.

NHS UK
nhs.uk
Information about health problems and treatments, including details of local NHS services in England.

NHS talking therapies self-referral
nhs.uk/service-search/mental-health/find-an-nhs-talking-therapies-service
Information about local NHS therapy services for certain mental health problems. You can self-refer (England only) but you must be registered with a GP.

PTSD Resolution
0300 302 0551
ptsdresolution.org
Helps veterans, reservists and their families with trauma and distress.

PTSD UK
ptsduk.org
Provides information about PTSD and C-PTSD, including different types of treatment, ways to help yourself and how to support someone with PTSD.

RoadPeace
08454 500 355
roadpeace.org
Information and support for people bereaved or seriously injured due to road crashes.

The Survivors Trust
0808 8010 818
thesurvivorstrust.org
Lists local specialist services for survivors of sexual violence, including advocates and Independent Sexual Violence Advisors (ISVAs).

Victim Support
0808 168 9111
victimsupport.org.uk
Provides emotional and practical support for people affected by crime and traumatic events

Appendix F

Participant Consent Form: Experts by Profession

Participant Consent

Interactive form for online consent

STUDENT RESEARCH PROJECT ETHICS REVIEW
Mental Health and Clinical Neurosciences

Project Title:	Adapting Narrative Exposure Therapy (NET) for Autistic Adults Experiencing Traumatic Stress
Researcher:	Sophie Dinsdale, sophie.dinsdale@nottingham.ac.uk
Supervisor:	Professor Thomas A Schröder, thomas.schroder@nottingham.ac.uk
Ethics Ref:	MHCN-2024-3145-1

Have you read and understood the Participant Information?	☐Yes ☐No
Do you agree to take part in the questionnaires exploring how Narrative Exposure Therapy could be adapted for autistic adults?	☐Yes ☐No
Do you know how to contact the researcher if you have questions about this study?	☐Yes ☐No
Do you understand that you are free to withdraw from the study without giving a reason?	☐Yes ☐No
Do you understand that once you have taken part it may not be technically possible to withdraw your data?	☐Yes ☐No
Do you give permission for your data from this study to be shared with other researchers in the future provided that your anonymity is protected?	☐Yes ☐No
Do you understand that non-identifiable data from this study including quotations might be used in academic research reports or publications?	☐Yes ☐No
I confirm that I am 18 years old or over	☐Yes ☐No

By selecting 'Yes', I indicate that I understand what the study involves, and I agree to take part. I consent to take part in this research study.	☐Yes ☐No

Appendix G

Participant Advertisement Email: Experts by Experience

Dear XXX

My name is Sophie Dinsdale and I am a second-year Trainee Clinical Psychologist. I am currently completing a study to investigate how Narrative Exposure Therapy, a type of trauma therapy, could be adapted for use with autistic adults. This study has received ethical approval from the Mental Health and Clinical Neurosciences Research Ethics Sub-Committee (ref: MHCN-2024-3145-1).

I would like to hear the views of experts by experience. I am contacting you to explore whether your organisation would be willing to advertise this study on your website and/or social media platforms. I have attached the study advertisement poster.

Thank you for considering.

If you have any questions, please contact me.

Best wishes,

Sophie Dinsdale
sophie.dinsdale@nottingham.ac.uk

Appendix H

Participant Advertisement Poster: Experts by Experience



Appendix I

Participant Information Sheet: Experts by Experience

PARTICIPANT INFORMATION

STUDENT RESEARCH PROJECT ETHICS REVIEW
Mental Health and Clinical Neurosciences

Project Title: Adapting Narrative Exposure Therapy (NET) for Autistic Adults Experiencing Traumatic Stress

Student: Sophie Dinsdale, sophie.dinsdale@nottingham.ac.uk

Supervisor/Chief Investigator: Professor Thomas A Schröder,

thomas.schroder@nottingham.ac.uk

Ethics Reference Number: MHCN-2024-3145-1

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions. Feel free to talk to others about the study and please contact us with any questions. If you wish to find out more or to participate, please contact Sophie Dinsdale, sophie.dinsdale@nottingham.ac.uk.

What is the purpose of this study?
This study aims to explore how Narrative Exposure Therapy (NET) can be adapted for autistic adults. NET is a type of psychological therapy that can be helpful for people who have experienced one or more traumatic experiences.

Why have I been invited?
You are being invited to take part because you have a diagnosis of autism spectrum disorder and have an insight into how you might be best supported. This could inform how clinicians might support other autistic people. We are inviting up to fifteen participants like you to take part.

Do I have to take part?
No. It is up to you to decide whether or not to take part. If you do decide to take part, we will ask you to provide consent online. You may change your mind about being involved at any time or decline to discuss a particular question.

You are free to withdraw at any point before or during the study without giving a reason. If you wish to withdraw please contact the student completing the project, Sophie Dinsdale, sophie.dinsdale@nottingham.ac.uk.

If you withdraw during the study, we will no longer collect any information about you or from you, but we will keep the information about you that we have already obtained as this information may have already been used in some analyses and may still be used in the final study analyses. If you decide to withdraw after participating in the study you can withdraw your data within five

days. After this time data may be anonymised and included in analyses, and it will no longer be technically possible to withdraw your data.

What will I be asked to do?
If you wish to take part, please contact the student, Sophie Dinsdale sophie.dinsdale@nottingham.ac.uk to discuss further.

If you then choose to take part, you will be sent the link to a questionnaire. The questionnaire will include a brief overview of Narrative Exposure Therapy. You will be asked to consider how Narrative Exposure Therapy could be adapted for use with autistic adults experiencing traumatic stress. You do not need to have previous experience or knowledge of Narrative Exposure Therapy to take part. It is expected that this will take between 45 minutes – one hour.

Once responses have been received from all participants, you will be invited to complete up to two further questionnaires. In these subsequent questionnaires, you will be asked to review the adaptations suggested in the first questionnaire. It is expected that subsequent questionnaires will take between 20 – 30 minutes.

Will the research be of any personal benefit to me?
There is no direct benefit to you from taking part but the information we get from this study may help us to understand more about treating traumatic stress in the autistic population. This information will contribute to the development of guidelines for using Narrative Exposure Therapy for this purpose.

Are there any possible disadvantages or risks in taking part?
We don't expect there to be any disadvantages or risks to taking part. However, the research relates to a type of trauma therapy. Some people can become upset when thinking about trauma. It is important that you consider if this may be triggering for you, particularly if you have experienced a traumatic event previously, and if so, if it is appropriate that you take part. If you find that the study evokes difficult feelings, please find information on sources of support attached to the bottom of this information sheet.

The study involves some time spent looking at a computer screen. Some people may become fatigued when doing so for extended periods of time. We advise you to regularly look away from the screen if your eyes are tired, and to take regular breaks.

What will happen to the information I provide?
To ensure confidentiality, only the research team will have access to the questionnaire data. Participants will be identified by a participant number only. We would like to be able to quote what you say in reports or publications. We will make sure that your anonymity is protected, but if you do not wish us to quote you, please tell us.

The information that you provide will be used to write a thesis for the partial fulfilment of the Trent Doctorate in Clinical Psychology, and may also be used to write academic papers to be published in peer-reviewed journals and in presentations at conferences. If you would like a summary of the results, please email the supervisor Professor Thomas A Schröder, thomas.schroder@nottingham.ac.uk for a copy.

Anything you say during the study will be kept confidential, unless you reveal something of concern that may put yourself or anyone else at risk. It will then be necessary to report to the appropriate persons.

We will follow ethical and legal practice and all information will be handled in confidence. Under UK Data Protection laws, the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally–identifiable information possible. You can find out more about how we use your information and to read our privacy notice at: https://www.nottingham.ac.uk/utilities/privacy.aspx

We would like your permission to use anonymised data in future studies, and to share our research data (e.g. in online databases) with other researchers in other Universities and organisations both inside and outside the European Union. This would be used for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty. At the end of the project, all raw data will be kept securely by the University under the terms of its data protection policy after which it will be disposed of securely. The data will not be kept elsewhere.

If you have any questions or concerns, please don't hesitate to ask. We can be contacted before and after your participation at the email addresses above.

What if there is a problem?
If you have any queries or complaints, please contact the student's supervisor/chief investigator in the first instance. If this does not resolve your query, please write to the Administrator: MS-MHCNS-Ethics@exmail.nottingham.ac.uk and the Administrator will pass your query to the Chair of the Committee.

If you remain unhappy and wish to complain formally, you should then contact the Faculty of Medical and Health Sciences Ethics Committee Administrator, Faculty Hub, Medicine and Health Sciences, E41, E Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH or via E-mail: FMHS-ResearchEthics@nottingham.ac.uk

We believe there are no known risks associated with this research study; however, as with any online activity the risk of a breach to confidentiality is always possible. We will do everything possible to ensure your answers in this study will remain anonymous.

Sources of support

National Autistic Society
https://www.autism.org.uk/advice-and-guidance/topics/mental-health/post-traumatic-stress-disorder
Advice and support for autistic individuals and those that support them.

Anxiety UK
03444 775 774 (helpline)
07537 416 905 (text)
anxietyuk.org.uk
Advice and support for people living with anxiety.

ASSIST Trauma Care
assisttraumacare.org.uk
Information and specialist help for people who have experienced trauma or are supporting someone who has.

Birth Trauma Association
birthtraumaassociation.org.uk
Support for anyone affected by birth trauma, including partners.

Combat Stress
0800 1381 619
combatstress.org.uk
Treatment and support for armed forces veterans who have mental health problems.

Disaster Action
disasteraction.org.uk
Information and support for people affected by major disasters in the UK and overseas.

EMDR Association UK
emdrassociation.org.uk
Professional association of EMDR clinicians and researchers in the UK and Ireland. Provides lots of information about EMDR. Includes a search tool to find EMDR-accredited therapists.

Freedom from Torture
freedomfromtorture.org
Supports survivors of torture.

Help for Adult Victims of Child Abuse (HAVOCA)
havoca.org
Information and support for adults who have experienced any type of childhood abuse, run by survivors.

The National Association for People Abused in Childhood (NAPAC)
0808 801 0331
support@napac.org.uk
napac.org.uk
Supports adult survivors of any form of childhood abuse. Offers a helpline, email support and local services.

NHS UK
nhs.uk
Information about health problems and treatments, including details of local NHS services in England.

NHS talking therapies self-referral
nhs.uk/service-search/mental-health/find-an-nhs-talking-therapies-service
Information about local NHS therapy services for certain mental health problems. You can self-refer (England only) but you must be registered with a GP.

PTSD Resolution
0300 302 0551
ptsdresolution.org
Helps veterans, reservists and their families with trauma and distress.

PTSD UK
ptsduk.org
Provides information about PTSD and C-PTSD, including different types of treatment, ways to help yourself and how to support someone with PTSD.

RoadPeace
08454 500 355
roadpeace.org
Information and support for people bereaved or seriously injured due to road crashes.

The Survivors Trust
0808 8010 818
thesurvivorstrust.org
Lists local specialist services for survivors of sexual violence, including advocates and Independent Sexual Violence Advisors (ISVAs).

Victim Support
0808 168 9111
victimsupport.org.uk
Provides emotional and practical support for people affected by crime and traumatic events

Appendix J

Participant Consent Form: Experts by Experience

Participant Consent

Interactive form for online consent

STUDENT RESEARCH PROJECT ETHICS REVIEW
Mental Health and Clinical Neurosciences

Project Title:	Adapting Narrative Exposure Therapy (NET) for Autistic Adults Experiencing Traumatic Stress
Researcher:	Sophie Dinsdale, sophie.dinsdale@nottingham.ac.uk
Supervisor:	Professor Thomas A Schröder, thomas.schroder@nottingham.ac.uk
Ethics Ref:	MHCN-2024-3145-1

Have you read and understood the Participant Information?	☐Yes ☐No
Do you agree to take part in the questionnaires exploring how Narrative Exposure Therapy could be adapted for autistic adults?	☐Yes ☐No
Do you know how to contact the researcher if you have questions about this study?	☐Yes ☐No
Do you understand that you are free to withdraw from the study without giving a reason?	☐Yes ☐No
Do you understand that once you have taken part it may not be technically possible to withdraw your data?	☐Yes ☐No
Do you give permission for your data from this study to be shared with other researchers in the future provided that your anonymity is protected?	☐Yes ☐No
Do you understand that non-identifiable data from this study including quotations might be used in academic research reports or publications?	☐Yes ☐No
I confirm that I am 18 years old or over	☐Yes ☐No

By selecting ‘Yes’, I indicate that I understand what the study involves, and I agree to take part. I consent to take part in this research study.

☐Yes ☐No

Appendix K

Participant Advertisement Email: NET Experts

Dear XXX

My name is Sophie Dinsdale and I am a third-year Trainee Clinical Psychologist in the UK National Health Service. I would like to invite you as a NET expert to take part in a study about how Narrative Exposure Therapy could be adapted for use with autistic adults presenting with traumatic stress. The study will form as my thesis completed in partial fulfilment of the Trent Doctorate in Clinical Psychology. This study has received ethical approval from the Mental Health and Clinical Neurosciences Research Ethics Sub-Committee (ref: MHCN-2024-3145-1).

Participation in the study is entirely voluntary. Involvement entails reviewing a list of the suggested adaptations and attending a focus group for up to two hours, where you will be invited to discuss some of the adaptations.

If you are interested, please follow the link in the attached advertisement. I would be grateful if you could share this with your colleagues.

If you have any questions, please contact me.

Thank you.

Best wishes,

Sophie Dinsdale
sophie.dinsdale@nottingham.ac.uk

Appendix L

Participant Advertisement Poster: NET Experts



Appendix M

Participant Information Sheet: NET Experts

PARTICIPANT INFORMATION

STUDENT RESEARCH PROJECT ETHICS REVIEW
Mental Health and Clinical Neurosciences

Project Title: Adapting Narrative Exposure Therapy (NET) for Autistic Adults Experiencing Traumatic Stress

Student: Sophie Dinsdale, sophie.dinsdale@nottingham.ac.uk

Supervisor/Chief Investigator: Professor Thomas A Schröder,

thomas.schroder@nottingham.ac.uk

Ethics Reference Number: MHCN-2024-3145-1

We would like to invite you to take part in a research study about how Narrative Exposure Therapy, a type of trauma therapy, might be adapted for use with autistic adults with symptoms of traumatic stress. Before you begin, we would like you to understand why the research is being done and what it involves for you.

What is the purpose of this study?
The purpose of the study is to explore how Narrative Exposure Therapy (NET) can be adapted for autistic individuals. It is well documented within the literature that autistic individuals may be at a higher risk of traumatic stress than individuals without autism. As such, it is important to understand how this population may be supported.

Why have I been invited?
You are being invited to take part because you have a good knowledge of NET and may be able to advise whether an adapted NET protocol suitable for use with the autism population still adheres to the principles and underlying theory of NET. We are inviting up to five participants like you to take part.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part, we will ask you to provide consent by virtually signing a consent form. You may change your mind about being involved at any time or decline to discuss a particular question. You are free to withdraw at any point before or during the study without giving a reason. If you wish to withdraw please contact the student completing the project, Sophie Dinsdale, sophie.dinsdale@nottingham.ac.uk. If you decide to withdraw after participating in the study you can withdraw your data within five days. After this time data may be anonymised and included in analyses, and it will no longer be technically possible to withdraw your data.

What will I be asked to do?

If you wish to participate, you will be sent a list of suggested adaptations to the NET protocol. You will be asked to consider whether the adaptations would influence the practice of NET. You will then be invited to take part in a focus group. The session will be facilitated via Microsoft Teams and will last for up to two hours. You do not need to have prior experience working with autistic clients to participate.

Will the research be of any personal benefit to me?
There is no direct benefit to you from taking part but the information we get from this study may help us to understand more about treating traumatic stress in the autism population. This information will contribute to the development of guidelines in using Narrative Exposure Therapy for this purpose.

Are there any possible disadvantages or risks in taking part?
You will be aware that NET is a type of trauma therapy. Some people can become upset when thinking about trauma. It is important that you consider if this may be triggering for you, particularly if you have experienced a traumatic event previously, and if so, if it is appropriate that you take part. If you find that the study evokes difficult feelings, please find information on sources of support attached to the bottom of this information sheet.

What will happen to the information I provide?
To ensure confidentiality, only the research team will have access to the questionnaire data. Participants will be identified by a participant number only. We would like to be able to quote what you say in reports or publications. We will make sure that your anonymity is protected, but if you do not wish us to quote you, please tell us.

The information that you provide will be used to write a thesis for the partial fulfilment of the Trent Doctorate in Clinical Psychology, and may also be used to write academic papers to be published in peer-reviewed journals and in presentations at conferences. If you would like a summary of the results, please email the supervisor Professor Thomas A Schröder, thomas.schroder@nottingham.ac.uk for a copy.

Anything you say during the study will be kept confidential, unless you reveal something of concern that may put yourself or anyone else at risk. It will then be necessary to report to the appropriate persons.

We will follow ethical and legal practice and all information will be handled in confidence. Under UK Data Protection laws, the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally–identifiable information possible. You can find out more about how we use your information and to read our privacy notice at: https://www.nottingham.ac.uk/utilities/privacy.aspx

We would like your permission to use anonymised data in future studies, and to share our research data (e.g. in online databases) with other researchers in other Universities and organisations both inside and outside the European Union. This would be used for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular

areas of research. All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty. At the end of the project, all raw data will be kept securely by the University under the terms of its data protection policy after which it will be disposed of securely. The data will not be kept elsewhere.

If you have any questions or concerns, please don't hesitate to ask. We can be contacted before and after your participation at the email addresses above.

What if there is a problem?
If you have any queries or complaints, please contact the student's supervisor/chief investigator in the first instance. If this does not resolve your query, please write to the Administrator: MS-MHCNS-Ethics@exmail.nottingham.ac.uk and the Administrator will pass your query to the Chair of the Committee.

If you remain unhappy and wish to complain formally, you should then contact the Faculty of Medical and Health Sciences Ethics Committee Administrator, Faculty Hub, Medicine and Health Sciences, E41, E Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH or via E-mail: FMHS-ResearchEthics@nottingham.ac.uk

We believe there are no known risks associated with this research study; however, as with any online activity the risk of a breach is always possible. We will do everything possible to ensure your answers in this study will remain anonymous.

Sources of support

Anxiety UK
03444 775 774 (helpline)
07537 416 905 (text)
anxietyuk.org.uk
Advice and support for people living with anxiety.

ASSIST Trauma Care
assisttraumacare.org.uk
Information and specialist help for people who have experienced trauma or are supporting someone who has.

Birth Trauma Association
birthtraumaassociation.org.uk
Support for anyone affected by birth trauma, including partners.

Combat Stress
0800 1381 619
combatstress.org.uk

Treatment and support for armed forces veterans who have mental health problems.

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Information and support for people affected by major disasters in the UK and overseas.

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Professional association of EMDR clinicians and researchers in the UK and Ireland. Provides lots of information about EMDR. Includes a search tool to find EMDR-accredited therapists.

Freedom from Torture
freedomfromtorture.org
Supports survivors of torture.

Help for Adult Victims of Child Abuse (HAVOCA)
havoca.org
Information and support for adults who have experienced any type of childhood abuse, run by survivors.

The National Association for People Abused in Childhood (NAPAC)
0808 801 0331
support@napac.org.uk
napac.org.uk
Supports adult survivors of any form of childhood abuse. Offers a helpline, email support and local services.

NHS UK
nhs.uk
Information about health problems and treatments, including details of local NHS services in England.

NHS talking therapies self-referral
nhs.uk/service-search/mental-health/find-an-nhs-talking-therapies-service
Information about local NHS therapy services for certain mental health problems. You can self-refer (England only) but you must be registered with a GP.

PTSD Resolution
0300 302 0551
ptsdresolution.org
Helps veterans, reservists and their families with trauma and distress.

PTSD UK
ptsduk.org
Provides information about PTSD and C-PTSD, including different types of treatment, ways to help yourself and how to support someone with PTSD.

RoadPeace
08454 500 355
roadpeace.org
Information and support for people bereaved or seriously injured due to road crashes.

The Survivors Trust
0808 8010 818
thesurvivorstrust.org
Lists local specialist services for survivors of sexual violence, including advocates and Independent Sexual Violence Advisors (ISVAs).

Victim Support
0808 168 9111
victimsupport.org.uk
Provides emotional and practical support for people affected by crime and traumatic events

Appendix N

Participant Consent Form: NET Experts

Participant Consent

Interactive form for online consent

STUDENT RESEARCH PROJECT ETHICS REVIEW
Mental Health and Clinical Neurosciences

Project Title:	Adapting Narrative Exposure Therapy (NET) for Autistic Adults Experiencing Traumatic Stress
Researcher:	Sophie Dinsdale, sophie.dinsdale@nottingham.ac.uk
Supervisor:	Professor Thomas A Schröder, thomas.schroder@nottingham.ac.uk
Ethics Ref:	MHCN-2024-3145-1

Have you read and understood the Participant Information?	☐Yes ☐No
Do you agree to take part in the study exploring the adapted protocol for Narrative Exposure Therapy for use with autistic adults?	☐Yes ☐No
Do you know how to contact the researcher if you have questions about this study?	☐Yes ☐No
Do you understand that you are free to withdraw from the study without giving a reason?	☐Yes ☐No
Do you understand that once you have taken part it may not be technically possible to withdraw your data?	☐Yes ☐No
Do you give permission for your data from this study to be shared with other researchers in the future provided that your anonymity is protected?	☐Yes ☐No
Do you understand that non-identifiable data from this study including quotations might be used in academic research reports or publications?	☐Yes ☐No
I confirm that I am 18 years old or over	☐Yes ☐No

By selecting ‘Yes’, I indicate that I understand what the study involves, and I agree to take part. I consent to take part in this research study.

☐Yes ☐No

Appendix O

Stage One: Round One Questionnaire – Experts by Profession

Screening

What is your age?

- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65 +
- Prefer not to say

Please select your profession.

- Psychologist
- Nurse
- Occupational Therapist
- Psychiatrist
- Social Worker
- Speech and Language Therapist
- Support Staff (including staff supporting access to housing, educational and support services, financial advice, and personal and community safety skills).

How many years of experience do you have in working with autistic adults?

Please note: you must have 2 or more years of experience in working with autistic adults to participate in the study.

Enter your answer

Demographics

What is your gender identity?

- ◯ Female
- ◯ Male
- ◯ Non-binary/gender queer/agender/gender fluid
- ◯ Other
- ◯ Prefer not to say

What is your ethnicity?

- ◯ Asian or Asian British (including Indian, Pakistani, Bangladeshi, Chinese, any other Asian background)
- ◯ Black, Black British, Caribbean or African (including Caribbean, African, any other Black, Black British, or Caribbean background)
- ◯ Mixed or multiple ethnic group (including White and Black Caribbean, White and Black African, White and Asian, any other Mixed or multiple ethnic background)
- ◯ White (including English, Welsh, Scottish, Northern Irish or British, Irish, Gypsy or Irish Traveller, Roma, any other White background)
- ◯ Other
- ◯ Prefer not to say

Prize draw entry

Do you wish to enter our prize draw to win one of two £25 Amazon vouchers?

- ◯ Yes
- ◯ No

Email entry

Please enter your email address so we can forward to you the next round of the study. Please remember that you can withdraw at any time.

Enter your answer

Narrative Exposure Therapy: Description

Narrative Exposure Therapy (NET) is a type of therapy used to treat symptoms of traumatic stress. Traumatic stress can occur when an individual has experienced one or more events that were extremely frightening.

During NET, the client repeatedly talks about each trauma in detail. As a result, they re-experience the emotions, cognitions, behavioural, physiological, and sensory elements associated with the event. They also narrate positive life experiences.

This process allows the client to recognise that their traumatic stress is a result of past experiences and that its activation is nothing but a memory. They thus lose the emotional response to the recollection of the trauma, consequentially leading to a reduction in traumatic stress symptoms.

NET typically comprises the following stages:

- Assessment and psychoeducation
- The lifeline
- Narration and re-narration

You will be provided with a brief description of each stage and asked to consider how each stage could be adapted for use with autistic adults. In your responses, please consider the core features of ASD as outlined in the DSM-5 (i.e., persistent difficulties with social communication and social interaction; restricted and repetitive patterns of behaviours, activities, or interests [including sensory behaviours]).

Please note: identify-first language (i.e., "autistic person") is used throughout the present study as opposed to person-first language (i.e., "person with autism") as per the guidance published by the National Autistic Society and consultation with experts by experience prior to the commencement of the study.

Assessment and Psychoeducation

Assessment and psychoeducation are typically covered over the course of one session.

Assessment
During the initial assessment, the therapist introduces themselves (i.e., name, profession). They complete measures with the client to learn more about their traumatic experiences. This may include:

- The Life Event Checklist (LEC-5) (a list of 16 events known to potentially result in distress; the client is asked to indicate if they have experienced any of the events listed). See more: https://www.ptsd.va.gov/professional/assessment/documents/LEC5_Standard_Self-report.PDF
- The Posttraumatic Stress Disorder checklist (PCL-5) (a 20-item self-report measure that assesses the 20 DSM-5 symptoms of PTSD). See more: https://www.ptsd.va.gov/professional/assessment/documents/PCL5_Standard_form_week.PDF
- Alongside this, the therapist assesses for any symptoms of dissociation.

Psychoeducation

The therapist and client discuss the client's symptoms and explore whether NET is appropriate. The therapist describes why the client may feel the way they do. Psychoeducation in NET should entail the following elements:

- Normalisation (i.e., it is normal and understandable to have such a response to a traumatic event).
- Legitimisation (i.e., the symptoms experienced today are the result of the client's response to the trauma).
- Description of trauma reactions; which may entail discussion of the following: 1) the fear network (i.e., a network containing sensory, cognitive, emotional, and physiological elements of a traumatic memory, where memories of multiple traumas can exist at the same time, and be triggered by the exposure to any of the cues held within them. Thus, the greater the number of traumatic experiences, the more opportunities for such memories to be triggered in the present day); 2) the brain model (i.e., within the fear network, hot memories [sensory information, cognitions, emotions, physiological feelings] are stored separately from cold memories [facts and context], meaning when a traumatic memory is triggered, the individual often does not have the information available [fact and context] to place the [hot] memory in its context [i.e., the past]).
- Explanation of the therapeutic procedure (i.e., a step-by-step explanation of NET); which may entail the following: 1) The explanation that it is common to experience fear and high levels of arousal during narration. The severity of this response is unknown until the memory has been retrieved, so the client may be surprised by their responses; 2) Advising that sessions will be taken to a point of completion i.e., whatever has been triggered in the session will be worked through until the client is comfortable again. However, information processing may continue between sessions, and there may be a transition phase where symptoms of traumatic stress worsen.

Would adaptations be helpful?

- ◯ Yes
- ◯ No
- ◯ Unsure

Please explain (i.e., if answering 'yes', what adaptations could be helpful?; if answering 'no', why?)

Enter your answer

The Lifeline

In the Lifeline exercise, the therapist lays a piece of ribbon or string on the floor. They explain that one end of the ribbon signifies when the client was born and the other end, which is rolled up, signifies the life yet to come. The therapist explains “we are taking a birds-eye view of your life”.

The client is then asked to list the important or significant events they have experienced throughout their life. The therapist supports them in placing the events in chronological order. At this stage, the client is encouraged to only ‘headline’ the events by providing a short sentences or a few words, as details of the events will come in later sessions where the therapist can ensure there is enough time for safe exploration.

Clients place a stone where traumatic events occurred, and a flower where positive events occurred.

It is advised that the lifeline exercise is completed in one session. Once the session is finished, the therapist asks the client how they should 'pack away' their lifeline for the day. It is advised that the lifeline is not left on the floor when the client leaves, as clients often report feeling protective over their lifeline, and do not want it to remain exposed in the room.

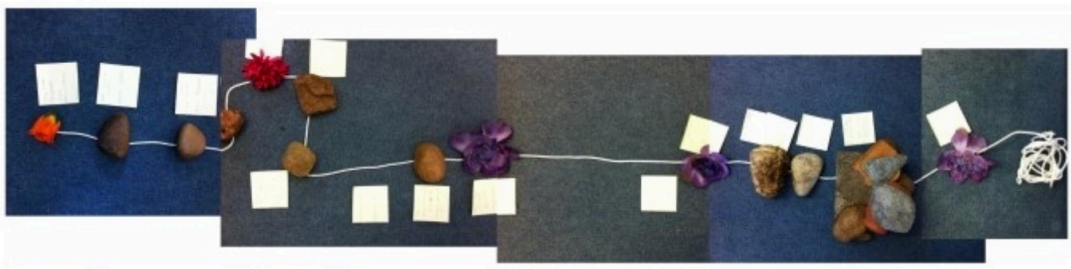


Figure: Example of a lifeline. Flowers represent positive events, stones represent traumas

Would adaptations be helpful?

- ◯ Yes
- ◯ No
- ◯ Unsure

Please explain (i.e., if answering 'yes', what adaptations could be helpful?; if answering 'no', why?)

Enter your answer

Narration

During the narration, the therapist and client explore each traumatic event to construct a consistent narrative of the client's experiences. The therapist supports the client to integrate the 'hot' and 'cold' memories of an event by supporting the mental reliving and emotional processing of each event.

To do so, the therapist gathers contextual information about the event before it is spoken about in detail; they may ask the following:

- Time and setting (i.e., when the event took place... the time of day, year)
- Location and activity (i.e., where the event took place... where was the client at the time, what were they doing).
- The beginning (i.e., establishing the point the event 'starts').

When approaching a traumatic memory, the narration slows down. The therapist supports the client in narrating their experience step-by-step and minute-by-minute. The therapist seeks the sensory information, emotions, cognitions, and physiological responses experienced during the event, and contrasts this to the client's experience in the present (i.e., "did you feel helpless then? How do you feel right now?"). As such, the therapist encourages the client to stay connected to the present, by placing 'one foot in the present, and one foot in the past'.

A session should never be stopped during the height of fear or anxiety. This is because evidence suggests that ending a session when the emotion is at a peak level of intensity can aggravate symptoms. The therapist should stay with the client in the trauma narration until arousal has reduced.

Would adaptations be helpful?

- ◯ Yes
- ◯ No
- ◯ Unsure

Please explain (i.e., if answering 'yes', what adaptations could be helpful?; if answering 'no', why?)

Enter your answer

Re-narration

Between sessions, the therapist writes down the client's narrative, and at the beginning of the subsequent session, reads it to the client. The client will be asked to fully imagine and relive the events with the purpose of correcting and adding detail to the narrative. This allows for further habituation.

The therapist and client then proceed with processing the events on the lifeline.

This procedure is repeated until a final narrative of the client's experiences is produced. In the final session, the completed narrative is read to the client and all final corrections are made.

Would adaptations be helpful?

- ◯ Yes
- ◯ No
- ◯ Unsure

Would adaptations be helpful?

- ◯ Yes
- ◯ No
- ◯ Unsure

Please explain (i.e., if answering 'yes', what adaptations could be helpful?; if answering 'no', why?)

Enter your answer

Duration and total number of sessions

NET is typically delivered in 6-14 sessions, each lasting for 90-120 minutes. The total number of sessions should be agreed upon at the start of therapy to reduce potential avoidance.

Would adaptations be helpful?

- ◯ Yes
- ◯ No
- ◯ Unsure

Please explain (i.e., if answering 'yes', what adaptations could be helpful?; if answering 'no', why?)

Enter your answer

Appendix P

Stage One: Round One Questionnaire – Experts by Experience

Demographics

What is your age?

- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65 +
- Prefer not to say

What was your sex at birth?

- Female
- Male
- Prefer not to say

What is your gender identity?

- ○ Female
- ○ Male
- ○ Non-binary/gender queer/agender/gender fluid
- ○ Other
- ○ Prefer not to say

What is your ethnicity?

- ○ Asian or Asian British (including Indian, Pakistani, Bangladeshi, Chinese, any other Asian background)
- ○ Black, Black British, Caribbean or African (including Caribbean, African, any other Black, Black British, or Caribbean background)
- ○ Mixed or multiple ethnic group (including White and Black Caribbean, White and Black African, White and Asian, any other Mixed or multiple ethnic background)
- ○ White (including English, Welsh, Scottish, Northern Irish or British, Irish, Gypsy or Irish Traveller, Roma, any other White background)
- ○ Other
- ○ Prefer not to say

For how long have you had a formal diagnosis of autism spectrum disorder?

Enter your answer

Prize draw entry

Do you wish to enter our prize draw to win one of two £25 Amazon vouchers?

- ◯ Yes
- ◯ No

Email entry

Please enter your email address so we can forward to you the next round of the study. Please remember that you can withdraw at any time.

Enter your answer

Narrative Exposure Therapy: Description

Narrative Exposure Therapy (NET) is a type of therapy used to treat symptoms of traumatic stress. Traumatic stress can occur when an individual has experienced one or more events that were extremely frightening.

During NET, the client (the person receiving the therapy) talks about each trauma in detail. They are asked to share the emotions they felt, what they thought, and what they noticed in their body and the environment at the time. They also talk about positive life experiences.

NET typically involves the following stages:

- Assessment and psychoeducation
- The lifeline
- Narration and re-narration.

You will be provided with a brief description of each stage and asked to consider how each stage could be adapted for use with autistic adults.

Please note: identify-first language (i.e., "autistic person") is used throughout the present study as opposed to person-first language (i.e., "person with autism") as per the guidance published by the National Autistic Society and consultation with experts by experience prior to the commencement of the study.

Assessment and Psychoeducation

Assessment and psychoeducation are typically covered in one session.

Assessment
In an assessment, the client tells the therapist about their symptoms. The client and therapist develop a shared understanding of the client's difficulties. This helps the therapist to determine if NET is an appropriate treatment. The client and therapist may complete questionnaires to support this.

Psychoeducation
'Psychoeducation' is where the therapist supports the client to make sense of their difficulties. The therapist describes why the client may feel the way they do, and how NET could help.

In NET, psychoeducation should involve the following:

- Helping the client to see that their symptoms are a normal and understandable response to trauma.
- Explaining how the brain responds to trauma, and how this results in the client's symptoms.
- A step-by-step explanation of the therapy (for instance, what will happen and when).
- It is also important that the therapist informs the client that it is common to become upset during NET. The severity of this is unknown until the traumatic memory has been accessed, so the client may be surprised by their responses. The client should be advised that whatever has been triggered in the session will be worked through until the client is comfortable again. Additionally, trauma processing may continue between sessions, and there may be a transition phase where symptoms 'get worse before they get better'.

Would adaptations be helpful?

- ◯ Yes
- ◯ No
- ◯ Unsure

Please explain (i.e., if answering 'yes', what adaptations could be helpful?; if answering 'no', why?)

Enter your answer

The Lifeline

In the Lifeline exercise, the therapist lays a piece of ribbon or string on the floor. They explain that one end of the ribbon signifies when the client was born and the other end, which is rolled up, signifies the life yet to come. The therapist explains “we are taking a birds-eye view of your life”.

The client is then asked to list the important or significant events they have experienced throughout their life. The therapist supports them in placing the events in chronological order. At this stage, the client is encouraged to only ‘headline’ the events by providing a short sentence or a few words, as details of the events will come in later sessions where the therapist can ensure there is enough time for safe exploration.

Clients place a stone where traumatic events occurred, and a flower where positive events occurred.

It is advised that the lifeline exercise is completed in one session. Once the session is finished, the therapist asks the client how they should 'pack away' their lifeline for the day. It is advised that the lifeline is not left on the floor when the client leaves, as clients often report feeling protective over their lifeline, and do not want it to remain exposed in the room.

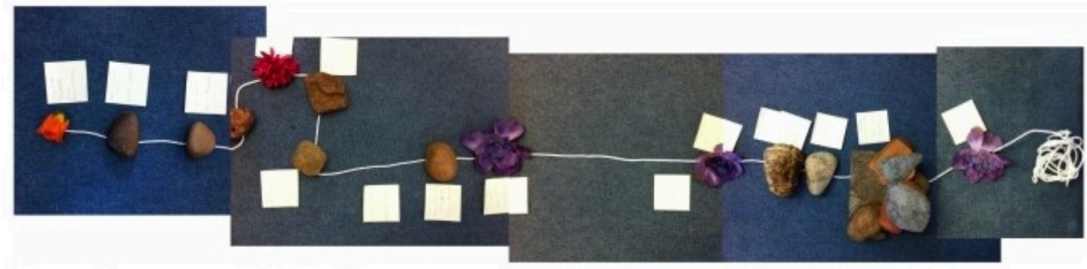


Figure: Example of a lifeline. Flowers represent positive events, stones represent traumas

Would adaptations be helpful?

- ◯ Yes
- ◯ No
- ◯ Unsure

Please explain (i.e., if answering 'yes', what adaptations could be helpful?; if answering 'no', why?)

Enter your answer

Narration

During the narration, the therapist and client explore each traumatic event to construct a consistent narrative of the client's experiences. To do so, the therapist may ask questions about the following:

- Time and setting (i.e., when the event took place... the time of day, year)
- Location and activity (i.e., where the event took place... where was the client at the time, what were they doing).
- The beginning (i.e., establishing the point the event 'starts').

When approaching a traumatic memory, the therapist asks the client to slow down in their narration: they are asked to narrate their experience step-by-step and minute-by-minute. The therapist asks the client questions about their experience, considering the emotions they felt, what they thought, and what they noticed in their body and the environment at the time. They also ask the client how they feel in the present, as they narrate.

A session should never be stopped when the client is experiencing significant fear or anxiety. This is because studies have shown this to worsen symptoms. Instead, the therapist should stay with the client in the trauma narration until the client feels better.

Would adaptations be helpful?

- ◯ Yes
- ◯ No
- ◯ Unsure

Please explain (i.e., if answering 'yes', what adaptations could be helpful?; if answering 'no', why?)

Enter your answer

Re-narration

Between sessions, the therapist writes down the client's narrative, and at the beginning of the next session, reads it to the client. The client is asked to fully imagine and relive the events to allow for further processing. They will be asked to correct any errors and add further detail if needed.

The therapist and client then proceed with the next event on the client's lifeline.

This procedure is repeated until a final narrative of the client's experiences is produced. In the final session, the completed narrative is read to the client and all final corrections are made.

Would adaptations be helpful?

- ◯ Yes
- ◯ No
- ◯ Unsure

Please explain (i.e., if answering 'yes', what adaptations could be helpful?; if answering 'no', why?)

Enter your answer

Duration and total number of sessions

NET is typically delivered in 6-14 sessions, each lasting for 90-120 minutes. The total number of sessions should be agreed upon at the start of therapy.

Would adaptations be helpful?

- ◯ Yes
- ◯ No
- ◯ Unsure

Please explain (i.e., if answering 'yes', what adaptations could be helpful?; if answering 'no', why?)

Enter your answer

Appendix Q

Focus Group Topic Guide – NET Experts

Introduction

Thank you so much for your time in reviewing the proposed adaptations, and for coming to the focus group today. I am confident you are all very well-versed in focus groups, but just to say that the session will be recorded, and I invite you all to feel free to share your opinions even if it differs from that of others.

You completed a questionnaire where you were asked to rate each adaptation in terms of its consistency with the principles of NET. You rated X adaptations in total– of this number,

- X were rated by all as consistent with the principles of NET, and feasible,
- X were rated by some as not entirely consistent, but feasible
- X were rated by some as inconsistent and infeasible

The focus of our discussion will be around the X that were rated as infeasible, and we will have some discussion around the themes of the adaptations rated as not entirely consistent, but feasible

Discussion of Infeasible Adaptations

Aim: to understand why they might be infeasible, whether they could be revised, and if they should be excluded (i.e., 'What do you think of this adaptation? Could it be revised to align with NET? Should it be excluded?

Discussion of Inconsistent, but Feasible Adaptations

Aim: to understand why these adaptations might not be consistent with NET, and whether they could be modified to be more consistent (i.e., 'Why might these adaptations not be consistent? Could they be modified?)

Meta-level Discussion

Aim: to understand whether the adaptations as a whole preserve the core principles of NET.

Prompts

- Could you explain further?
- Could you give an example?
- What do others think?

Conclude

There are some things we haven't been able to discuss. If something comes up that you feel we should or could have discussed, please put this in an email, as we will take note of all data we receive.

Thank you for your time.

Appendix R

Ethical Approval



Mental Health and Clinical Neurosciences Research Ethics Sub-Committee

09/05/2024

Supervisor: Thomas Schroder

Applicant : Sophie Dinsdale

Project: 3145Narrative Exposure Therapy (NET) for Autistic Adults Experiencing Traumatic Stress

The committee is pleased to confirm that the above study now has approval on the basis of your application and any subsequent clarifications. You must conduct your research as described in your application, adhere to all conditions under which the ethical approval is granted, and use only materials and documentation specified in your application.

If you need to make any changes (for example to extend your data collection timeframe, change the mode of data collection, or the measures being used), you must create and submit an Amendment Form. To do this, select the 'Create Sub Form' option from the Actions Menu on the left-hand side of the page in the online system and then select 'Amendment Form'.

With best wishes

Dr Katy Jones and Dr Jen Yates

Chairs of the Mental Health and Clinical Neurosciences Research Ethics Sub-Committee

Appendix S

Qualitative Content Analysis Coding Schedule – Proposed Adaptations

Table S1

Coding Schedule – Adaptations Proposed in Stage One Round One

Element of NET	Code	Description	Example Quote	Potential Adaptation
Assessment & Psychoeducation				
Lifeline				
Narration				

Re-narration	
Duration/Total Number of Sessions	

Appendix T

Qualitative Content Analysis Coding Schedule – Adaptations Requiring Clarification

Table T1

Coding Schedule – Adaptations Requiring Clarification in Stage One Round Three

Potential Adaptation	Code	Description	Example Quote	Clarification
X				
Y				
Z				

Appendix U

Qualitative Content Analysis Coding Schedule – NET Expert Focus Group

Table U1

Coding Schedule – Stage Two NET Expert Focus Group

Potential Adaptation	Code	Description	Example Quote	Consistency/Feasibility
X				
Y				
Z				

Appendix V

Duplicated Proposed Adaptations Between Groups

Table V1
Duplicated proposed adaptations between groups

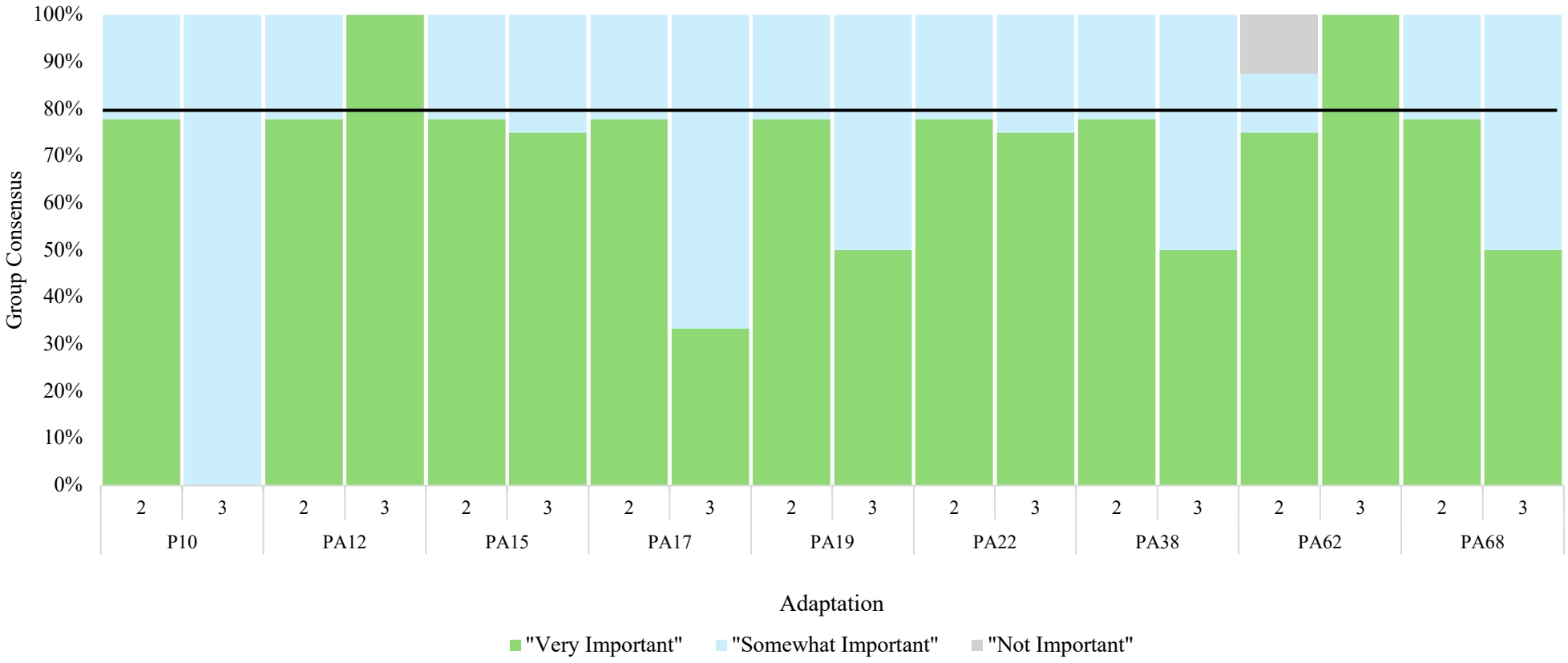
EBP Proposed Adaptation	EBE Proposed Adaptation	Adaptation References
"The therapist should support the client with emotion identification and labelling"	"The therapist should support the client in explaining their emotions"	P1/E2
"The client should be able to choose their own symbols/representations of traumatic events and positive events as opposed to the default use of stones and flowers"	"The client should be able to choose their own symbols to represent positive events and traumatic events"	P27/E14
"Clients should be made aware of/be prepared for the lifeline exercise prior to its completion"	"Clients should be told about this exercise in advance so that they can think about what events they might want to include"	P36/E20
"The client should be provided with a copy of the narrative to read and correct outside of sessions"	"The client should be provided the written narrative to read before the session"	P63/E36
"If a client becomes distressed, the session should be lengthened until they feel safe to leave"	"If the client becomes overwhelmed, the session should not end until they feel better"	P69/E26

Appendix W

EBP Near-Consensus Adaptations, Re-rated in Round Three

Figure W1

EBP Near-Consensus Adaptations, Re-rated by EBP in Round Three



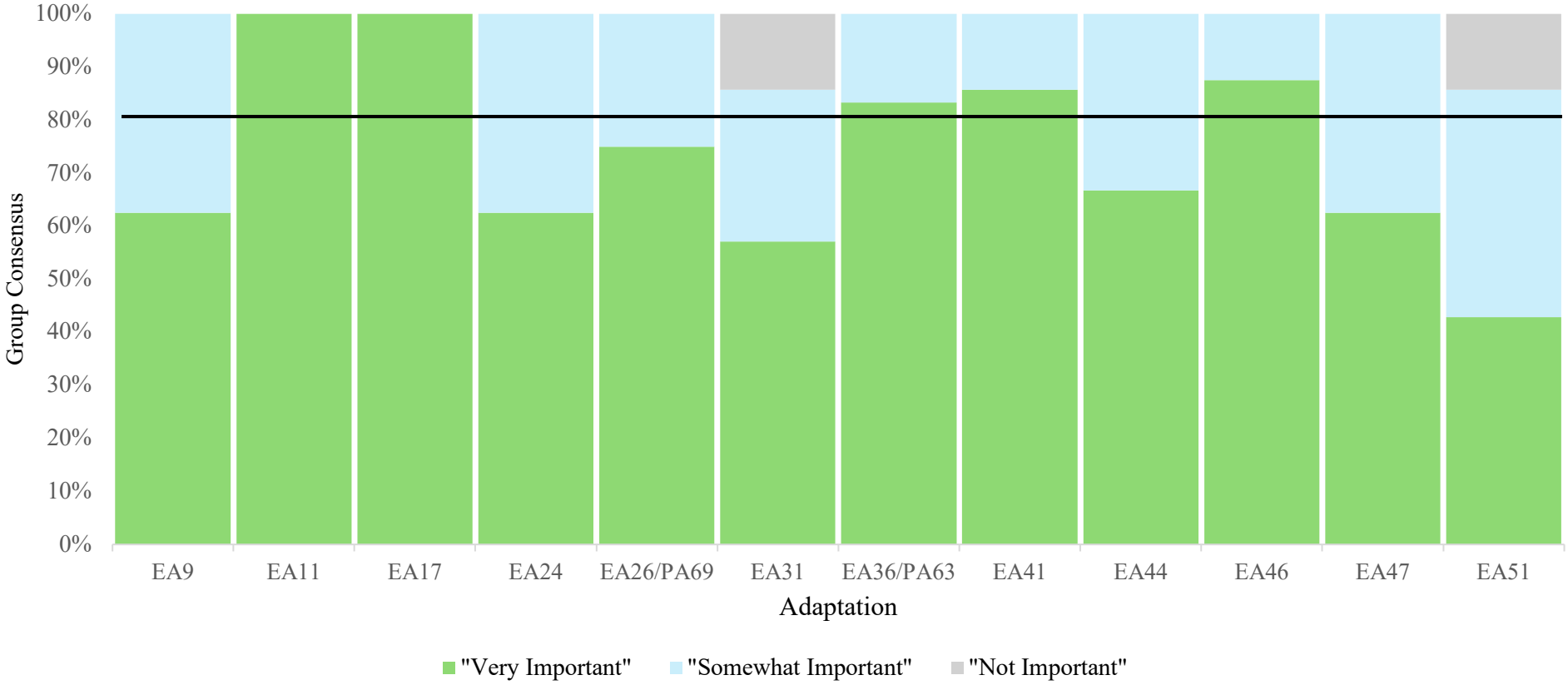
Note. '2' indicates ratings in round two, '3' indicates ratings in round three. The solid black line represents the consensus threshold (≥ 80%).

Appendix X

EBE Near-Consensus Adaptations, Re-rated in Round Three

Figure X1

EBE Near-Consensus Adaptations, Re-rated by EBE in Round Three



Note. '2' indicates ratings in round two, '3' indicates ratings in round three. The solid black line represents the consensus threshold (≥ 80%).

Appendix Y

Sensitivity Analysis

Table Y1

Participants Opposing Adaptations

	Number of Participants	
Element of NET	EBP	EBE
Round One		
Assessment and Psychoeducation	0	1
The Lifeline	2	4
Narration	0	1
Re-narration	3	2
Duration/total number of sessions	0	2
Number of these participants continuing into Round Two		
Assessment and Psychoeducation	N/A*	0
The Lifeline	0	2
Narration	N/A*	0

Re-narration	1	1
Duration/total number of sessions	N/A*	1
Number of these participants continuing into Round Three		
Assessment and Psychoeducation	N/A*	0
The Lifeline	0	2
Narration	N/A*	0
Re-narration	1	1
Duration/total number of sessions	N/A*	1

Note. * 'No' was not indicated for any participants

Table Y2

Sensitivity Analysis

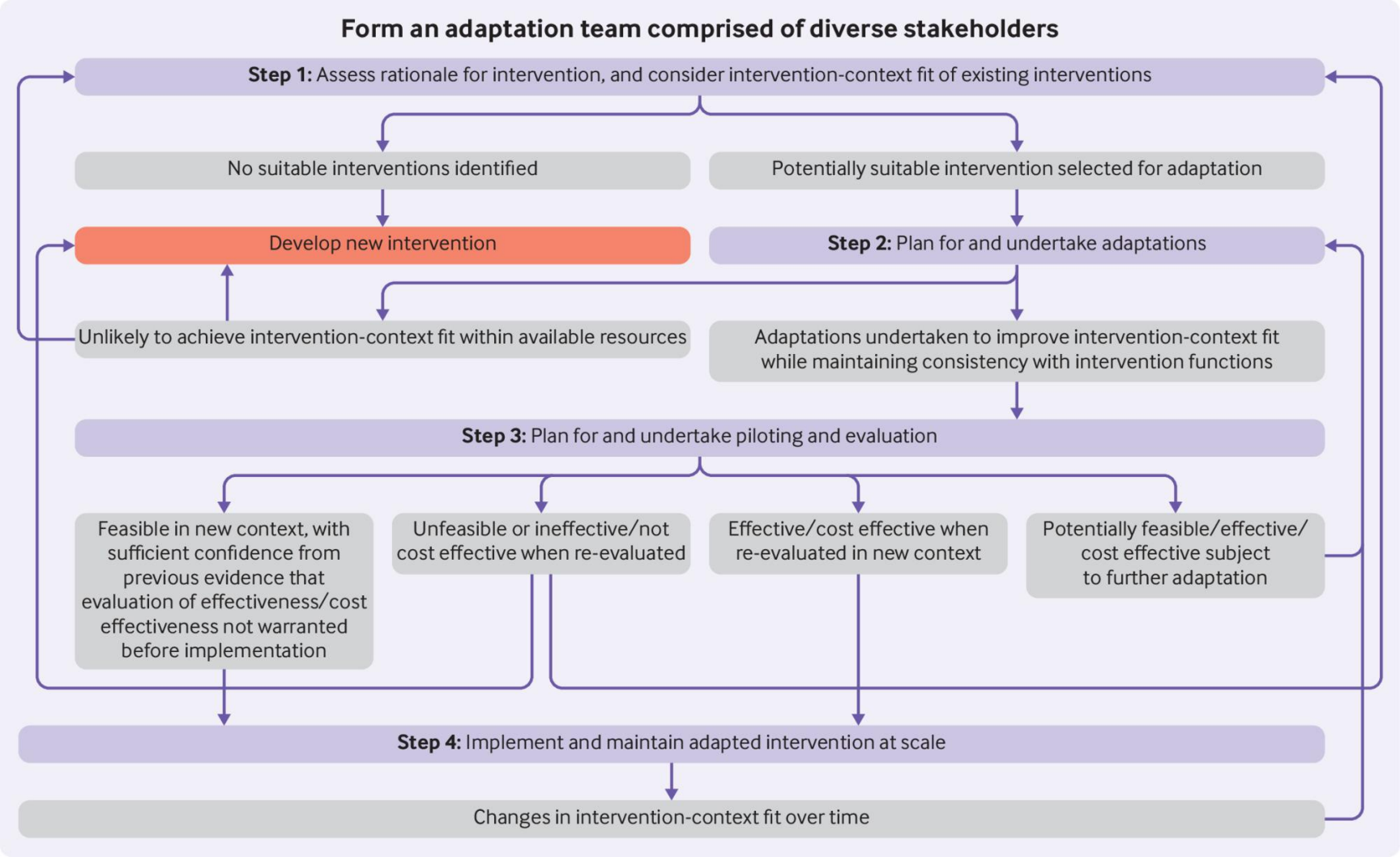
	Number of Adaptations Reaching Consensus (≥ 80%) if Participants Indicating 'No' in Round One are Classed as:			
	EBP		EBE	
	'Missing Data'	'Not Important'	'Missing Data'	Not Important
Round Two				
Assessment and Psychoeducation	N/A*		N/A**	
The Lifeline	N/A**		7	0
Narration	N/A*		N/A**	
Re-narration	6	3	3	1
Duration/Total Number of Sessions	N/A*		2	1
Round Three (re-rating own groups adaptations, and those proposed by the other group)				
Assessment and Psychoeducation	N/A*		N/A**	
The Lifeline	N/A**		3	2
Narration	N/A*		N/A**	
Re-narration	3	0	8	1
Duration/Total Number of Sessions	N/A*		5	4

Note. * 'No' was not indicated for any participants

** The participant indicating 'no' did not complete this round

Appendix Z

ADAPT Guidance Framework (Moore et al., 2021)



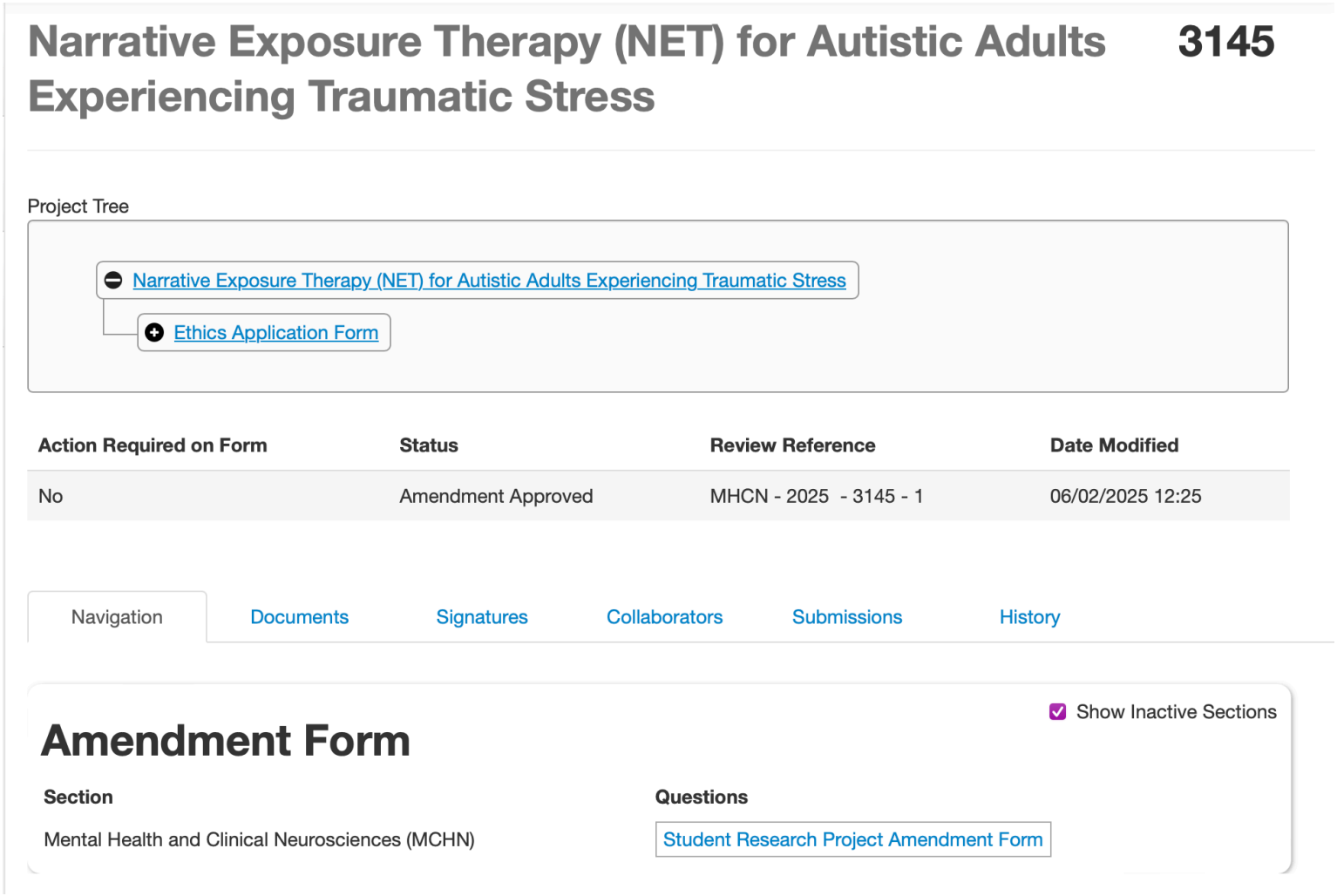
Appendix AA

ADAPT Reporting Guidelines for Adapted Interventions (Moore et al., 2021)

- Describe the population health problem being dealt with
- Describe the original intervention and its context and report its evidence base
- Describe the new context, and similarities and differences to the original context
- Describe the rationale, type, and processes undertaken to adapt the intervention, including which stakeholders were involved
- Describe the adapted intervention in detail to enable replication
- Describe how well the adapted intervention was delivered in the new context
- Describe the rationale for the type of re-evaluation
- Describe the role of original intervention developers in the adaptation

Appendix BB

Ethical Approval – Amendment



Narrative Exposure Therapy (NET) for Autistic Adults Experiencing Traumatic Stress 3145

Project Tree

- Narrative Exposure Therapy (NET) for Autistic Adults Experiencing Traumatic Stress
  - Ethics Application Form

Action Required on Form	Status	Review Reference	Date Modified
No	Amendment Approved	MHCN - 2025 - 3145 - 1	06/02/2025 12:25

Navigation | Documents | Signatures | Collaborators | Submissions | History

Show Inactive Sections

Amendment Form

Section	Questions
Mental Health and Clinical Neurosciences (MCHN)	Student Research Project Amendment Form

Appendix CC

Data Management Plan

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Data Management Plan Template

1. Data description

Qualitative and quantitative data will be collected using multiple rounds of Microsoft-based online questionnaires to survey up to 30 participants. All data will be downloaded onto an Excel spreadsheet (saved as an .xls file, with all identifiable data removed). This will be saved at UoN OneDrive. Excel files will be exported into SPSS for analysis. The volume of the data will be determined by the number of participants.

Qualitative and quantitative data will also be collected via an online focus group hosted on Microsoft Teams. The session will be recorded (generating an MP4 file) and transcribed using the Microsoft Teams automated transcription service (generating .txt file). The focus group will last for up to two hours and will be attended by up to six individuals (including myself); it is estimates that the audio file and transcribed file will equate to < 1 GB. The anonymised transcribed responses will be transferred to an SPSS spreadsheet and/or Excel file where it will be analysed.

2. Data collection and/or generation

Data will be collected using an online survey hosted by Microsoft, an established program for data collection and a University of Nottingham supported survey software. Participants will be assigned an identifying number which will be saved in a UoN OneDrive file. Participants will be asked to provide their email address so that subsequent questionnaires can be sent. This will be securely stored on a UoN OneDrive with their identifying number. Data from the focus group will be collected over Microsoft Teams, an established software tool supported for use by the University of Nottingham. The focus group will be recorded via Microsoft Teams. This will create an MP4 video file which will be saved to a UoN OneDrive folder. The recording will be deleted on the device it was made. I will be using the Automated Transcription Service, a tool approved and supported by the University of Nottingham to do the initial transcription of the recordings. I will check through each transcription personally to ensure accurate transcription, data quality and anonymity. I will adhere to the UK Data Service guidance on anonymising qualitative data. To use the Automated Transcription Service the MP4 files will be converted to MP3. The Automated Transcription Service automatically deletes MP3 files when the transcription is completed and generates a text file of the transcript which will be saved in another University of Nottingham OneDrive folder. Data will be imported into Excel and SPSS. All identifiable information will be removed.

3. Ethics & Privacy

Personal data will be collected during this project, and the project has considered ethical and legal implications in its data storage, as well as appropriate security of personal data. All participants will agree to data collection and data handling. Research will follow standard ethical procedures of the Faculty of Psychiatry and Applied Psychology and the University of Nottingham. Specific aspects

will be considered by the Faculty Ethics Committee as appropriate. In particular, the creation of data from surveys and focus groups will require ethical approval, including consent forms outlining the storage and use for research purposes of data, including access to those data by project researchers and other researchers, both during and after the life of the project. Participants will be informed that they can withdraw their participation at any stage during or after the observations. As we will be working with personal data we will ensure that we comply with the Data Protection Act 2018, including GDPR requirements. This will include providing research participants with the relevant privacy information and ensuring appropriate safeguards for the storage and handling of data are in place. Email addresses will be collected from participants who want to be entered into a prize draw which is optional. This information will not be used for data analysis or published in further studies. These identifiable details will be removed from the study data and transferred to another folder and protected securely.

4. Data storage and security

Data will initially be stored on the Online Survey platform whilst there are responses being collected. A participant number/ ID will automatically be generated to protect individuals from being identified and ensure the data is anonymised. Once all data is collected it will be transferred to an Excel spreadsheet and kept anonymised for further analysis with the same unique study identification number. Participants' e-mail addresses used to enter the prize draw will be kept in a different study folder and destroyed once contact has been made with the winners. Winners will have 30 days from the date they were notified of winning to claim the prize. All research data including consent and personal data will be password-protected and stored securely in a locked archive.

The data collected from the recording of the focus group will be saved to a UoN One Drive. The data will be anonymised and exported to an Excel and SPSS file. We will use the UoN- provided storage for our working data. UoN licenses Microsoft OneDrive ISO 27001 information security management compliant services that allows secure and controlled sharing of data amongst the research team. University of Nottingham OneDrive encrypts both data in transit and at rest and is approved against the University's Handling Restricted Data Policy. We will store data for a period of no less than 7 years after the research project finishes. The researcher who gathered or processed the data may also store the data indefinitely and reuse it in future research.

The chief investigator will be responsible for the storage and management of the data collected during this study. The overall responsibility for data security is held by the University of Nottingham Chief information security officer. Whilst the data is being analysed it will be accessible to any member of the study team, the use of UoN One Drive will facilitate this and allow for team members based at different locations to still have access to the data set.

We will ensure that our research aligns with the requirements of the University's Research Data Management Policy, Information Security Policy, Code of Research Conduct and Research Ethics. As we are working with personal data, we will abide by the University's Handling Restricted Data Policy and Data Protection Policy. All third party commercial data or new data that may be suitable for commercial exploitation will be protected by the University's Intellectual Property policy.

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5. Data management, documentation, and curation

All data will be managed according to the University of Nottingham's data management policy (accessible to University staff through the library website) - https://www.nottingham.ac.uk/library/research/research-data-management/index.aspx ; https://uniofnottm.sharepoint.com/sites/DigitalResearch/SitePages/Research-Data-Management-Policy.aspx3.1. It is the policy of the University of Nottingham that all research data be managed in a manner that supports its authenticity, reliability, security, discoverability and, where appropriate, accessibility for re-use.

6. Data preservation

I will adhere to General Data Protection Regulation, 2018 and ensure the protection of the research and protect participants rights and privacy. Anonymised research data created by the project will be deposited in the University of Nottingham research data archive, https://rdmc.nottingham.ac.uk. Audio files will not be deposited as they could include identifiable data. A DataCite DOI is issued for each publishes dataset facilitating the ability to cite the data in associated research outputs. The University of Nottingham data archive is underpinned by commercial digital storage which is audited on a twice-yearly basis for compliance with the ISO 27001 standard. University of Nottingham will retain and preserve research data in line with University of Nottingham requirement for a minimum of 7 years, but data will be retained for longer periods of time where it is of continual value to users.

7. Data sharing, publication and access

All data will be anonymised, ensuring it would not be possible to identify an individual from their responses. All data processing and sharing will adhere to the University of Nottingham Data Protection Policy. The dataset will not contain any personally identifiable or commercially sensitive information and thus will be shared via the University of Nottingham data archive under a CC-BY license. There will be no need to update the data past the project period. All published outputs will contain a Data Availability Statement including the data cite DOI which directs to the relevant data set. Data will be released at the same time as any published outputs which are underpinned by the data or by 1 year from the end of the project at the latest.

Copyright & IPR for all project research data is owned by University of Nottingham.

Adapting Narrative Exposure Therapy (NET) for Autistic Adults

University of Nottingham
UK | CHINA | MALAYS

Sophie Dinsdale, Thomas Schröder, Mark Hudson

Background

Autistic adults are at an increased risk of experiencing traumatic events (Rumball, 2019; Peterson et al., 2019). NET is a trauma-focused therapy recommended for the treatment of traumatic stress in adults (National Institute for Health and Care Excellence, 2018; Schauer et al., 2011). However, its use with autistic adults has only briefly been described (Fazel et al., 2020) and it is unknown if and how this therapy could be adapted for use with this population.

Research Questions

Stage One

1. What are the views of experts by profession on how NET should be adapted for autistic adults experiencing traumatic stress?
2. What are the views of experts by experience on how NET should be adapted for autistic adults experiencing traumatic stress?
3. What are the expert groups' views on each other's views?

Stage Two

4. Are the proposed adaptations consistent with the principles and theory of NET?

Method

The study comprised a Delphi study (Stage One) and a focus group (Stage Two).

Stage One

A sample of fifteen experts by profession (EBP) and fifteen experts by experience (EBE) completed three rounds of an online questionnaire.

Round One

Participants were presented an overview of NET and asked to indicate if adaptations would be helpful and offer suggestions of what may be important.

Round Two

Participants rated the adaptations suggested by their expert group in terms of their importance. Those that were rated as 'very important' by ≥80% of the group were accepted at this stage.

Round Three

Participants rated the adaptations suggested by their expert group that were close to the consensus threshold in the previous round (i.e., 70-79%). They also rated the adaptations meeting 70-100% consensus by the other expert group. Participants also provided clarification on a given number of adaptations deemed to be subjective and ambiguous.

Stage Two

A sample of three NET Experts completed an online survey to review the adapted protocol and determine whether it was consistent with the principles of NET and feasible in practice. They then attended a focus group to discuss the adapted protocol in further detail.

Results

Stage One

Following Round One, participant responses were analysed using manifest content analysis. The EBP group identified an initial 76 adaptations and the EBE group identified 54 adaptations. Following three rounds, consensus was reached by both groups on 28 adaptations for inclusion in the adapted protocol, and a further 27 by one group, which should be considered for some autistic clients.

Stage Two

Following the NET expert review, one adaptation was excluded for being inconsistent with the principles of NET and thus infeasible in practice. Six were amended to increase consistency and feasibility. A total of 54 adaptations were included in the final protocol.

Conclusions

The study identified a total of 54 adaptations that may be helpful when using NET with autistic adults. The adaptations include changes to the process of NET and in the therapeutic technique. The adaptations are subject to further refinement and should be piloted with a sample of autistic adults experiencing traumatic stress to explore their feasibility.

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