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Muss Rewind Therapy to alleviate symptoms related to some form of traumatic experience: A thematic analysis of participants' experiences and their perceived effectiveness of MRT

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Abstract

Sometimes referred to as a memory reconsolidation treatment, Muss Rewind Therapy (MRT) is a brief psychological intervention which has shown promise in treating symptoms related to some forms of traumatic experience. This study aimed at adding to minimal existing research by exploring the experiences of UK participants who have chosen to self-refer for MRT for help with symptoms they attributed to some form of previous traumatic experience. Ten participants were interviewed online, and qualitative data were collected using video recordings and transcription. A semistructured framework was employed to explore participants' individual experiences of MRT. All participants rated MRT as helping alleviate the symptoms they related to a previous traumatic experience. Several key themes emerged regarding the participants' experiences of the treatment, including the overall role of the therapist; participants being at the end of their tether before seeking help; experiencing negative emotions during the intervention; repetition of the MRT process in the therapy room; and experiencing some positive outcomes. However, it was unclear whether positive impacts reported after MRT were due specifically to MRT or nonspecific therapy factors because of variations in the way the MRT protocol was delivered and inclusion of other techniques in or before the MRT sessions. Whilst more rigorous research is needed, including research which follows a strict protocol when MRT is provided, to compare MRT versus control group, this novel addition to the existing research, which looks at clients' perspectives on their experiences and their perceived effectiveness of MRT, can add to and inform further research development.

KEYWORDS
flashbacks, Muss Rewind Therapy, PTSD, reconsolidation, trauma

1 | INTRODUCTION

Psychological trauma is a significant public health issue affecting thousands of people every year (Kleber, 2019). Trauma is defined by the American Psychological Association as "any disturbing experience resulting in fear, helplessness, dissociation, confusion, or other disruptive feelings which have a lasting negative effect on a person's attitudes, behaviour and functioning" (American Psychological Association, 2023). Studies show that experiencing or witnessing a traumatic event is common, with more than 70% of approximately 70,000 adults reporting exposure to some form of traumatic event by midlife adulthood (Kessler et al., 2017).

Psychological distress following exposure to a traumatic event is frequently experienced, and trauma exposure is associated with higher rates of psychiatric diagnosis and a range of problems, including depression, conduct disorder, self-harm, substance use, suicide attempt and interpersonal difficulties (Lewis et al., 2019). Furthermore, following exposure to a traumatic event, a smaller proportion of people go on to develop post-traumatic stress disorder (PTSD) (Atwoli et al., 2015). PTSD is characterised by a specific set of symptoms occurring after traumatic exposure, with temporal variation in the onset of symptoms (Wynn et al., 2017).

Differences exist between the conceptualisation of PTSD within the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the World Health Organization's (WHO) International Statistical Classification of Diseases and Related Health Problems (ICD 11th ed, 2018); however, Cloitre (2020, p. 129) highlights the similarities, including three core elements or clusters:

(i) The re-experiencing in the present of the traumatic event.
(ii) Avoidance of traumatic reminders.
(iii) A sense of current threat.

Whilst a differentiation between traumatic stress and PTSD has been contested over the years (Weathers & Keane, 2007), within this paper we use the term PTSD as shorthand to describe psychological reactions to trauma and the psychiatric conceptualisation of post-traumatic stress in relation to diagnostic criteria. Across this broad definition, the three core elements highlighted by Cloitre (2020) serve as a clinically relevant heuristic to inform psychological therapy for trauma presentations.

Within the United Kingdom (UK), a large general population survey, known as the Adult Psychiatric Morbidity Survey of Mental Health and Wellbeing, highlighted that around a third of adults had experienced at least one major trauma, with 4.4% of people meeting screening criteria for PTSD, yet just one in eight of whom had been diagnosed with PTSD by a mental health professional (Fear et al., 2014). This suggests there is likely a large proportion of people with PTSD who are not accessing mental health services. Moreover, in the UK, people often self-refer to counselling and psychotherapy practitioners or services following exposure to traumatic events without undergoing a psychiatric diagnostic interview. The implication for counselling and psychotherapy practitioners is that they are likely to encounter people with significant psychological trauma symptoms who are seeking help, and the key elements of PTSD or psychological stress highlighted by Cloitre (2020) can serve to guide practice.

A range of evidence-based psychological therapy approaches are suggested in response to trauma presentations (Forbes et al., 2020; National Institute for Health and Social Care Excellence, 2018). According to Forbes et al. (2020), the four approaches with the highest levels of supporting research are as follows:

(i) Cognitive processing therapy (e.g., Resick et al., 2017)
(ii) Cognitive therapy for PTSD (e.g., Ehlers et al., 2005)

Implications for practice and policy

- The paper discusses clients' experiences and perceived effectiveness of Muss Rewind Therapy (MRT) for help with symptoms following some form of self-defined traumatic experience. Whilst not an evidence based therapy, MRT is offered by some counsellors and psychotherapists in the UK as confirmed by those listed on the International Association for Rewind Trauma Therapy (IARTT) website (iartt.com) All participants reported some favourable outcomes after MRT, including less emotional arousal that they associated with the impact of the traumatic experience.
- MRT as an intervention does not usually require clients to talk about their past or their traumatic experience. However, in this study, clients reported that talking about their past was often a precursor to MRT. This suggests that it would be helpful, if not essential, for MRT practitioners to have other skills and techniques, for example those held by counsellors and psychotherapists, to enable them to listen to and help clients when they reveal they have symptoms related to a self-defined traumatic experience.
- Conversely, MRT could be offered by counsellors and psychotherapists when working with clients seeking help to cope with the present-day impact of the traumatic experience but not wanting to talk about the traumatic experience in any detail.
- Our findings add to the limited existing research on MRT in the UK and can be utilised to explain MRT's beneficial impact on some clients. However, further research is required, including a need for studies with clear fidelity to the intervention's protocol to understand precisely what is helping the client. Further research is also needed to understand the mechanisms of MRT and its potential link to reconsolidation theory, which is beyond this project's scope.

(iii) Eye movement desensitisation and reprocessing (EMDR; e.g., Shapiro, 2018)
(iv) Prolonged exposure (e.g., Foa et al., 2007)

Across trauma therapy approaches, an improvement in threat-focussed attention and self-critical post-traumatic cognitions has been suggested as a key mechanism of change (Kangaslampi & Peltonen, 2022). Therapy approaches employ variable strategies to advance this goal, including variation in the extent to which memory of traumatic events is explicitly focussed upon. Forbes et al. (2020) categorised evidence-based psychological therapies for PTSD into two main areas: interventions focussing on the memory of the traumatic event and interventions aiming to reduce traumatic stress symptoms without focussing on the memory or thoughts about the trauma.

Forbes et al. (2020) proposed that evidenced-based approaches can be reassuring to practitioners and patients given their demonstrated efficacy in controlled trials. However, there are many barriers reducing access and availability of these approaches. Barriers include a limited number of therapists qualified to deliver such interventions, cost, need to attend weekly sessions over a significant period of time and variation in the availability of treatment approaches (Simon et al., 2021).

Moreover, the reliance on randomised controlled trials (RCT) underpinning narrow contemporary notions of evidence-based practice (Morse, 2006) can result in therapeutic approaches, which demonstrate effectiveness in clinical practice, not being considered for recommendation in treatment guidelines due to a need for more data. Indeed, treatment recommendations for PTSD do not include alternative or complementary therapies precisely because systematic reviews underpinning treatment guidelines exclude studies perceived as not meeting methodological inclusion criteria. Studies that are described as reporting complementary or alternative treatments are often also purposefully excluded, as was the case with the recent APA guidelines (American Psychological Association, 2017).

One such novel therapeutic approach that falls outside current treatment guidelines is Muss Rewind Therapy (MRT). MRT has been described by Adams and Allan (2018, p. 464) as an imaginal exposure treatment, which presents a "promising treatment technique for the trauma that may also be able to be used in conjunction with other treatments." MRT is different from other imaginal exposure treatments such as writing scripts, imagery rescripting, listening to recordings, watching videos or other visualisation techniques, as there is no requirement for the client to share details of the traumatic experience with the therapist.

Despite limited studies into MRT's effectiveness (Adams & Allan, 2018; Muss, 1991, 2002; Utuza & Muss, 2012), MRT is offered by counsellors and psychotherapists in the UK (IARTT, 2022a).

Astill Wright, Horstmann, et al. (2021) state that the development or delivery of the MRT therapeutic model has been informed by reconsolidation theory and describe MRT as a "nonpharmacological reconsolidation-based therapy." Nader and Hardt (2009, p. 224) state that consolidation and reconsolidation are "transient neurobiological processes" that are involved in the stabilising and permanency of memories. Furthermore, retrieval or recall of previously consolidated memory enables the memory to "re-enter states of transient instability," enabling a new version of the memory to be stabilised (p. 224). This process of reconsolidation "dampens the impact of the memory so that it is less arousing, less troubling when you remember it later" (LeDoux, 2017). This process has also been described as the "brain's innate mechanism by which new learning experiences directly revise existing content of memory acquired by prior learning" (Ecker & Bridges, 2020, p. 287).

The elaboration and incorporation of trauma memories into one's longer-term memory store are identified as key aspects of psychological therapy for trauma (Brewin & Holmes, 2003; Ehlers & Clark, 2000). Despite differences in theoretical conceptualisations of memory and mechanisms by which this might most efficaciously be achieved, the importance of memory reconsolidation is apparent. Indeed, research suggests reconsolidation may be able to remove entirely symptoms related to traumatic memories, as opposed to inhibiting reactions to the memory or hindering its retrieval (de Quervain et al., 2016; Pitman, 2015; Tylee et al., 2017). Reconsolidation may be the mechanism by which MRT helps clients with their symptoms. However, research into MRT's proposed links to reconsolidation or establishing the exact way MRT works are beyond the scope of this project. This qualitative research instead explores the experiences and perceived effectiveness of MRT from the perspective of UK clients.

A therapy protocol modified from MRT training (IARTT, 2022a) was proposed for an RCT for MRT (Astill Wright, Barawi, et al., 2021; Astill Wright, Horstmann, et al., 2021). The protocol is reproduced below to help the reader understand how MRT is delivered and to contextualise the comments of the participants taking part in this study:

"The participant is introduced to the technique and the theory behind it before being asked to imagine he/she is in a cinema watching a film of her/his traumatic event as if it had been captured on CCTV. Rather than the film commencing at the moment of trauma, the participant is informed that the film starts just before the traumatic event took place and is then followed by the regular intrusive recall, which includes all the images, sounds and smells plus (if this is part of the regular recall) what could have happened next but did not. Once the recall ends, the participant is (metaphorically) invited to enter the screen, and at that point, the film is rewound at speed back to the exact starting point (where all was well before the trauma). The forward part of the process of recalling the trauma lasts no longer than 2 minutes, and the rewind part about 10 seconds" (Astill Wright, Horstmann, et al., 2021; Astill Wright, Barawi, et al., 2021, p. 5).

The introduction includes an explanation that the therapist will help the client imagine they are sat comfortably and feeling safe whilst sitting alone in a cinema before the film begins. At the end of the rewind of the film, the therapist will check that the client is coping with any emotional arousal that may have occurred. There is a specific emphasis in the introductory explanation that the client does not have to reveal any details of the experience itself. For the practitioners and therapists to feel confident that the technique has

been undertaken correctly, participants are encouraged to practise it multiple times (Astill Wright, Barawi, et al., 2021; Astill Wright, Horstmann, et al., 2021).

This research specifically investigated the experiences of participants in the UK who, as was necessary with other therapeutic interventions during COVID-19, received their sessions online.

Whilst MRT is offered to clients who describe symptoms similar to those mentioned earlier for PTSD that they can relate back to a self-proclaimed traumatic experience, there is no requirement in the UK for a PTSD diagnosis for MRT to be offered. In addition to there being no requirement to talk about the traumatic experience, the main difference to other imagination therapies is that after re-imagining the experience in chronological order (as a film that starts just before the traumatic experience [a safe place]), the film is then imagined going backwards at speed to end at the safe place again.

Whilst it is beyond the scope of this research to fully explain the mechanisms of MRT and any link to reconsolidation, comparisons can be made with Ecker and Bridges' (2020) suggestion that reconsolidation is an experience-driven process, and three experiences are needed for it to occur. First, there needs to be reactivation of the target emotional learning, and the emotions must be fully felt. In MRT, the target emotional learning experience is reactivated by imagining watching it in as much detail as possible on the screen. Second, whilst the target emotional learning has been reactivated, there needs to be a disconfirmation or a juxtaposition experience. During MRT, the film rewinds and ends in the "safe" place just before the event occurred. Finally, Ecker and Bridges (2020) argue that confirmation and disconfirmation need to happen several times in the session, and the MRT process is usually repeated several times.

However, Ecker and Bridges (2020) state that the target emotional learning must first be elicited through conversation and the use of salient cues, identifying the event that causes emotional arousal. Whilst MRT clients are aware of specific symptoms they want to work on and self-identify the traumatic experience they link back to, the details do not have to be revealed or discussed with the therapist.

The very limited existing MRT research has focussed primarily on the approach's effectiveness. In contrast, this study aimed at exploring participants' experiences and perceived effectiveness of MRT for help with symptoms attributed to experiencing a traumatic event or events. This exploration of clients' perspectives of their experiences and perceived effectiveness represents a novel addition to existing research in relation to MRT.

2 | MATERIALS AND METHODS

2.1 | Design

This study used a qualitative approach, underpinned by a constructionist epistemology and a double hermeneutic process that led to descriptions and an understanding of the participants' experiences and perceived effectiveness of MRT, which was context-specific and inclusive of the participants' and researcher's own interpretations. Smith and Osborn (2003, p. 53) referred to this dual process as a double hermeneutic, whereby "the participants are trying to make sense of their world" whilst, at the same time, "the researcher is trying to make sense of the participants trying to make sense of their world."

As a nonrandomised naturalistic study, the researchers had no control over how MRT was delivered or whether it was offered alongside other techniques. However, it was made clear in the information sent to participants that the interview was specifically about MRT they had received from a therapist.

The research aim was to identify and explore common themes of the UK participants' experiences and perceived effectiveness of MRT. The participants were individuals who have self-referred (a common pathway to therapy in the UK) for MRT to help with the impact of a self-defined traumatic experience or experiences.

2.2 | Recruitment and participants

A purposive sample of 10 self-selected participants was recruited from therapists listed on the IARTT website (IARTT, 2022b). An email was sent to every practitioner listed, all of whom had met the IARTT requirements of attending the training and submission of two case studies to the IARTT. The email invited practitioners to inform clients about the research project. The clients had partaken in MRT for help with symptoms they suffered from and could relate to a self-defined stressful specific traumatic experience or experiences. Interested clients were asked to contact the first author (LH) directly and were then sent a participant information sheet and consent form. There was no requirement for a formal PTSD diagnosis, which is the norm in the UK for self-referring and self-reporting clients seeking help for symptoms they relate back to an earlier experience. However, three participants stated (this could not be verified by the researcher) that they had a pre-existing PTSD diagnosis from consultations with their GP, NHS hospital or another counsellor. Four had a diagnosis of PTSD suggested (not confirmed) by MRT-providing therapists. Two had sought help specifically for symptoms which they self-identified as related to PTSD. The participants gave limited details of previous support, but all had some previous help, including counselling, hypnotherapy, cognitive behavioural therapy (CBT) or GP support. The therapists' details were explicitly not collected as this was not within the scope of this research project. UK Muss Rewind Therapists come from a variety of backgrounds, and whilst accredited bodies exist for therapists, MRT is not statutory-regulated in the UK. Whilst the traumas were self-defined, and little detail was elicited from them, all participants described real or imagined experiences of "actual or threatened death, serious injury, or sexual violence," fitting in with the DSM-5 definition of trauma.

Participants were not asked explicitly about their trauma so as not to cause any harm, and this was made clear in the participant information sheet. Table 1 includes the limited information some chose to share to give a broad overview of the clients' traumatic experiences.

TABLE 1 Participant characteristics.

P	Male (M) female (F)	Age	Details of self-reported stressful experience that they chose to reveal in the interview	How long ago	Face to face (FF) or online (O)	Time between trauma and rewind	Time between rewind and interview	Self-reported reasons for consulting the MRT practitioner
1	M	20–30	Distressing interaction (not revealed in detail) with angry workplace colleague leading to several weeks off work	3–4 years	O	2+ years	14 months	Rushes of anxiety if perpetrator's name mentioned Anger "Jekyll and Hyde" Think you had done wrong Felt worthless I was a nasty person Snappy/short with people Poor sleep Very doom and gloom
2	M	50–60	Abused in childhood Family member attempted suicide Estranged from family member	Childhood	FF then O	30+ years	9 months	Flashbacks Did not like self Hesitant to socialise Disabling health anxiety Severe depression Anxiety Sorrow Not sleeping Disabling Thought dying would be easier
3	F	60–70	Bullying in playground—the specific recurring memory triggered memories to other childhood trauma (not revealed in the interview)	Childhood	O	60+ years	Approx. between 1 year and 14 months (exact therapy dates not known by participant at interview)	Upsetting reoccurring memory Would just pop up It is just a memory that brought me down and led to other memories being brought up Scared of facing the fear Using a lot of energy to keep suppressed Weepy Brought up feelings when memory reoccurred Felt down when memory reoccurred/how might have being down made memory reoccur? Would trigger other bad memoires

(Continues)

TABLE 1 (Continued)

P	Male (M) female (F)	Age	Details of self-reported stressful experience that they chose to reveal in the interview	How long ago	Face to face (FF) or online (O)	Time between trauma and rewind	Time between rewind and interview	Self-reported reasons for consulting the MRT practitioner
4	F	50–60	Complex—many events not revealed in the interview	Childhood onwards	O	40+ years	Approx. between 1 year and 14 months (exact therapy dates not known by participant at interview)	Not eating around others Hypervigilant Panic attacks In a life-threatening state Anger: "I wanted to scream" Insomnia Depression No resistance to stress Not coping with daily life Sensory overload Suicidal
5	F	40–50	Near death of child then self	End of 2019	O	1–2 years	4 months	Flashbacks Not mentioning words relating to the event Panic attacks In a high state of alert Anxious Not a good parent Not looking after children Not leaving house Crying
6	F	50–60	Traffic accident then witnessing another	6 years/4 years	O	5+ years	11 months	Waking in night and thinking about it straight away Self-critical of driving is incorrect, imagining police noticing Talked to friends a lot about the trauma without meaning to (annoying them) Blaming self Being pessimistic Comfort eating Not thinking clearly Talking about trauma all time
7	F	40–60	Childhood abuse	Childhood	O	30+ years	9 months	Memories popping up Depression Eating disorder Off work Avoiding people

TABLE 1 (Continued)

P	Male (M) female (F)	Age	Details of self-reported stressful experience that they chose to reveal in the interview	How long ago	Face to face (FF) or online (O)	Time between trauma and rewind	Time between rewind and interview	Self-reported reasons for consulting the MRT practitioner
8	M	20–30	Traffic accident	1–2 years	O	1–2 years	7 months	Cannot remember the event Having these sudden bursts of emotion Actively trying to remember Suicidal Fearful Aggressive Not fun anymore Not positive anymore Negligent towards others Shut off Depressed, overthinking Not sleeping Impulsive and risky behaviour whilst driving
10	F	50–60	Attacked at work	8 years	O	7 years	Approx. between 1 year and 14 months (exact therapy dates not known by participant at interview)	Flashbacks Panic attacks Hypervigilance Blamed self Beat self up Questioned if related to the onset of FND
11	M	30–40	Traumatic event in a war zone	16 years	O	15 years	Less than 1 year (exact therapy dates not known by participant at interview)	Nightmares Anger Walking time bomb Not being best partner or parent

A sample size of 10 participants, when combined with the use of semistructured interviews, can provide a large enough sample size to allow "deep, case-orientated analysis" and to give "new and richly textured understanding" (Sandelowski, 1995, p. 183).

Participant characteristics, including the impact of the traumatic experience, are shown in Table 1. All participants were UK residents.

2.3 | Procedure

LH obtained ethics approval from Nottingham Trent University's School of Social Sciences Ethics Committee (10 March 2021). Written informed consent was obtained from all participants before the interview, confirming their willingness to participate and allowing the use of their anonymised data.

LH recorded and conducted iterative semistructured interviews online using Microsoft Teams videoconferencing software. Each interview was approximately 60 min in duration and used a semi-structured topic guide (Appendix A). LH was in a private room, and the clients chose a safe and comfortable location. The final question was, "is there anything else that you feel I should have asked or you would like to add?" which was added to reveal any potential new lines of enquiry (Hume & Platt, 2007).

2.4 | Data collection and analysis

LH transcribed the video recordings of the semistructured interviews using an intelligent verbatim approach, and the subsequent data (transcripts) were analysed using the NVivo (12) software.

A reflexive thematic analysis approach (RTA; Braun & Clarke, 2019) was adopted to ensure that data collection and analysis were carried out in a rigorous and methodical manner. The steps include familiarisation with the data, transcribing the data, generating codes, searching, reviewing and sorting the codes into defined and named themes, which can be further reviewed, analysed and written up in the report (Braun & Clarke, 2006). The breaking down of the data into codes allowed for similarities and differences in the participants' experiences to be highlighted, and these were then used to generate rich, detailed themes (Braun & Clarke, 2013). The themes were reviewed and agreed by the co-author (MH). RTA includes the steps outlined by Braun and Clarke (2006), but highlights the importance of the researcher's analytical process. LH employed bracketing, described by Starks and Brown Trinidad (2007) as recognising but not setting aside prior knowledge and assumptions, and attended to the participants with an open mind. This was aided by using a reflexive record throughout the research process, as this may improve the reliability and validity of the data by ensuring that the researcher's own preconceptions and expectations are considered (Wadman et al., 2018).

3 | RESULTS

An overarching theme was the importance of "the role of the practitioner," which is common to all therapies (Lambert & Barley, 2001), and four further themes were also identified:

1. End of tether
2. Negative emotions
3. Repetition
4. Positive impact of the MRT session or sessions

3.1 | The role of the practitioner

Participants described the importance of the practitioner's role in enabling MRT; this theme comprised several subordinate concepts, including building a trusting relationship, acknowledging the person's trauma, understanding and explanation of Muss's technique, and therapeutic synergy with other aspects of therapy.

3.2 | Trust and acknowledgement of trauma

Participants being able to trust their practitioner was often a deciding factor in relation to the decision to incorporate MRT, a new therapy technique within existing therapy relationships.

Furthermore, friends recommending the therapist, empathy, professionalism, knowledge, perception and a caring manner all helped to establish trust and were cited as reasons for going ahead with the therapy:

> "I would say it was that trust, and you know, she, I think it's also kind of like a caring thing as well."
>
> [P11]

> "It was crucial that I already knew her, and I already had that trust in her."
>
> [P8]

Trust was clearly very important for clients, but notably, this sense of trust was usually established during previous sessions, prior to the practitioner introducing MRT. Whilst two self-referred for MRT, eight participants had MRT suggested to them by the practitioner after revealing they had experienced a traumatic event or events. Indeed, a vital aspect of the decision to undertake MRT for some was that they had been able to talk about their traumatic event with the therapist beforehand:

> "…even though she said to me with the rewind that I didn't have to reveal any details to her, I wanted to, and I chose to all the way through."
>
> [P4]

Others explained it was important to them that the therapist understood them and their background and, in one case, talking about the past and its impact led to a realisation of how severe the impact of the event had been.

> "I was obviously not realising that I was that bad, and that was the wake-up call."
>
> [P8]

However, whilst in the minority, some participants preferred not to discuss the trauma in detail:

> "I would not have done it if they had asked me to tell them, I wouldn't have done it because I don't want to talk to them about it and I wouldn't want it to."
>
> [P11]

Whilst, in some cases, it is a requirement to explore trauma in depth in early intervention, as highlighted by Lambert (2005), one of the common factors of many therapies is that people are encouraged to talk and discuss things they fear. Therefore, it seems important that MRT therapists have appropriately developed skills to listen to the client's trauma if necessary and to be prepared to help with any arousal that occurs, prior to the MRT intervention.

3.3 | Understanding and explanation of MRT

The practitioners explained Muss Rewind Therapy in various ways (possibly due to tailoring to individual client needs with the aim of

making them feel comfortable), and all participants thought that the explanation played an important part in their ability to commence and continue their MRT sessions:

> "……she (the practitioner) did explain the theory of how it uncouples from the emotional memory, amygdala and puts into the hippocampus and makes it a narrative memory. That all made sense to me, and I needed to understand that in order to do it."
>
> [P3]

Furthermore, whilst recognising the importance of the explanation, several participants mentioned that they did not immediately fully understand what they had to do:

> "I think that's the hardest part of rewind. It's understanding what you're supposed to do with yourself and the memory itself."
>
> [P4]

According to Phoenix (2007), understanding the reasons behind the heightened emotions and intrusive recall of events associated with trauma can help clients to feel more in control of their responses when emotions and memories are triggered. This feeling of starting to be in control again could be part of the reason why participants continued with MRT even when experiencing some scepticism.

> "I think I said, 'what load of old crap. This is something so simple it's not going to work. What are you doing?' And we went straight into it!"
>
> [P11]

3.4 | Therapeutic synergy

All participants indicated that they welcomed a therapeutic approach that allowed for other tools and techniques to be included before the MRT session, alongside the MRT protocol or afterwards, including breathing techniques, guided relaxation, hypnotherapy and ongoing counselling.

> "… it was clear what she was doing was trying to get me to have an understanding of why these things were happening… she was trying to put all the pieces in place …when I talked about them."
>
> [P2]

> "I had intensive therapy……internal family systems ….and person-centred therapy and I wanted to (reveal the details) …because my complex trauma was very much about not being heard."
>
> [P4]

> "So, I went back to her and had several sessions…just generally talking, then rewind was suggested……. I had CBT as well."
>
> [P5]

> "We'd several sessions doing different techniques then we did the rewind."
>
> [P6]

Whilst not explicitly directed to practise MRT as "homework" outside sessions, one client who deals with fatalities in his day-to-day job appreciated using the MRT as a tool to help himself at home. After a bad day, he finds a quiet place and uses breathing techniques and rewind by himself: "You feel a little bit better, then carry on with your day" [P11]. However, whilst the participant suggested it is the MRT that helps, it may be the breathing technique or MRT, or both, that are helping him.

Whilst participants revealed the use of other tools and techniques, their impact was beyond the scope of this research, and the direction of questioning was explicitly to promote in-depth conversation about MRT.

3.4.1 | Subtheme 1: end of tether

After realising or being informed that their symptoms related to trauma, participants decided to participate in MRT, despite most anticipating that it might be a challenging experience for them. They described not only having "to face a fear" [P3], "be determined" [P8] or "man up" [P11] but also needing to "go into this with an open mind and with positivity" [P8].

The participants chose to carry on due to the impact the symptoms were having on them:

> "Yeah, I mean anything that would help. Really try and get me out of this, you know, fog, fog of despair that I was in so, you know, I would have. Yeah, I would have tried it. There's no reason not to."
>
> [P7]

Recognising that MRT may not be backed by lots of research evidence, one participant explained they were at a stage where they would try anything:

> "There was partly I've got to the end of my tether and would try absolutely anything. Whether it was research-backed or not, I would just try it."
>
> [P10]

3.4.2 | Subtheme 2: negative emotions

The MRT protocol includes participant imagining they are in a cinema and watching their trauma or traumas on a screen. However,

most of the participants found the ability to just watch the trauma, as opposed to reliving it, difficult to begin with:

> "…. I think the most difficult thing that I found, though, even when I understood that the process, was that I found myself dragged into the action again."
>
> [P4]

Consequently, participants reported experiencing and struggling with a range of negative emotions and thoughts. A sense of shock, sadness, anger, self-pity and feeling vulnerable were phenomena both during and sometimes immediately after the MRT "film." For some, the negative emotions and feelings when watching the film led to physical symptoms such as sobbing and feelings of exhaustion or irritability during the session:

> "… so it is almost like constantly digging and digging so I became quite irritable at times."
>
> [P8]

In some cases, these negative emotions and feelings continued to remain when the session was subsequently repeated, with one participant specifically reporting that they were "very distressed" and crying for hours when she thought one session had gone "wrong" and "a pandora's box had been opened" [P4]. Another mentioned, "I remember thinking to myself, this is a shit film" [P7].

Participants clearly distinguished between the emotions whilst watching the film going forwards and the rewinding:

> "…going forward, it was absolute tragedy, right? Coming back, it was, I don't know where this is going, you know, but it just felt weird."
>
> [P2]

However, one element of the protocol that nine participants mentioned helped them was starting the film in a safe or happy place. For some, this was immediately before the event, but for others, it was imagining any safe place. When the film was rewound, participants reported returning to the safe or happy place, which was experienced as reassuring and comforting.

3.4.3 | Subtheme 3: repetition

Some participants reported that the MRT protocol was repeated across therapy sessions. This may be due to practitioners' concerns that clients may not have fully followed the procedure. Furthermore, some participants referred to completing questionnaires, with scores determining whether MRT needed to be repeated in follow-up sessions. The MRT protocol specifies using the Impact of Events Scale (Horowitz et al., 1979) to gauge effectiveness. It was beyond the scope of this research to compare participants' scores on such measures pre- and post-MRT. Moreover, some participants reported multiple experiences of the MRT protocol being applied within the same therapy session. This process of repeated exposure seemed to help participants become more comfortable each time MRT was repeated:

> "I remember that the score the second time around wasn't much lower than the first time, so she said, 'I think it would be good if we did it again.' So, for, for some reason, three times rings a bell, we did three sessions to see how it went over the space of time… but I definitely felt better."
>
> [P1]

One participant reported repeating the MRT about nine times in the first session, whilst another said, "the more I did it (MRT) …. I knew good would come from it." [P2]

Participants reported that repetition helped to prevent the re-experiencing of the trauma and replace it with watching it on a screen. This distancing from the trauma could lead to lowered arousal:

> "The third time I noticed immediately what was happening, managed to pull myself back out to the role of observer in the cinema, and then shortly after I rewound the film by throwing myself into the memory, and I finished with me back in my safe place and that relaxed state of well-being and happiness and then I noticed that my whole body completely relaxed at that."
>
> [P3]

Repeated exposure to traumatic events is common in exposure therapies, and it is possible that repeated exposure may be an important contributory mechanism within MRT.

3.4.4 | Subtheme 4: positive impact of MRT session or sessions

Participants reported significant positive impacts of MRT sessions, underpinned by subthemes of immediate relief, less intrusive recall, lowered arousal and better quality of life.

3.5 | Immediate relief

Whilst participants reported negative experiences of MRT, such as feeling emotional or exhausted, many went on to report some immediate change—"feel totally different" and "peace of mind" [P2]; "sense relief" [P8]; "definitely a release of, of anger" [P1]. However, it was not always clear whether this was simply because they had managed to "get through" the MRT session, or whether they were experiencing actual improvements in trauma symptoms:

> "The immediate aftermath was just a sense of relief that I am dealing with this thing so it may not come

> now, but I'm gonna fix this, so yeah.... It lightens you and you just, like, immediately just to know that. It's gonna suck for a bit, but in a minute, it's definitely not going to suck so that things will get better."
>
> [P8]

The rewinding of the film could elicit immediate feelings of change:

> "I felt at ease. I thought I'd been released. It felt like someone had literally put a spring on me and it was pulling me back, with backwards. You know, as if I was being pulled away from it like this...At ease, the emotions then, soon as I rewound the emotions, the sorrowness, and it just went. It was just a case of I was being pulled out of this thing, you know, it allowed me to release and let go of some very traumatic and very sorrowful things."
>
> [P2]

Other participants mentioned a feeling of letting go:

> "I remember it was almost like leaving it all behind, ... Think good, you know, like, look, a weight had been lifted... it was comfortable and good that it was done."
>
> [P1]

Another participant described her favourite part of the session as:

> "Watching myself at the end standing next to the screen after going forwards and backwards and not having any fear."
>
> [P10]

3.6 | Less recall and lower arousal

Significantly stated impacts of MRT were the reduction in or elimination of negative emotions and behaviours when recalling the traumatic event or events. Participants who had suffered from involuntary recall (flashbacks and nightmares) stated that they thought MRT had helped them in reducing or eliminating such experiences:

> "I could bring memory forward and not get upset, and put it back. To the back of mind again. And that was great."
>
> [P3]

The speed with which participants noticed a reduction in involuntary recall was also commented upon: "Yeah, I think that it's extremely rapid (trigger stopped). I mean, way beyond my expectations" [P4].

Some felt this change during sessions after repeated exposure to MRT. However, for others, it was a more gradual realisation over a few days or weeks, that arousal, which was linked with their memories, had reduced or completely disappeared:

> "It was about a week and a half later. First of all, I noticed I wasn't getting flashbacks all the time ....and when I was getting them, that was like watching an advert on TV. It had no meaning to me, literally. I didn't get angry, I didn't start talking to myself, and chuntering away, didn't get frustrated and I just, I remember I said to her (partner), 'I just feel different.'"
>
> [P2]

When specifically asked whether they thought these gains were due to MRT, participants reported they believed they were and affirmed that some of their previous symptoms were reduced or completely gone.

For some participants, gains included a reduction in distress in relation to previous triggers, which did not now seem to set off emotions and feelings. One participant who had avoided certain words linked to her trauma realised she was saying them without any triggering effect:

> "I just said the word and I didn't, I didn't think anything of it. I just said it and it was so strange, I had no images pop in my head. .... but that's when I thought, 'oh my God, maybe something's happened or something's changed.'"
>
> [P5]

Furthermore, one participant reported how she could now talk about the trauma without crying:

> "The stuff that was in the, the rewinds – it doesn't come up like it did. The wind's been taken out of its sails."
>
> [P7]

Even those who still had some residual symptoms reported having benefited:

> "I think it helped me to put it 'back in the box.' I still have panic attacks, hyper-vigilance, but I tend to accept it better now. These symptoms haven't all gone away. Though, I mean, it was just the fear of the symptoms went away.... I got the ability to recall the incident without having the emotion attached to it."
>
> [P10]

Residual symptoms are not uncommon following psychological therapies for PTSD, including NICE recommended approaches (Olff et al., 2020; Larsen et al., 2019). Whilst this study does not explore

MRT effectiveness, it is important to note that residual symptoms are common across trauma-focussed psychological therapy approaches.

3.7 | Better quality of life

Through its constituent elements and MRT's reported ability to lead some to a sense of rapid relief, or reduction in intrusive recall and arousal symptoms, MRT was experienced as leading to improvements in participants' quality of life, "including being more motived and transforming family life" [P1].

This improvement was noticed as trauma symptoms receded, enabling a calmer state, more confidence, a clearer mind, quietness, less anxiety and having the headspace to tackle other issues, which were all mentioned as improvements to participants' lives, giving them a sense of moving forwards:

> "It gave me some headspace. It took some stuff away." [P7]

Whilst the degree to which positive gains could be solely attributed to MRT was not always clear, since MRT was often provided within established therapeutic relationships or alongside other treatment approaches, participants reported improvements in their social and psychological domains. Prior to MRT, some reported that relationships with people, in general, had been adversely affected, but improved after MRT due to experiencing reductions in stress, worry and anger, whilst others reported MRT facilitated them "moving on" (from the trauma) [P1], and leaving the past behind: "I felt like it… I was dropping all these demons and leaving it behind" [P2].

Others talked about taking part in activities that they could not before, for example:

> "So, we went and for the first time in my life that I can remember, we had a lovely day at the seaside, and I had no triggering at all." [P4]

Being able to re-engage in previously avoided activities was experienced by some as a positive "springboard" towards increasing activity and engaging in a wider range of interests:

> "So, I'm doing a lot more now my life is changed since the end of last year because it's like that step up to improve more. So, it's like let's develop further, we have done this, and it was success. Then, let's read this. Let's look at that, or whatever join." [P6]

MRT could potentially, therefore, help clients on their path towards post-traumatic growth and consolidating trauma experience into their lives without the distress caused by trauma symptoms:

> "Yes, they're like, 'well, we see you're different now; you're not you're not as mean; you're not as aggressive…' Yeah, I've gone back to being how I was before." [P8]

4 | DISCUSSION

This study is the first to explore participants' experiences of MRT and their perception of its effectiveness and presents a novel contribution to the literature in this area. The lack of research evidence in relation to clients' experiences of MRT and the limited scope of the MRT empirical evidence means that counsellors and psychotherapists could easily overlook this approach for trauma therapy. Whilst being linked to reconsolidation theory as a possible explanation of its mechanism, Haour et al. (2019) noted that the scientific proof of a therapeutic action can take more than 20 years. Therefore, the effectiveness of treatment might be recognised before its mechanisms are fully understood and qualitative research offers an insight into what clients find obscure or challenging, as well as their perceived positive outcomes of new therapies (Hoskins et al., 2019). Therefore, whilst limited, this study has sought to partially address the gap in the research on MRT. The findings of this study show that despite negative emotions experienced during MRT, participants did experience some improvements in the symptoms which they attributed to a traumatic experience or experiences. Participants specifically attributed several changes to MRT, including a reduction in negative emotions linked to the memory of the event and a reduction in involuntary recall of the event.

Whilst evaluating MRT's overall effectiveness is beyond this paper's scope, participants' perceptions of its effectiveness suggest that MRT is a promising treatment approach for trauma. Even though some participants reported residual trauma symptoms after MRT, this compares equivocally with the psychological approaches to trauma therapy considered to have the highest standards of empirical research evidence (Larsen et al., 2019; Olff et al., 2020).

However, it appears that, in routine practice, MRT may be introduced alongside a range of other eclectic therapeutic practices or used within the context of an ongoing therapeutic relationship. Within the therapy relationship, and MRT sessions, participants experienced common factors (Lambert & Barley, 2001), including empathy and the sense that the practitioner cared. The importance of the therapeutic alliance to general psychological therapy outcomes is well established, accounting for approximately 30% of the variance in psychological therapy outcomes (Lambert & Barley, 2001). Within trauma-focussed work, the quality of the therapeutic alliance may predict improvements in trauma symptoms (Beierl et al., 2021). Within this study, a key theme was the importance of being able to trust the MRT practitioner in order to form a strong therapeutic alliance. Trust was key to the participants disclosing their trauma, deciding to engage in MRT and continuing with the sessions even when

they became difficult. However, according to participants' experiences, in routine practice, MRT is often provided within established therapeutic relationships or alongside other treatment approaches. Whilst this makes it difficult to discern the most important aspects of MRT, the participants were clear in their descriptions of its effectiveness as they perceived it pertaining to their own experiences.

The variation in how MRT appears to be applied could be seen as reducing fidelity to Muss's original model (Muss, 1991) and confounding the effectiveness of MRT with aspects of myriad other therapeutic approaches. Participants reported variations in how different therapists applied MRT, particularly regarding psychoeducation detail, instructions for starting and ending "the movie," guidance for practising MRT on their own at home and whether to incorporate additional techniques such as breathing exercises. Whilst participants' recollections of session content may be fallible, and participants' understanding of MRT technique could diverge from that of practitioners, the high degree of variation in practice suggests that further research may be required. Such work could include greater use of a manualised approach in an attempt to maximise fidelity to the model and reduce contamination from other therapeutic approaches. Such work is underway within a randomised controlled trial (Astill Wright, Barawi, et al., 2021; Astill Wright, Horstmann, et al., 2021). However, in practice, MRT practitioners could benefit from a competency framework similar to those already existing for other therapies, such as the CBT competency frameworks underpinning CBT delivery within the English Increasing Access to Psychological Therapies (IAPT) programme (Roth & Pilling, 2007). Such an approach could help practitioners improve MRT's consistency, increase fidelity to the MRT model and improve MRT's status in relation to empirically supported treatments.

However, MRT appears to possess theoretical proximity and practical similarity to other forms of psychological therapy, which frequently engage with and activate trauma memory (Olff et al., 2020). As an approach making use of imaginal exposure, MRT bears similarity to other cognitive approaches working with "hotspots" or specific parts of trauma memory associated with peak emotional distress (Grey et al., 2001) and established cognitive behavioural models of imaginal exposure or reliving (Grey et al., 2002). Despite possible conceptual and procedural similarities with such other approaches, previous research drawing on pre and postintervention results suggests MRT and memory reconsolidation are effective ways of working with trauma symptoms (Adams & Allan, 2018; Gray & Liotta, 2012; Muss, 1991). MRT appears to share some conceptual proximity to other well-known forms of trauma-focussed therapy, such as Ehlers and Clark's (2000) cognitive model of PTSD, which proposes that intrusive re-experiencing of trauma memories can be reduced by elaborating trauma memories into a person's long-term autobiographical memory. Ehlers and Clark advocate imaginal exposure or reliving of the trauma experience to achieve elaboration of the trauma memory. Component techniques of imaginal exposure recommended by Ehlers and Clark (2000) include verbalising or writing a detailed account of the event and focussing upon "hotspots" of memory associated with peak levels of distress. Such approaches may be helpful in elaborating and changing the meaning of the trauma memory. Ehlers and Clark (2000) also suggested that practitioners need to employ techniques to modify participants' current sense of threat and to encourage change to current dysfunctional behavioural and cognitive strategies employed by the participant. MRT therefore potentially represents one way to rapidly assist clients in elaborating trauma memories, by reducing their distress and sense of threat, and which may help clients move away from unhelpful coping strategies as a way of managing trauma symptoms.

Whilst an empirical investigation of the theoretical mechanisms underpinning MRT and those of other trauma-focussed therapies would significantly add to existing research, it is beyond the aim of this qualitative research. Further research could be undertaken in this regard. Moreover, a cohort study including a control group that has not received MRT could have yielded informative data for comparison. Such an approach has been used in many existing PTSD research projects, such as those listed in the APA Clinical Practice Guideline for the treatment of PTSD (2017), to compare the efficacy of psychological interventions with no intervention or another intervention.

According to MRT training (IARTT, 2022a), repetition is sometimes necessary to ensure clients have followed the instructions correctly. All participants mentioned the repetition of watching "the film" several times, including up to 10 times in a session for one participant. Furthermore, some participants mentioned one consequence of repeatedly "watching the movie" was their arousal being reduced the more times they watched it. This prompts the question of whether repetition is a vital mechanism of action within MRT. Exposure therapies such as TF–CBT also repeat exposure to the trauma multiple times until the anxiety has subsided (e.g., Foa et al., 2007). For some participants, it may have been the repeated exposure that helped them, as opposed to the overarching MRT protocol. Indeed, Brewin et al. (1996) posited that memory repetition is needed until a person accepts what happened to them and the threat of recurrence is realistically assessed, leading to the integration of the trauma memory with the person's other autobiographical memory and sense of self.

This study has highlighted participants' experiences and perceived effectiveness of MRT. It echoes Adams and Allan's (2018) suggestion that MRT may offer a promising treatment technique for trauma that may be used as a standalone procedure or in conjunction with other treatment approaches. The findings from this study add to existing research as they report clients' perspectives. However, there are limitations to the study, including elapsed time from MRT sessions and reliance on the participants' memory and recall of MRT sessions, which means the findings presented can only ever represent a partial account of participants' experiences of MRT. Problems with the time interval between receiving MRT and reporting the experience of MRT could be improved in future research by interviewing participants soon after the MRT session. Nonetheless, participants' accounts of MRT would still rely on self-report data. However, self-reported data, including perceptions, experiences and self-reflections, have a long history

of being used in counselling, psychotherapy and psychology research (Polkinghorne, 2005). Such an approach draws upon a rich intellectual tradition tracing its routes back to hermeneutics and interpretivism (Rolfe, 2015), which has been argued to powerfully justify client's accounts of their experiences as a highly valid form of evidence (Morse, 2006).

It must be noted that all participants received at least one of their MRT sessions online as a consequence of the COVID-19 pandemic, which could have had an impact on their experience and outcome. However, this is true of all therapies that moved online during COVID-19, and whilst it is acknowledged that this could lead to challenges for the therapist and the client, including the therapist's ability to read clients' emotions and feel connected to them, research has shown online experience of therapy tends to reduce any negative views towards online treatments and their efficacy (Békés et al., 2021). Moreover, online therapies have been shown to be effective in treating psychological trauma (Simon et al., 2021), and therapists forced to transition to online work during COVID-19 reported a generally positive attitude towards working online (Békés & Aafjes-van Doorn, 2020). Further research would be needed to determine the efficacy of MRT delivered online compared with face to face, but in this study, clients perceived MRT to be somewhat effective, despite being online.

Whilst the study sample was adequate for an in-depth qualitative evaluation, it was not sufficient for statistical generalisability, but can still provide useful insights (Yardley, 2008). However, since participants were recruited by MRT practitioners signposting potential participants to the research, there is the possibility of selection bias since practitioners may have only signposted participants whom they deemed had responded positively to MRT intervention and thus were more likely to describe a positive experience. However, at interview, participants expressed both negative and positive aspects of their experience of MRT, and all participants declared a willingness to take part in the research in order to inform and help other potential participants and practitioners who were either seeking MRT or offering it. Whilst not part of the research, the participants did mention that other tools and techniques were sometimes used before or in the same sessions as MRT. Further research with MRT-only participants would make future findings more informative. Additionally, since participants were recruited via therapists in private practice, there is the possibility that participants from lower social economic groups could have been precluded from the research, potentially missing important information in relation to experiences of MRT in the wider population. Furthermore, no record was taken of the individual therapists' experiences or qualifications; this potential diversity could have also impacted the clients' experiences and outcomes of MRT.

Despite its limitations, this study has highlighted clients' experiences of MRT, which indicate that it may be a promising approach for working with trauma, but further research is required, including a need for practitioners to demonstrate stricter adherence to an MRT protocol and the potential development and use of an MRT competence framework. Additional studies may be needed to help discern the most important elements within MRT. Future research could also take note of the importance placed by participants on building trust, repetition of the MRT protocol and explanation of the treatment in their decision to begin MRT. In particular, steps could be included to help practitioners with the process of integrating MRT within established therapeutic relationships prior to MRT taking place.

5 | CONCLUSION

The thematic analysis of data from semistructured interviews led to the development of themes suggesting that, despite experiencing difficulties within MRT sessions, including negative emotions and feelings, participants believed the MRT sessions had positively impacted their lives. Participants highlighted that trust in the practitioner, the practitioner's explanation of MRT and the repetition of the MRT protocol were all important parts of the experience from their perspective. MRT was reported to help participants' experiences of negative emotions when recalling traumatic events and reduce the frequency of involuntary recall. Participants also reported broader positive changes in their quality of life after having MRT. This novel addition to the existing research, which focusses on the perspectives of clients, adds to existing research and can inform further research development. However, more rigorous research is needed to dismantle the most effective components of MRT and to evaluate MRT in relation to other therapeutic techniques and approaches.

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CONFLICTS OF INTEREST STATEMENT

No potential conflicts of interest exist.

DATA AVAILABILITY STATEMENT

Due to the confidential nature of this research, supporting data of interviews are not available.

ETHICAL APPROVAL

Ethics approval was obtained from the Nottingham Trent University School of Social Sciences Ethics Committee (10 March 2021), and written informed consent was obtained from all participants to partake in the interviews and to use their anonymised data.

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REFERENCES

Adams, S., & Allan, S. (2018). Muss' rewind treatment for trauma: Description and multi-site pilot study. *Journal of Mental Health*, *27*(5), 468–474. https://doi.org/10.1080/09638237.2018.1487539

American Psychological Association. (2017). *Clinical practice guideline for the treatment of post-traumatic stress disorder (PTSD) in adults*. https://www.apa.org/ptsd-guideline/ptsd.pdf (Accessed: November 12, 2022).

American Psychological Association. (2023). *Trauma. [Online]*. American Psychological Association. https://dictionary.apa.org/trauma (Accessed February 15, 2023).

Astill Wright, L., Barawi, K., Simon, N., Lewis, C., Muss, D., Roberts, N., Kitchiner, N. J., & Bisson, J. I. (2021). The reconsolidation using rewind study (RETURN): Trial protocol. *European Journal of Psychotraumatology*, *12*(1), 1844439. https://doi.org/10.1080/20008198.2020.1844439

Astill Wright, L., Horstmann, L., Holmes, E. A., & Bisson, J. I. (2021). Consolidation/reconsolidation therapies for the prevention and treatment of PTSD and re-experiencing: A systematic review and meta-analysis. *Translational Psychiatry*, *11*(1), 453. https://doi.org/10.1038/s41398-021-01570-w

Atwoli, L., Stein, D. J., Koenen, K. C., & McLaughlin, K. A. (2015). Epidemiology of post-traumatic stress disorder: Prevalence, correlates and consequences. *Current Opinion in Psychiatry*, *28*(4), 307–311. https://doi.org/10.1097/yco.0000000000000167

Beierl, E. T., Murray, H., Wiedemann, M., Warnock-Parkes, E., Wild, J., Stott, R., Grey, N., Clark, D. M., & Ehlers, A. (2021). The relationship between working Alliance and Symptom Improvement in Cognitive Therapy for posttraumatic stress disorder. *Frontiers in Psychiatry*, *12*. https://doi.org/10.3389/fpsyt.2021.602648

Békés, V., & Aafjes-van Doorn, K. (2020). Psychotherapists' attitudes toward online therapy during the COVID-19 pandemic. *Journal of Psychotherapy Integration*, *30*(2), 238–247. https://doi.org/10.1037/int0000214

Békés, V., Aafjes-van Doorn, K., Luo, X., Prout, T. A., & Hoffman, L. (2021). Psychotherapists' challenges with online therapy during COVID-19: Concerns about connectedness predict therapists' negative view of online therapy and its perceived efficacy over time. *Frontiers in Psychology*, *12*, 705699. https://doi.org/10.3389/fpsyg.2021.705699

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

Braun, V., & Clarke, V. (2013). *Successful qualitative research*. Sage.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research In Sport, Exercise and Health*, *11*(4), 589–597. https://doi.org/10.1080/2159676x.2019.1628806

Brewin, C., Dalgleish, T., & Joseph, S. (1996). A dual representation theory of post-traumatic stress disorder. *Psychological Review*, *103*(4), 670–686. https://doi.org/10.1037/0033-295x.103.4.670

Brewin, C. R., & Holmes, E. A. (2003). Psychological theories of posttraumatic stress disorder. *Clinical Psychology Review*, *23*, 339–376.

Cloitre, M. (2020). ICD-11 complex post-traumatic stress disorder: Simplifying diagnosis in trauma populations. *The British Journal of Psychiatry*, *216*(3), 129–131. https://doi.org/10.1192/bjp.2020.43

de Quervain, D., Schwabe, L., & Roozendaal, B. (2016). Stress, glucocorticoids, and memory: Implications for treating fear-related disorders. *Nature Reviews Neuroscience*, *18*(1), 7–19. https://doi.org/10.1038/nrn.2016.155

Ecker, B., & Bridges, S. K. (2020). How the science of memory reconsolidation advances the effectiveness and unification of psychotherapy. *Clinical Social Work Journal*, *48*(3), 287–300. https://doi.org/10.1007/s10615-020-00754-z

Ehlers, A., & Clark, D. (2000). A cognitive model of post-traumatic stress disorder. *Behaviour Research and Therapy*, *38*(4), 319–345. https://doi.org/10.1016/s0005-7967(99)00123-0

Ehlers, A., Clark, D., Hackmann, A., McManus, F., & Fennell, M. (2005). Cognitive therapy for post- traumatic stress disorder: Development and evaluation. *Behaviour Research and Therapy*, *43*(4), 413–431. https://doi.org/10.1016/j.brat.2004.03.006

Fear, N. T., Bridges, S., Hatch, S. L., Hawkins, V., & Wessely, S. (2014). Post-traumatic stress disorder. In S. McManus, P. Bebbington, & R. B. T. Jenkins (Eds.), *Adult psychiatric morbidity survey* (Vol. *chapter 4*, pp. 106–130). NHS Digital.

Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences therapist guide (treatments that work)*. Oxford University Press.

Forbes, D., Bisson, J., Monson, C., & Berliner, L. (2020). *Effective treatments for PTSD* (3rd ed.). The Guildford Press.

Gray, R., & Liotta, R. (2012). PTSD: Extinction, reconsolidation, and the visual-kinesthetic dissociation protocol. *Traumatology*, *18*(2), 3–16. https://doi.org/10.1177/1534765611431835

Grey, N., Holmes, E., & Brewin, C. R. (2001). Peritraumatic emotional "hot spots" In memory. *Behavioural and Cognitive Psychotherapy*, *29*, 367–372. https://www.cambridge.org/core/journals/behavioural-and-cognitive-psychotherapy/article/abs/peritraumatic-emotional-hot-spots-in-memory/BF4F80358EF64B81BC480E5E2A5B0749

Grey, N., Young, K., & Holmes, E. (2002). Cognitive restructuring within reliving: A treatment for peritraumatic emotional "hotspots" In post-traumatic stress disorder. *Behavioural and Cognitive Psychotherapy*, *30*, 37–56. https://www.cambridge.org/core/journals/behavioural-and-cognitive-psychotherapy/article/abs/cognitive-restructuring-within-reliving-a-treatment-for-peritraumatic-emotional-hotspots-in-posttraumatic-stress-disorder/130D62B23AEF57DD3649A42C423032D9

Haour, F., Dobbelaere, E., & de Beaurepaire, C. (2019). Scientific evaluation of EMDR psychotherapy for the treatment of psychological trauma summary: Scientific evaluation of EMDR psychotherapy. *Journal of Neurology & Neuromedicine*, *4*(2), 5–14. https://doi.org/10.29245/2572.942x/2019/2.1234

Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of event scale: A measure of subjective stress. *Psychosomatic Medicine*, *41*(3), 209–218. https://doi.org/10.1097/00006842-197905000-00004

Hoskins, J. I., Blood, L., Stokes, H. R., Tatham, M., Waller, G., & Turner, H. (2019). Patients' experiences of brief cognitive behavioral therapy for eating disorders: A qualitative investigation. *International Journal of Eating Disorders*, *52*(5), 530–537. https://doi.org/10.1002/eat.23039

Hume, M., & Platt, S. (2007). Appropriate interventions for the prevention and management of self-harm: A qualitative exploration of service-users views. *BMC Public Health*, *7*(1), 9. https://doi.org/10.1186/1471-2458-7-9

IARTT. (2022a). *IARTT|International Association for Rewind Trauma Therapy|IARTT Courses|The Course*. [online]. Iartt.com. Available at: <http://www.iartt.com/become-a-practitioner/the-course/>. (Accessed May 4, 2022).

IARTT. (2022b). *IARTT|International Association for Rewind Trauma Therapy|Find a Practitioner*. [online] Available at: <http://www.iartt.com/find-a-practitioner/>. (Accessed May 4, 2022).

Kangaslampi, S., & Peltonen, K. (2022). Mechanisms of change in psychological interventions for posttraumatic stress symptoms: A systematic review with recommendations. *Current Psychology*, *41*(1), 258–275.

Kessler, R., Aguilar-Gaxiola, S., Alonso, J., Benjet, C., Bromet, E., Cardoso, G., Degenhardt, L., Girolamo, G., Dinolova, R., Ferry, F., Florescu, S., Gureje, O., Haro, J., Huang, Y., Karam, E., Kawakami, N., Lee, S., Lepine, J., Levinson, D., Navarro-Mateu, F., … Koenen, K. (2017). Trauma and PTSD in the WHO world mental health surveys. *European Journal of Psychotraumatology*, *8*(5), 1353383. https://doi.org/10.1080/20008198.2017.1353383

Kleber, R. J. (2019). Trauma and public mental health: A focused review [review]. *Frontiers in Psychiatry*, *10*, 451. https://doi.org/10.3389/fpsyt.2019.00451

Lambert, M. (2005). Early response in psychotherapy: Further evidence for the importance of common factors rather than "placebo effects". *Journal of Clinical Psychology*, *61*(7), 855–869.

Lambert, M., & Barley, D. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, research, practice, Training*, *38*(4), 357–361. https://doi.org/10.1037/0033-3204.38.4.357

Larsen, S. E., Bellmore, A., Gobin, R. L., Holens, P., Lawrence, K. A., & Pacella-Labarbara, M. L. (2019). An initial review of residual symptoms after empirically supported trauma-focused cognitive behavioral psychological treatment. *Journal of Anxiety Disorders*, *63*, 26–35. https://doi.org/10.1016/j.janxdis.2019.01.008

LeDoux, J. E. (2017). What is memory reconsolidation and consolidation. *YouTube*. YouTube. Retrieved November 23, 2022, from https://www.youtube.com/watch?v=JKiV3FNpXhk.

Lewis, S., Arseneault, L., Caspi, A., Fisher, H., Matthews, T., Moffitt, T., et al. (2019). The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people in England and Wales. *The Lancet Psychiatry*, *6*(3), 247–256. https://doi.org/10.1016/s2215-0366(19)30031-8

Morse, J. M. (2006). The politics of evidence. *Qualitative Health Research*, *16*(3), 395–404. https://doi.org/10.1177/1049732305285482

Muss, D. (1991). A new technique for treating post-traumatic stress disorder. *British Journal of Clinical Psychology*, *30*(1), 91–92. https://doi.org/10.1111/j.2044-8260.1991.tb00924.x

Muss, D. (2002). The rewind technique in the treatment of post-traumatic stress disorder: Methods and application. In C. R. Figley (Ed.), *Brief treatments for the traumatised* (pp. 306–314). Greenwood.

Nader, K., & Hardt, O. (2009). A single standard for memory: The case for reconsolidation. *Nature Reviews. Neuroscience*, *10*, 224–234.

National Institute for Health and Social Care Excellence. (2018). *Post-traumatic stress disorder*. National Institute for Health and Social Care Excellence https://www.nice.org.uk/guidance/ng116/chapter/recommendations#management-of-ptsd-in-children-young-people-and-adults

Olff, M., Monson, C. M., Riggs, D. S., Lee, C., Ehlers, A., & Forbes, D. (2020). Psychological treatments Core and common elements of effectiveness. In D. Forbes, J. Bisson, C. Monson, & L. Berliner (Eds.), *Effective treatments for PTSD* (3rd ed., pp. 169–187). The Guildford Press.

Phoenix, B. (2007). Psychoeducation for survivors of trauma. *Perspectives in Psychiatric Care*, *43*(3), 123–131. https://doi.org/10.1111/j.1744-6163.2007.00121.x

Pitman, R. (2015). Harnessing reconsolidation to treat mental disorders. *Biological Psychiatry*, *78*(12), 819–820. https://doi.org/10.1016/j.biopsych.2015.10.002

Polkinghorne, D. E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counselling Psychology*, *52*(2), 137–145.

Resick, P., Monson, C., & Chard, K. (2017). *Cognitive processing therapy for PTSD*. Guildford Press.

Rolfe, G. (2015). Foundations for a human science of nursing: Gadamer, Laing, and the hermeneutics of caring. *Nursing Philosophy*, *16*(3), 141–152. https://doi.org/10.1111/nup.12075

Roth, A., & Pilling, S. (2007). *The competences required to deliver effective cognitive and Behavioural therapy for people with depression and with anxiety disorder*. Department of Health.

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health*, *18*(2), 179–183. https://doi.org/10.1002/nur.4770180211

Shapiro, F. (2018). *Eye movement desensitisation and reprocessing (EDMR) therapy* (3rd ed.). Guildford Press.

Simon, N., Robertson, L., Lewis, C., Roberts, N. P., Bethell, A., Dawson, S., & Bisson, J. I. (2021). Internet-based cognitive and behavioural therapies for post-traumatic stress disorder (PTSD) in adults. *Cochrane Database of Systematic Reviews*, *5*(5), CD011710. https://doi.org/10.1002/14651858.CD011710.pub3

Smith, J., & Osborn, M. (2003). Interpretive phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods*. Sage.

Starks, H., & Brown Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, *17*(10), 1372–1380. https://doi.org/10.1177/1049732307307031

Tylee, D., Gray, R., Glatt, S., & Bourke, F. (2017). Evaluation of the reconsolidation of traumatic memories protocol for the treatment of PTSD: A randomised, wait-list-controlled trial. *Journal of Military, Veteran and Family Health*, *3*(1), 21–33. https://doi.org/10.3138/jmvfh.4120

Utuza, A. J. S., & Muss, D. (2012). Treating traumatic memories in Rwanda with the rewind technique: Two-week follow-up after a single group session. *Traumatology*, *18*, 75–78 Sage Journals.

Wadman, R., Vostanis, P., Sayal, K., Majumder, P., Harroe, C., Clarke, D., Armstrong, M., & Townsend, E. (2018). An interpretative phenomenological analysis of young people's self-harm in the context of interpersonal stressors and supports: Parents, peers, and clinical services. *Social Science & Medicine*, *212*, 120–128. https://doi.org/10.1016/j.socscimed.2018.07.021

Weathers, F. W., & Keane, T. M. (2007). The criterion a problem revisited: Controversies and challenges in defining and measuring psychological trauma. *Journal of Traumatic Stress*, *20*(2), 107–121. https://doi.org/10.1002/jts.20210

Wynn, G. H., Benedek, D. M., Johnson, L., Choi, K., Zhang, L., Hu, X., Pollard, H., & Ursano, R. (2017). Post-traumatic stress disorder. In P. Conn (Ed.), *Conn's Translational Neuroscience* (pp. 499–515). Academic Press ISBN 9780128023815.

Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. A. Smith (Ed.), *Qualitative psychology. A practical guide to research methods* (p. 238). SAGE Publications.

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Appendix A

A.1 | Topic guide for the interview

Topic Guide

About the participant

- First, would you please tell me a little bit about yourself? Would you like to share a little bit about the background that brought you to the sessions?

Leading to (although might have answered already):
Before the session:

- In what ways would you describe how PTSD was impacting you before the session/s?
- How did you cope with the ways that you were being impacted?
- Why did you decide to seek help?
- How long was it between the trauma and you seeking help?
- How many other sessions with the therapist did you have before the Muss Rewind session (if at all) and, briefly, how did they make you feel?

The therapy session:

- If you are happy to do so, please can you think back and talk me through your immediate memory of the session? From when you arrived to when you left. Just what you can remember.
- If you don't mind, I might ask questions as we go along to help me understand your experience more.

(Taking notes and probing as appropriate to find more depth in descriptions).

At the end of the session description if not already mentioned:

- What was particularly helpful for you in the session? How did that help?
- How did you feel when imagining you were watching yourself in the film?
- How did you feel about the memory when you were "watching it"? (film going forwards and then backwards—I will not prompt with these words)
- How did the session come to a conclusion?
- How did you feel at the end of the session?
- Was there a least favourite part of the session? How did that make you feel?
- Was there a particularly favourite part of the session and how did that make you feel?

After the therapy:

- How do you think the session helped you? WHAT, HOW, WHEN
- Please can you tell me about how you felt it helped you in the days/weeks after your session?
- What did people around you notice, if anything, that you think was due to the session/s?
- How would this compare to other help you might have had for PTSD?
- Is there anything else at all that you would like to add that would help readers of the final report understand what it is like to have Muss Rewind for PTSD?

Debrief.

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