SWEDISH INSTITUTE FOR
COGNITIVE PSYCHOTHERAPY

THE SWEDISH INSTITUTE FOR
CBT/SCHEMA THERAPY

Client experience of one-session treatment with Modified Lifespan Integration (MLI) after sexual trauma

Degree Thesis:
Legitimate psychotherapy training with a focus on cognitive behavioral therapy
Swedish Institute for Cognitive Psychotherapy, Autumn 2020.

Supervisor:
Caroline Wachtler, Med. Dr, MD and specialist in general medicine

Co-supervisor:
Gita Rajan, MD, specialist in general medicine, doctoral student at Karolinska Institute and Director of WONSA

Examiner:
Stefan Borg, MD, associate professor at Karolinska Institute and Specialist in Psychiatry

*Aspects translated into English 4/6/2025. Original study completed in Swedish

Summary

Background: The study is part of the process evaluation of a randomized controlled trial conducted by World Of No Sexual Abuse (WONSA) and Karolinska Institute to evaluate the treatment effect of one-session treatment with Modified Lifespan Integration (MLI) for Posttraumatic Stress Disorder (PTSD) after single sexual trauma.

Purpose: To gain knowledge about how clients with PTSD symptoms resulting from sexual violence experienced one-session treatment with MLI.

Materials and methods: This is a qualitative interview study with five female clients who exhibited PTSD symptoms and who received one-session treatment with MLI. Semi-structured individual interviews were conducted and analyzed using deductive content analysis.

Results: MLI was experienced as a very intensive treatment method that aroused strong emotional reactions and also affected the body physically during the session. It was reported that the treatment led to reduced PTSD symptoms regarding avoidance, intrusive memories, physical symptoms, cognitive distortions and negative emotions. An increased ability to set limits was observed. Self-destructive behavior ceased.

Conclusion: Based on these results, there are good reasons to conduct continued research on the MLI treatment method.

Keywords: Sexual single trauma, PTSD, Lifespan Integration, MLI, one-session treatment

Foreword

To those I interviewed: Thank you for sharing your experiences and your time.
Thank you Caroline Wachtler for guiding me so professionally, kindly and patiently.
Thank you for your trust, Gita Rajan.

Method

Design

A qualitative interview study was conducted and a deductive content analysis was performed. The method was chosen so that as much experience-based knowledge as possible could be obtained, structured and analyzed. The study is part of the process evaluation of a randomized controlled trial (RCT) conducted by WONSA and Karolinska Institute to evaluate the effect of MLI on PTSD symptoms after sexual trauma.

Context

In the RCT, 36 participants were randomized to either treatment or waiting list control, all participants received treatment within the framework of the study. The treatment included an information meeting with a WONSA doctor and an MLI session (90 – 140 minutes). No follow-up conversation was included in this study (in clinical treatment, it is common for the therapist to meet the client for a 45-minute session before the MLI treatment and also offer a follow-up session).

Modified Lifespan Integration PTSD protocol. WONSA has combined the LI PTSD protocol with parts of another LI protocol (Standard protocol, see Pace, 2015) and thus created the Modified Lifespan Integration PTSD protocol (MLI) for single trauma (wonsa.se, 2020). See summary description of the MLI, preparatory information meeting and treatment session below:

Preparatory information meeting. Psychoeducation is given regarding PTSD and the theory on which Lifespan Integration is based. The purpose of the different treatment elements in the upcoming MLI intervention is clarified. The client is informed of the following; the importance of not terminating the treatment session prematurely, affect regulation in the event of strong emotions occurs by the therapist reading the timeline faster, the therapist will not provide space for reflection and comfort during the reading of the timeline, and that at the end of the session, when the client has calmed down, there will be space to reflect together. The therapist informs that the treatment session is set up in this way so that the PTSD symptoms will subside as quickly as possible.

The client is instructed to bring to the upcoming MLI session a written list of episodic memories (these “key memories” form the timeline) starting at the time the trauma just ended up to the present (in clinical treatment, clients who are unable to write the timeline can receive help with this from the therapist during the preparatory session).

MLI treatment session: Phase 1: Rapid exposure. With the support of the therapist, the client is asked to tell about what happened one or two weeks before the trauma. Then, about what happened just before the trauma and, in chronological order, about what happened during the trauma. If the client stops in the story, the therapist helps the client to move on by asking "what happened next?". While the client is telling the story, the therapist writes down "key memories", that is, a few words that follow the sequence of events, for example; "the door opens". In this way, a timeline is established that, together with the timeline the client wrote before the session, will be used by the therapist in phase 2.

Phase 2: 10–20 repetitions of the timeline. The client is asked to close their eyes (if possible).

The therapist begins by reading the timeline that the client has brought with them, which starts with a memory from when the trauma has just ended. The therapist then repeatedly reads the entire timeline (the traumatic event and the aftermath) to the client while the client internally visualizes the key memories leading up to the present. The therapist reads one key memory at a time, with the client signaling when she brings the memory to her internal vision. If the client notices that the key memories have been put in the wrong order or recalls more memories, these are written in the correct order on the timeline one by one.

Throughout the session, the therapist is sensitive to signs of overactivation and under-activation and regulates the client's activity level so that it is kept within the tolerance window. Signs of overactivation include increased breathing, tense muscles, changed facial color, and confused speech. Overactivation is regulated down, among other things, by the therapist reading the timeline faster (so that the client "moves through the memory" at a faster pace) or suggesting the client to open their eyes. If the client shows signs of not being emotionally affected (under-activated), the therapist can "raise the temperature" by, for example, reading the timeline more slowly, suggesting the client to close their eyes, and reinforcing the visualization by, for example, saying "can you see it in front of you?". When the client can visualize the sequence of events without becoming overactivated, phase 3 begins.

Phase 3: Re-script and timeline rehearsal. The therapist helps the client to revisit the trauma memory with their older self (the age the client is in the therapy room) in a visualization. Depending on what the younger self needs, the older self can, for example, comfort, help the younger self defend herself, express anger, or punish the perpetrator. The older self then takes the younger self to a safe place where the older self explains to the younger self that she has survived, that the traumatic event is over, and that she will now see what happened after the trauma. The therapist then reads the timeline starting from the key memory that comes just after the trauma is over and the rest of the timeline up to

the present. Further rehearsals with the entire timeline is done, with or without re-script, depending on what the client needs.

The session can be ended when the client is able to hear the therapist read out the entire timeline at a calm pace without becoming overactivated (wonsa.se, 2020).

Participants

Selection of participants for the RCT. Inclusion criteria: 15 years or older, a sexual assault that occurred 0 – 5 years before inclusion in the study. Exclusion criteria: language difficulties, substance abuse, multiple traumas, active psychotic illness, ADHD and autism spectrum disorder.

The treatments were carried out during the period March 2016 – June 2019.

Recruitment for the process evaluation. 21 clients who had undergone one-session treatment with MLI during the period spring 2018 – summer 2019 at the WONSAS specialist clinic were contacted via email in January 2020 and asked if they wanted to participate in the study. Along with information about the study (Appendix 2), an “Informed Consent” form (Appendix 3) was also attached. Five clients agreed to be interviewed face to face.

Data collection

A semi-structured research interview (Appendix 4) was used. The clients were booked in for an interview. Four interviews were conducted at the undersigned's workplace. One interview was conducted at the client's home. The interview time varied between 46–106 minutes. Before the interviews began, the clients were given the information that had also been sent to them via email on an earlier occasion. In connection with this, brief verbal information was also given about the purpose of the study and the undersigned's role. The "Informed Consent" form was also reviewed verbally.

The interviews were recorded on a voice recorder and then transcribed verbatim by a transcription company with a confidentiality agreement hired by WONSA. The recordings have been stored securely and, after the transcription was completed, were handed over to WONSA for further storage.

Analysis

All transcribed text was read repeatedly. The material was then coded briefly to identify meaningful units. To facilitate further coding of the material, a framework with different

sub-areas was created, which was based on the process that the individual went through before, during and after treatment. An overview of the different sub-areas of the framework can be found in Box 1.

1. Before the treatment
2. Information meeting
3. Expectations of the treatment
4. Tried other treatment before MLI
5. Phase 1. Rapid exposure (client tells the story)
6. Phase 2. Repetition of the timeline (therapist reads aloud)
7. Phase 3. Re-script and repetition of the timeline
8. Immediately after the treatment
9. Experience of the therapist
10. Experience of the treatment as a whole
11. Has anything changed after the MLI treatment?

Text box 1. Framework.

Each participant was assigned a number (26, 27, 28, 29, 30). Text passages related to the respective sub-area were then sorted into the framework. The texts were then read again, whereby meaningful units were identified and coded. The codes were then grouped within each sub-area and condensed into categories. See an example of the coding process in Table 1. The analysis was carried out in close collaboration with supervisor Caroline Wachtler. Based on the different sub-areas, the analysis is reported descriptively.

Table 1. Three examples of the qualitative analysis process.

Subarea	Citation	Code	Category
Rescript	“It wasn’t my fault”	Feelings of Guilt	Relief from Guilt
Has anything changed since the MLI treatment?	"...tried to make out with me, and then I pushed him away and walked away, and I'd never done that before"	Boundary setting	Able to set boundaries
Has anything changed since the MLI treatment?	“I am still very cautious, but I am not as scared”	Recognizing emotions	Emotions manageable

Ethical considerations

The ethics application had previously been approved (filing number 2015/1868–31/2). Participation has been voluntary and the clients have received both written and verbal information before deciding whether they wanted to give their written consent to participate in the study. All material has been de-identified, so no participant will be identified. The semi-structured interview has meant that the clients themselves have been able to influence what has been discussed. The focus has been on the experience of the MLI intervention. Although the focus of the interviews has not been on the sexual trauma itself, participation in the interviews has inevitably activated the memory of the trauma. All clients have been given the opportunity to contact the interviewer after the interview if any concerns arise. There has also been a readiness to contact a doctor at WONSA in case the interviews would negatively affect mental health. All of the above means that the value of receiving in-depth information about a new treatment method is judged to be greater than the risks for the study participants.

Results

The participants in this study were five women aged 18–38 years. All had sought treatment to deal with residual PTSD symptoms after experiencing a sexual trauma. Four of the five clients had experienced a significant single trauma. One client had also experienced severe sexual trauma after the trauma that was the focus of the MLI intervention. The clients received an information meeting and a treatment session with MLI.

Before treatment

All clients described a clear loss of function related to the sexual trauma. There were reports of easily aroused fear, crying and panic attacks in connection with reminders of what had happened, tense alertness, painful internal images, self-blame, strong feelings of shame, difficulty relaxing, nightmares, social isolation, lack of hope for the future, ruminations about what could have been done differently so that what had happened would not have happened, reduced ability to work and difficulties in setting limits. It emerged that previous self-destructive tendencies that a couple of clients had struggled with were reinforced after the trauma and led to accelerated self-harm and “acceptance” of further sexual violence. The strategies for trying to deal with the trauma have been many, for example; attempts to minimize what had happened in your mind, not telling anyone, active attempts not to think about the trauma and to withdraw from social contexts.

Tried other treatment before MLI. All clients had tried other treatment before MLI treatment but had not felt helped. They had previously sought help from psychologists and counsellors in child and adolescent psychiatry, the Youth Clinic, private psychotherapy and group therapy. It emerged that the clients had experienced a lack of competence among the therapists, a lack of a specific plan for processing the trauma and did not feel they fit into the group when attempting group treatment.

Expectations of the treatment. It emerged that it was experienced positively that the treatment would only consist of one session. Low expectations were also revealed. "Yes, because I just, if therapy doesn't work (had several different therapeutic contacts before) then this can't possibly work either (laughter). So I wasn't very optimistic" (29).

Information meeting. All clients remembered that the doctor who informed them of the upcoming MLI session drew on a whiteboard. There were descriptions of having felt well prepared for the upcoming treatment.

Phase 1: Rapid exposure (client tells)

In this phase, the client is asked to, with the support of the therapist, tell about what happened. While the client tells, the therapist notes down supporting words and sentences that follow the sequence of events.

Relief. There were experiences of relief at being able to tell exactly everything in detail and that it felt good not to have to take into account how this felt to the therapist.

More memories. It was testified that it was difficult to tell out loud.

"That was what I found to be kind of hard the first time actually telling it out loud, and it made me remember things even more when I started to go into even more detail, then I started to think – just yes but that's it, this is what he said, sort of" (30).

Worry about maybe not being believed. It turned out that there had been worry that the therapist would interpret an incoherent description of what had happened as if you were lying.

"It was hard to, well it was so hard for me to have a sequence of events that was right. And it became hard for me because then it was – did this actually happen, sort of? And things like that, you know I started to doubt myself and I just – is she (referring to the therapist) doubting me, sort of? And then I became very unsure and then I didn't feel good" (29).

Phase 2: Repetition of the timeline (the therapist reads aloud)

In this phase, the therapist reads the timeline aloud to the client. One memory at a time is read out, whereby the client visualizes the memory and signals to the therapist that she has made contact with the memory by, for example, nodding or humming.

Sorting together. It was described that in this phase it became possible to change the timeline so that the memories came in the correct order. “...if we say I told the story and she read it out and then maybe I just – no, it went wrong there and so we switched places between the two instead. And so we did that until I felt it was absolutely right, and then we started to unravel it” (29).

Attention to details and facts. It was reported that it was experienced as helpful that a lot of focus was on the facts. What actually happened, what the perpetrator did, what it looked like around. “It became more fact-based, so it was like this – what were you wearing? What was he wearing? What did his room look like? Something like that...then it almost took the focus off the trauma, more like a slideshow of what happened” (29).

Internal images/internal film. It was described that the sequence of events was played out as if in an internal slideshow or an internal film. “Because if I just sit and close my eyes and someone tells me in detail, almost minute by minute, the whole incident, then it becomes much more like a film being played out...” (30).

Physical reactions. Strong physical reactions were reported in connection with the activation of the traumatic memory. The descriptions included shaking, sweating, chills, tension, a lump in the throat, heaviness in the chest, stomach pain, tears and the feeling of being glued to the chair. "...I remember how my arms felt very heavy, stuck to the chair and how I sat a bit tensely backwards like this" (26).

The desire to avoid. Thoughts emerged about not wanting to hear more and wondering about the purpose of having to hear about the difficult thing over and over again. "So maybe what struck me was this - how many times am I going to have to hear this? (laughter) that's enough now...I'm going to break down" (27). There was evidence of wanting to protect oneself from the memories by nodding without having contact with the memory. "...I remember that it felt like I was blocking myself and creating a protection and just kind of nodding so that I could move on" (26).

Reduced discomfort the more times the therapist repeats the timeline. Strong feelings emerged of almost not being able to endure at the beginning of this phase. It was described that as the therapist repeated the sequence, it became more bearable to hear the timeline and to visualize the sequence of events in one's mind. "Er...that is, when I had heard her read it to me several times. It turned out that it got a little easier each time she read it out anyway, erm...the first time it was really, really hard..." (30).

The experience of being the one who told the story repeatedly. There were descriptions of being the one who told the story many times. "What I found helpful was just going through it over and over again and kind of being forced to do it almost to the point where you're like this - well, now I can't bear to tell it again..." (28). There was also testimony of the experience of the therapist reading the timeline a number of times and then repeating what the therapist had just read from the timeline.

Phase 3: Re-script and rehearsal of the timeline. In this phase, the client is given the opportunity to influence different parts of the course of the trauma memory by in a visualization entering into the action with their older self (the age the client is in the therapy room) and meeting their younger self (the age they were in the trauma situation). It was testified that this part of the treatment was experienced as very strengthening and touching. Being able to enter into the action with their older self and meeting their younger self was described as a turning point, it was in connection with this, that things calmed down inside. The clients comforted, relieved guilt, gave hope, patted their younger self and stood up for themselves against the perpetrator. There were descriptions of it feeling real, as if they were meeting their younger self for real.

Shame and guilt relief. Being able to go into the trauma memory and talk to oneself was described as an experience of reaching oneself in depth for the first time with the message that what had happened was not one's own fault. It was testified that it was valuable for one's younger self to hear "it wasn't your fault" as well as valuable for one's older self to be able to formulate and say this. "I was able to remove the blame from myself, eh I think that was probably where it was like a lot of not putting it on myself, that I hadn't done anything wrong. So that I think that's where it turned around in some way" (27).

Relief at being able to change. Relief emerged at having the opportunity to influence the situation. "You felt a little more like this, so like this more strength. You felt more eh powerful in the situation, instead of being a mouse and then I became a lion" (29). Realization that time has passed. It was described that the visualization brought the realization that time has passed and that life has continued.

> “You (the younger self) are a part of me but you…you like…it's not me now. Or so…I'll take care of you but that…that…and so your vulnerability is not mine, or so…you have grown up anyway” (26).

Immediately after the treatment.

A feeling of fragility, vulnerability and confusion was described when the clients left the clinic. There were experiences of being physically sore all over the body, fatigue and a need to sleep. It was testified that the trauma memory was clearer in the week following the MLI treatment and that this was experienced as difficult, but that it felt better afterwards.

> “But since then I have felt good. But I also think that it is a bit because I…so now I can, now I don't have to think about it in the same way, but when I think about it, it becomes a bit difficult of course” (29).

It was expressed that the MLI session had been so demanding that it was good that it was only one session.

> “Then afterwards I was interested in seeing if it could actually help. If I would need to go back, because I probably wouldn't have been able to do that at the time” (29).

Aftercare needs. It emerged that it felt lonely to leave the clinic for those who had no one to meet after the session and that it might have felt better if a friend or family member had shown up. Thoughts emerged that it would have been nice to stay at the clinic for a while after the treatment, perhaps to be offered some coffee.

Experience of the therapist

Appreciation emerged that the therapist was neutral and did not seem emotionally affected, that the therapist was experienced as calm, humble and attentive.

> "...I think she saw and heard me and that I was very sad and that I think she noticed it" (27). It was testified that it felt unsafe and uncomfortable to only meet the therapist once. "...I felt that it was a bit strange to...go through all this with a person you have not met before" (26).

Overall treatment experience

All clients described the treatment as demanding. They expressed understanding that the different treatment components were necessary and that in retrospect it was not seen as a negative thing that it really hurt here and there.

"I would say that everything was very difficult and stressful in different ways. I wouldn't say that anything was less difficult. But I think that everything was very necessary, I think" (29). One client stood out by describing that she was calm and focused throughout the treatment session. This client had experienced severe sexual trauma after the rape that was the subject of this MLI treatment (nearer present). For her, it was distracting that "fresher" traumas were included in the timeline (28).

Perspective. There were descriptions of the memory "opening up", so to speak. That one remembered more, saw the context from a helicopter perspective, saw what one could have done differently and could not have done differently.

Less alone. There were descriptions of no longer feeling so alone. This was related to both the preparatory information meeting and the treatment session. "Then it became like this – oh, this is someone who knows what I have been through now" (28).

Difficulty trusting a stranger. One client described that it felt difficult to tell a complete stranger about the abuse and that insecurity came to characterize the entire treatment session. The client did not close her eyes and she felt unable to communicate to the therapist that the pace of the timeline being read did not feel good and that she did not get in touch with the memory images that were read out. She felt a need to talk during the session, but did not feel that there was space for this. She felt that the treatment session was too short and that she did not feel finished when the session was over. Thoughts emerged that it would have felt better, safer and less lonely if the therapist had also been

the person who had provided the information about the upcoming MLI treatment and that it would have been good to have a return visit after the treatment (26).

Has anything changed after the MLI treatment?

It was expressed that one would probably always be affected by what happened but that the MLI treatment had reduced the mental and physical impact.

All the pieces were in place. It emerged that it was felt to be crucial to have received help with getting all the parts of the trauma memory in place and that this was seen as the reason why intrusive image memories had ceased.

Fewer stimuli linked to the perpetrator. It was testified that the MLI treatment resulted in reduced connections between different stimuli and the perpetrator.

> "...if I smelled a perfume or something, then I went crazy and got all the images in my head...like a camera roll, sort of. But now it's...now I don't get it anymore, I don't know...it's just stopped completely...", "...So now there's not as much at all that reminds me of him. Because before it was like I was so afraid of getting the images in my head, that I always got them in my head. Now I don't have to think about it" (29).

It is possible to think about and talk about the trauma. It was described that the memory of what happened was still there and that the memory had also become clearer. It was stated that it was still difficult to think about the event, but that thoughts of what happened no longer took over and affected the whole day. It was also stated that it actually no longer felt difficult to approach the memory.

> “I would say that it (the memory) is clearer, definitely much clearer and I don’t think it is difficult to approach the memory anymore. Before, when I approached it, I was like this, you back away and start thinking about something else just out of habit because you think that this is a terrible thing that I don’t want to think about” (28).

It emerged that it had become possible to talk about what you had been through.

> “I can talk about it without breaking down. I can admit it to myself and others” (27), “...I think it’s nice if someone knows that I’ve been through it, erm my family knows it. It feels kind of nice not to carry it myself...” (30).

Feelings more manageable. It was stated that after undergoing MLI treatment, it was possible to be professional at work, even when the trauma memory was activated. It was described that an unexpected meeting with the perpetrator after MLI treatment had been frightening, but that it was possible to gather oneself fairly quickly afterwards and continue

the evening as planned. It was described that the fear and discomfort remained but that it was not as strong. “I’m still very cautious, but I’m not as scared” (29).

Shame and guilt relief. It was stated that after the MLI treatment there had been a shift from having felt shame and not wanting anyone to know what had happened to no longer feeling shame. From having been tormented by feelings of guilt to no longer blaming oneself.

> “I still remember it the same way, if I think about it and such, but it’s just that I don’t… I don’t blame myself anymore, erm, I just feel sorry for myself” (30).

Self-compassion. There was evidence of a newfound self-respect and a more forgiving and kind attitude towards oneself. An increased understanding was described that what had happened continued to affect in different situations and that it was not strange, for example, to not be able to relax even though several years had passed since the incident. The clients who told of having self-harmed and found themselves in sexual violence to a greater extent than before after the sexual trauma they had been exposed to, testified that after the MLI treatment this had completely stopped. There emerged an experience that the encounter with the younger self (in the visualization) had also resulted in the contemporary self getting something back in the form of an insight into not being so hard on itself. There emerged a shift from having pondered over what one could have done differently (because it had happened should not have happened) to being able to think "...it happened, it can't be changed but you're good"
(29).

Strengthened confidence in one's own ability. There were experiences of having contributed to the treatment being effective to the greatest extent by being able to give one's younger self what she needed in the visualization.

> "If you tell yourself that you are worthy, then it is a very powerful feeling" (29). "I was able to remove the blame for myself" (27).

Setting boundaries. "Setting boundaries" here refers to the ability to perceive what feels okay or not okay for oneself and to be able to communicate this to the people involved. It was stated that the MLI treatment had meant a shift from having difficulty setting boundaries to this being significantly better after the treatment. It was described that the acquired ability to set boundaries had been useful in sexual relationships, in the event of unwelcome approaches at the pub and even with friends.

> “I have always had a hard time saying no, but I really felt that I had a very easy time…I had a much easier time setting limits for myself in general after that” (28).

Feeling of being able to live with what had happened. It became clear that the lack of hope for the future had been replaced by thoughts that there was probably a future after all.

> “Before, I kind of thought that he had ruined my life and I would never feel good again. Now I can see a future for myself, even if it is not very positive, it is still a future”, “Before, I was like this, if someone who knows me can do something, then anyone can do it. But now I am trying to change that mindset” (29).
>
> “…as soon as I see him, it is like he is not a real person, so it is like it really comes as a shock. But I can somehow live with it” (30).

Gratitude. Gratitude was expressed for having been given the opportunity to undergo the treatment. There were concerns about whether the method could also be used for other types of trauma and hopes that more people would have the opportunity to undergo the treatment.

References

Aakvaag. H. F., Thoresen. S., Wentzel-Larsen. T., Dyb. G., Röysamb. E., Olff. M. (2016). Broken and guilty since it happened: A population study of trauma-related shame and guilt after violence and sexual abuse. Journal of Affective Disorders. 204 (16–23).

American Psychiatric Association. Översättning till svenska av Herlofson, J. (2014) MINI-D 5 Diagnostiska kriterier enligt DSM-5. Stockholm: Pilgrim Press AB.

Amir, N., Stafford, J., Freshman, M. S., Foa, E. B. (1998). Relationship Between Trauma Narratives and Trauma Pathology. Journal of Traumatic Stress. 11 (2).

Arntz, A., Tiesema. M., Kindt, M. (2007). Treatment of PTSD: A comparison of imaginal exposure with and without imagery rescripting. Journal of Behavior Therapy and Experimental Psychiatry. 38 (4), 345–370.

Badour, C.L., Resnick, H.S., Kilpatrick, D.G. (2017). Associations Between Specific Negative Emotions and DSM-5 PTSD Among a National Sample of Interpersonal Trauma Survivors. Journal of Interpersonal Violence. 32 (11), 1620-1641.

Baker, R., Coenen, P., Howie, E., Williamson, A., Straker, L. (2018). The Short Term Musculoskeletal and Cognitive Effects of Prolonged Sitting During Office Computer Work. International Journal of Environmental Research and Public Health. 15 (8):1678.

Balkus, B. (2012). Lifespan Integration effectiveness in traumatized women. A dissertation to fulfill the requirement for a Doktor of Psychology in counseling psychology at Northwest University, USA.

Contractor, A. A., Weiss, N. H., Dranger, P., Ruggero, C., Armour, C. (2017). PTSD ś risky behavior criterion: Relation with DSM-5 PTSD symtom clusters and psychopathology. Psychiatry Research. 252, 215-222. doi: 10.1016/j.psychres.2017.03.008.

Covers, M., Jongh, Ad De., Huntjens, R, J., De Roos, C., Van Den Hout, M., Bicanic, I. A. (2019). Early intervention with eye movement desensitization and reprocessing (EMDR) therapy to reduce the severity of posttraumatic stress symptoms in recent rape victims: study protocol for a randomized controlled trial. European Journal of Psych traumatology 10 (1).

Ehlers, A. & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder: Behaviour Research and Therapy. 38 (4). 319–345. https://doi.org/10.1016/S0005-7967(99)00123-0

Faravelli, C., Giugni, A., Salvatori, S., Ricca, V. (2004). Psychopathology after rape. The American Journal of Psychiatry. Published online: https://doiorg.sll.idm.ocic.org/10.1176/appi.ajp.161.8.1483

Figley, C. R. (1995). Compassion Fatigue, Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized. New York: Taylor & Francis Group.

Foa, E. B. (1997). Trauma and women: course, predictors, and treatment. The Journal of Clinical Psychiatry. 58 Suppl 9:25-8.

Foa, E. B. (2007). Emotionell bearbetning vid PTSD – Terapeutmanual vid traumafokuserad KBT. Stockholm: Natur och Kultur.

Grunert, B, K., Weis, J, M., Smucker, M, R., Christianson, H, F. (2007). Imagery rescripting and reprocessing therapy after failed prolonged exposure for post-traumatic stress disorder following industrial injury. Journal of Behavior Therapy and Experimental Psychiatry. 38 (4).

Hensel-Dittmann, D., Schauer, M., Ruf, M., Catani, C., Odenwald, M., Elbert, T., et al. (2011). Treatment of traumatized victims of war and torture: A comparison of narrative exposure therapy and stress inoculation training. Psychotherapy and Psychosomatics. 80 (6), 345-52.

Holmes, E, A., Arntz, A., Smucker, M, R. (2007). Imagery rescripting in cognitive behavior therapy: Images, treatment techniques and outcomes. Journal of Behavior Therapy and Experimental Psychiatry. 38 (4), 297-305.

Horesh, D., Qian, M., Freedman, S., Shalev, A. (2016). Differential effect of exposure-based therapy and cognitive therapy on post-traumatic stress disorder symptom clusters: A randomized controlled trial. Psychology and Psychotherapy.

Hu, M. (2014). Lifespan Integration efficacy: A mixed methods multiple case study. Trinity Western University.

Imel, Z. E., Laska, K., Jakupcak, M., Simpson, T. L. (2013). Meta-analysis of dropout in

treatment for posttraumatic stress disorder. Journal of Consulting and Clinical Psychology. 81(3), 394-404.

Keefe, J.R., Stirman, S. W., Cohen, Z. D., DeRubeis, R. J., Smith, B. N., Resick, P. A. (2018). In rape trauma PTSD, patient characteristics indicate which trauma-focused treatment they are most likely to complete. Depression & Anxiety. doi:10.1002/da.22731.

Kessler, R. C. (2000). Posttraumatic Stress Disorder: The Burden to the Individual and to Society. The Journal of Clinical Psychiatry, 61 (5), 4-12.

lifespanintegration.com. Hämtad 23 augusti, 2020 från http://www.lifespanintegration.com

Messman-Moore, T. L., Ward, R. M., Brown, A. L. (2008). Substance use and PTSD symptoms impact the likelihood of rape and revictimization in college women. Journal of Interperson Violence. doi: 10.1177/0886260508317199

Michel, P-O. (Red.) (2018). Psykotraumatologi. Lund: Studentlitteratur.

Morina, N., Lancee, J., Arntz, A. (2017). Imagery rescripting as a clinical intervention for aversive memories: A meta-analysis. Journal of Behavior Therapy and Experimental Psychiatry. 55, 6-15.

Mörkved, N., Hartmann, K., Aarsheim, L. M., Holen, D., Milde, A. M., Bomyea, J. et al. (2014). A comparision of Narrative Exposure Therapy and Prolonged Exposure therapy for PTSD. Clinical Psychology Review. 34 (6), 453-467. http://doi.org/10.1016/j.cpr.2014.06.005

Nishith, P., Resick, P. A., Griffin, M. G. (2002). Pattern of change in Prolonged Exposure and Cognitive-Processing Therapy for female rape victims with Posttraumatic Stress Disorder. Journal of Consulting and Clinical Psychology. 70 (4), 880-886.

Pace, P. (2015). Lifespan Integration: Connecting ego states through time. Eirene Imprint.
Powers, M. B., Halpern, J. M., Ferenschak, M. P., Gillihan, S. J., Foa, E. B. (2010). A meta–analytic review of prolonged exposure for posttraumatic stress disorder. Clinical Psychology Review 30(6), 635-641. doi: 10.1016/j.cpr.2010.04.007.

Rajan, G., Wachtler, C., Lee, S., Wändell, P., Philips, B., Wahlström, L., et al. (2020).
A one-session treatment of PTSD after single sexual assault trauma. A pilot study of the WONSA MLI project: A randomized controlled trial. Journal of Interpersonal Violence.

Resick, P. A., Schnicke, M. C. (1993) Cognitive processing therapy for rape victims: A treatment manual. Newbury Park. CA: Sage.

Sareen, J., Cox, B., Stein, M. B., Afifi, T. O., Fleet, C., Asmundson, G. J. (2007). Physical and mental comorbidity, disability, and suicidal behavior associated with posttraumatic stress disorder in a large community sample. Psychosomatic Medicine. 69 (3), 242-248.

Siegel, D. J. (1999). The Developing Mind (2nd rev. ed.). New York. The Guilford Press.

Socialstyrelsen (2020). Hämtad 29 augusti 2020 från http://roi.socialstyrelsen.se/riktlinjer/posttraumatiskt-stressyndrom-vuxna

Stenmark, H., Catani, C., Neuner, F., Elbert, T., Holen, A. (2013). Treating PTSD in refugees and asylum seekers within the general health care system. A randomized controlled multicenter study. Behaviour Research and Therapy. 51 (10), 641-647.

Tiihonen Moller, A., Backstrom, T., Sondergaard, H. P., Hellstrom, L. (2014). Identifying risk factors for PTSD in women seeking medical help after rape. PLOS ONE. https://doi.org/10.1371/journal.pone.0111136

WONSA, 2020. MLI-manualen finns på wonsas hemsida. Gå in på hemsidan och klicka dig fram följande steg: Forskning–Publicerade studier–Manual. Hämtad 20 november, 2020 från http://www.wonsa.se

Yehuda, R., Lehrner, A. M., Rosenbaum, T. Y. (2015). PTSD and Sexual Dysfunction in Men and Women. The Journal of Sexual Medicine. 12 (5), 1107–1119. https://doi.org/10.1111/jsm.12856