Narrative interventions to treat psychopathology in persons with personality pathology and other populations: a mixed-methods systematic literature review

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Master Thesis

September 23, 2024

Abstract

Introduction

Narrative identity is a promising conceptualisation of identity that can possibly help people with personality disorders or other forms of psychopathology. Narrative interventions have been on the rise in the last decade and show promising results in reducing psychopathological symptoms, but no comprehensive review has been done on them. This review explores the characteristics, effectiveness, and client as well as counsellor experiences of narrative interventions for differing populations with psycho- or personality pathology.

Method

A mixed-methods systematic review was conducted. Five bibliographic databases were searched without study design restrictions, and manual selection methods of expert sources, previous searches, and reference tracking were used. A thematic analysis was done on client and counsellor experiences, which was integrated with quantitative results of effects in a meta-synthesis. This study was registered with the PROSPERO systematic review database (CRD42024526703).

Results

Thirty-six studies met the inclusion criteria. Most studies targeted people with depression, trauma, or anxiety in various countries. Interventions were categorised into four types: Narrative Exposure Therapy, Narrative Enhancement and Cognitive Therapy, reminiscence therapies, and other narrative interventions. Although characteristics varied across all four categories, three core elements could be identified: identity development, support/feedback from counsellor/peers, and agency enhancement. Various outcome measures were assessed by studies, and psychopathological symptoms were most consistently improved. Despite being positive, client and counsellor experiences of changes were not reflected by study measurements.

Conclusion

While the field is still in its infancy, narrative interventions present an alternative treatment option to people with psychopathology and especially personality disorders with promising effectiveness and longevity, high feasibility and acceptability. Further research is needed to examine the effectiveness of separate elements employed within interventions, explore online opportunities, which processes are at play that improve psychological complaints/wellbeing, longevity of effects, which target groups benefit most from narrative interventions, and explore participant experiences more often.

Introduction

Background

Personality disorders (PDs) are "long-standing disturbances within multiple domains of individuals' experience and understanding of themselves" and people with PDs tend to have "difficulties in engaging adaptively with others" (Lind et al., 2020, p.1). On a global level, it is estimated that 10-13% of the population have a personality disorder and PDs are diagnosed in 40-60% of psychiatric patients, thus being the most common of all psychiatric diagnoses (Hull, 2021). PDs, such as borderline personality disorder (BPD), tend to manifest in a range of symptoms that can result in serious clinical problems which have a detrimental impact on the patient's mental wellbeing (Lind et al., 2020; Paris, 2020). Moreover, many people with PDs have comorbid mental disorders, e.g., depression or substance use disorder, adding onto the already heavy mental toll that these clients experience (Lind et al., 2020). Consequently, making accurate diagnoses and using effective treatments is of utmost importance in this population, which may be an issue as controversies surrounding the diagnosis as well as treatment of PDs remain (Kim & Tyrer, 2010; Kramer et al., 2022).

Identity and Treatment of PDs

Although there has recently been some controversy regarding to how to diagnose PDs due to differing diagnostic systems that are either not well-implemented in practice or do not accurately portray PDs (Paris, 2020; Sharp & Wall, 2021), in general it can be said that people with PDs perceive difficulty in their identities, interpersonal relationships, and functioning within society (Lind et al., 2020). While more pronounced in people with BPD, disturbances in identity can be found in any person with a PD, thus making identity a crucial part of these disorders (Lind et al., 2020; Pilarska & Suchańska, 2015). Identity is thought to develop early on in infancy, to be most crucial in late adolescence, and is continuously in development throughout the rest of one's life (Marcia, 2006). Identity-related deficits, such as one's sense of identity and self-direction, are thus diagnostic criteria for diagnosing PD in an individual (Pilarska & Suchańska, 2015). Some of the resulting symptoms are, according to Millon (2004, as cited by Pilarska & Suchańska, 2015), adaptive rigidity (limited repertoire of coping mechanisms in different situations and problems), the destructiveness of coping strategies (vicious circles of pathological behaviours), and fragile balance (lack of stress tolerance, susceptibility to destabilisation of coping mechanisms). These overlap with the criteria of the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013), which add that the impairments are relatively stable across time and consistent across situations.

Despite the importance of a healthy identity to people with PDs, treatment of PDs is usually not focused on it. While there is no equal focus on each diagnosable PD, there are various treatments for PDs. For people with BPD, dialectical behaviour therapy, mentalisation-based therapy, transference focused psychotherapy, and schema therapy seem to be effective at mitigating symptoms (Dixon-Gordon et al., 2011; Woodbridge et al., 2021). Cognitive behavioural therapy (CBT), psychoanalytic therapy, or even family-based interventions may help people with antisocial PD. People with schizotypal or paranoid PD may benefit from CBT as well, but they also often undergo psychodynamic or cognitive therapy. As for people with avoidant PD, treatments usually include behavioural interventions (e.g., social skills training, graduated exposure), CBT, psychodynamic therapy, cognitive therapy, and metacognitive interpersonal therapy. However, regardless of this variety of therapies available for people with different PDs, patients sometimes do not respond to treatment (Woodbridge et al., 2021). Additionally, not enough research has been done to affirm that treatments for PDs, especially those that are not borderline or antisocial, are effective (Woodbridge et al., 2021). As such, finding an effective treatment for individuals with this type of psychopathology proves to be difficult as the richness of a person is not considered.

The Narrative Approach and Interventions

One solution to the issue of treatment may lie within the narrative approach. The narrative approach, or narrative identity, is a concept that has gained more interest within the past decade, as it is not only able to contextualise disturbed identity in people with personality pathology, but also offers an alternative model to pathology that is not only focused on symptoms but on recovery as well. More specifically, the narrative approach entails the "dynamic and evolving story people construct about their personal pasts, presents, and futures" (Lind et al., 2020, p.1). Narrative identity is then relevant to PDs as one of the key domains of impairment within PD is a disturbed sense of self which can be explored with narrative identity as an operationalisation by narrating one's sense of self and ways of relating to others (Shiner et al., 2021). Moreover, narrative identity is strongly associated with psychological wellbeing on an individual level through its contribution to a sense of self-continuity, but also on an interpersonal level due to the ability to explicate functions used to develop, maintain, and enhance social bonds with others that are crucial for long-lasting social relationships (Lind et al., 2020). One way in which narrative identity is used is through *The Life Story Interview,* which is a semi-structured interview in which participants are asked to describe major chapters in their lives, recalling key moments in detail (e.g., high points, low points, turning points) and discussing their values and goals. As opposed to a structured interview, a semi-structured

interview explores complex issues through probes and spontaneous questions that deepens the psychologist's understanding of the client (Wilson, 2014). Consequently, the client's narrative identity is explored through the interview which can then be investigated for any disturbances within thematic elements, structural features, and explicit content (Lind et al., 2020). As such, the approach encompasses a richness of a person that is often lacking in traditional diagnosis and treatment of psychopathology where only the current symptoms and past of a person are investigated, regardless of whether the client has a PD or other psychopathology.

Within the past two decades, the narrative approach has been used for treatment instead of solely being used as framework to explore a patient's issues. The content of these interventions is focused on the person's identity or life story which is either told orally or written down (Ellis & Jones, 2022; Lamers et al., 2015). The interventions tend to either be one-session long or comprised of multiple sessions (Fan et al., 2021; Pol et al., 2023). One-session narrative interventions place emphasis on the patient being able to talk freely about their life-story, whereas multiple session interventions either build up their sessions to culminate in a creative end-product (Pol et al., 2023; Willemse, 2009), or they are an add-on to standard treatment (Steuwe et al., 2016). Interventions can either be group- or individual-based, where the group format enables discussion between participants and sharing of similar experiences and the individual format reinforces processing of one's life story (Beernink & Westerhof, 2020; Steuwe et al., 2021). Further, some interventions are established as protocolised therapies that are actively embedded into therapy plans, such as narrative exposure therapy or narrative enhancement and cognitive therapy (Schauer et al., 2011; Yanos et al., 2011). As for the working mechanisms, it is generally thought that narration is something innately human that not only comes natural to people but is also a cross-cultural phenomenon, thus making it effective in alleviating psychopathological symptoms in varying populations (Ellis & Jones, 2022; Fan et al., 2021). Moreover, by telling and reflecting on one's story, people may be able to develop themselves and organise emotional or traumatic memories into a coherent story that gives them a sense of purpose and meaning in life (Adler, 2012; Habermas & Bluck, 2000). In a more recent empirical and conceptual review regarding narrative identity and PD by Lind and colleagues (2020), the authors suggested that treatment should address narrative identity disturbances through [1] life story reconstruction, [2] the centring of therapist-client collaboration, and [3] construction of agentic and redemptive stories. But to what extent these foci are addressed within interventions is unclear.

Although there are systematic reviews that focus on specific types of narrative interventions, none yet exists for the evaluation of different interventions and what their

characteristics, effects, nor client and counsellor experiences are. Thus, this review includes a multitude of studies with different designs. While originally intended to be a review focusing on narrative interventions for people with PDs, a preliminary search showed that little studies focused on this target group, resulting in studies on different target groups being included in the final selection of articles.

Thus, this systematic review will explore the following research questions:

1. What are characteristics of currently existing narrative interventions for psychopathology and PD in particular?
2. What is the effectiveness of narrative interventions on psychopathology in different populations and in PD in particular?
3. What are reported experiences of clinicians and participants who did a narrative intervention?

Methods

As the field of narrative interventions is still in its infancy, study designs varied greatly across articles. Thus, this systematic review followed a mixed-methods design, including both qualitative and quantitative data and did not exclude any study design. The PRISMA guidelines for reporting of systematic reviews (Page et al., 2021) were followed. This study was registered with the PROSPERO systematic review database (CRD42024526703).

In- and exclusion criteria

The in- and exclusion criteria were continuously discussed between the researchers before and during the screening process. Included were any articles that were [1] peer-reviewed, [2] empirical research (quantitative and qualitative), [3] written in English, [4] about life stories or self-defining memories, and [5] about an intervention that targets people with psychopathology. Excluded were interventions [6] that target mental flourishing only (instead of treating psychopathology), [7] that target cognition only, [8] where the narrative elements are only about autobiographical memories (no reconstruction or integration of new insights or emotions), [9] interventions for children, and [10] interventions for people with dementia (due to cognitive focus/continuous cognitive decline).

Information sources and search strategy

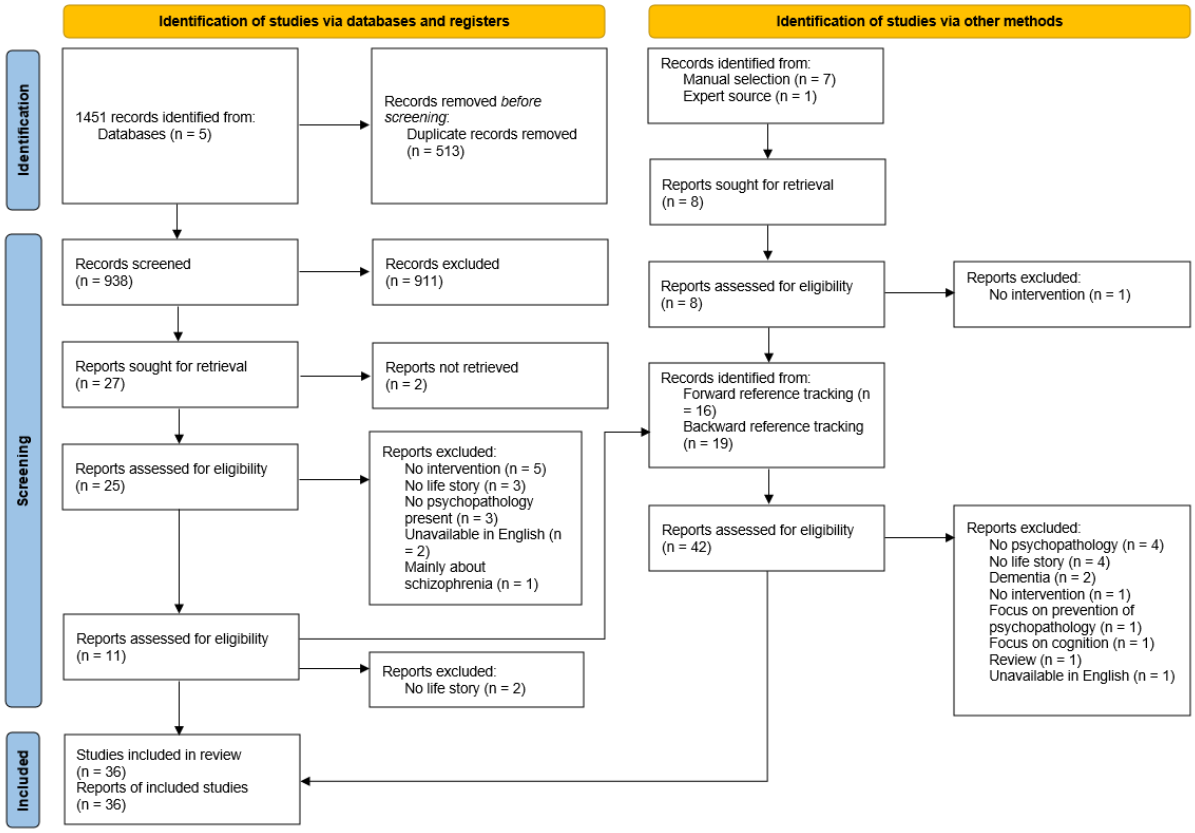
To identify published literature, five databases were used: Scopus, EBSCOhost PsycINFO, EBSCOhost PubMed, Web of Science, and Ovid EMBASE. An information specialist was consulted to refine the search strategy and initially proposed research questions were used for the key concepts of "narrative interventions" and "personality disorders". These terms were further broken down into related terms (narrative approach; personality pathology), narrower terms (narrative self, narrative identity; dissociative identity disorder, personality disorder interventions, personality disorder features), and broader terms (life stories, therapeutic intervention, therapeutic change, clinical trial; psychopathology, mental disorders, mental illness, psychiatric illness, psychiatric disorder) before integrating them into a search string. The final search was conducted on 22nd December 2023 using the search string in Appendix (see Appendix A).

Screening

In total, 1451 records were found which were screened by two researchers (VML and SMP) on title and abstract. To gain a better understanding of the field of narrative intervention studies, a preliminary selection of intervention articles was made by each researcher and disagreements and uncertainties regarding the eligibility were resolved in discussion, and a selection of 18 articles was made (see Figure 1). This selection consisted of eleven studies identified via databases and seven studies via manual selection/expert source. Forward reference tracking was conducted on this selection of articles, which resulted in 16 new articles being included. Finally, backward reference tracking was conducted on these 34 articles, which led to another 19 articles being considered for the final selection. This totalled to 53 studies that were assessed for eligibility. After adjustment of the in- and exclusion criteria and further discussion between the two researchers, a final selection of 36 articles remained. See Figure 1 for the flow of studies.

Figure 1

Flow of studies



Note. Adapted from Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., & McGuinness, L. A. (2021). The PRISMA 2020 statement: an Updated Guideline for Reporting Systematic Reviews. *British Medical Journal*, *372*(71). doi: 10.1136/bmj.n71

Data extraction

Data extraction was conducted with Excel and Word by the aforementioned researchers. We extracted both intervention and study characteristics. Intervention characteristics were: [1.1] name of intervention, [1.2] target group, [1.3] mode of delivery (setting, guidance, oral or written delivery, group or individual setting), [1.4] narrative elements or methods, and [1.5] tailoring. For study characteristics, information on [2.1] design, [2.2] population and sample, [2.3] outcome measures, [2.4] feasibility (dropout, attendance, acceptability), and [2.5] study goal achievement was extracted. Qualitative data on intervention experiences (citations and

questionnaires) by both participants and implementation team (if available) were extracted in full for text analysis.

Quality Appraisal of Studies

The methodological quality was assessed with the Mixed Method Appraisal Tool as different study designs are included (MMAT; Hong et al., 2018). Studies were rated using the criteria of a chosen study design category (qualitative research, RCTs, non-randomised studies, quantitative descriptive studies, and mixed-methods studies). These result in scores out of five for single method studies and out of 15 for mixed method studies. To avoid the oversimplification of scores, a full overview of the scoring is given. Excluding studies with low methodological quality tends to be discouraged by the authors of the tool (Hong et al., 2018).

Analysis

All data was analysed by the same two researchers independently. Since a meta-analysis of quantitative evidence was not appropriate due to the diversity of studies (regarding setting, participants, and outcome measures), a narrative analysis was conducted instead. To answer the first research question, intervention characteristics were extracted from the articles by collecting information on the narrative elements/methods employed in the intervention, deviations from the original protocol of the intervention (if applicable), and how it was delivered to the target group (setting, duration, homework). To investigate the effectiveness of the interventions, data on outcome measures and study characteristics (design, population/sample, feasibility (dropout, attendance) were collected. Moreover, whether the study goal was achieved was collected, too. Lastly, a thematic synthesis on qualitative data was conducted and data on satisfaction with treatment was collected (satisfaction scale, outcomes of qualitative evaluations of intervention elements). The thematic synthesis was conducted as described by Thomas and Harden (2008) in which the extracted text was semantically and latently coded ‘line-by-line’. The extracted texts, 157 in total, were quotes that were available in the articles and in supplementary material (e.g., “I have gained more self-confidence” (20)). Then, descriptive themes were developed, and analytical themes were generated. During synthesis, any disagreements by the researchers were resolved in discussion until a consensus was reached. Finally, qualitative and quantitative findings were integrated by comparing the findings of both syntheses.

Results

A total of N = 36 articles met the inclusion criteria, which were published between 2004 – 2023. Most (N = 25) were published in the last ten years, 13 of which in the last five years. Most (N = 32) articles presented main studies, with twelve articles presenting initial evaluations (2, 12, 31, 32, 35) and preliminary or pilot studies (4, 11, 14, 17, 24, 25, 30).

Characteristics of Existing Narrative Interventions

Four types of narrative interventions could be distinguished: Narrative Exposure Therapy (NET; N = 14; 1 – 14), Narrative Enhancement and Cognitive Therapy (NECT; N = 5; 15 – 19), Reminiscence Therapies (N = 8; 20 – 27), and 'others' (N = 9; 28 – 36). Most commonly targeted were people with trauma (N = 15; 1 – 14, 21), people with depression (N = 12; 20 – 23, 25, 26, 28, 29, 31, 34 – 36), and people with severe mental illness, i.e., psychotic disorders, major depressive disorder, or personality disorders that severely impact the person's functioning (N = 9; 15 – 19, 24, 30, 32, 35). Only four studies targeted solely people with personality disorder/pathology (BPD: 9, 12, 13; PD: 31), while three studies included people with PDs in their sample (17, 35, 36). Studies were conducted in different countries, with most (N = 11) being offered in the Netherlands (5, 7, 17, 20, 24 – 27, 29, 31, 36), four in the United States of America (USA; 4, 19, 23, 35), three in Germany (9, 12, 13), three in Iran (6, 22, 34), two in China (3, 14), two in South Korea (10, 33), two in Taiwan (16, 21), and one in each of these countries: Sudan (2), Uganda (8), Jordan (11), Israel (18), Saudi Arabia (1), Sweden (15), Portugal (28), Canada (30), and Chile (32). Details about each intervention category follow in the next sections and can also be found in Tables 1.1 (NET & NECT), 1.2 (reminiscence therapies), and 1.3 (other).

Narrative Exposure Therapy (NET)

NET is a manualised therapy developed by Schauer and colleagues (2011) in which the participant gives a detailed autobiography that is revised throughout the intervention. As it is a trauma-focused therapy, traumatic events and fragmented traumatic memories are integrated into a coherent narrative and a lifeline is either drawn on paper with flowers as happy events and stones as sad/traumatic events or other materials like rope. After the lifeline, the client narrates their traumatic experience slowly in chronological order as they experienced it. Meanwhile, the client is encouraged by the counsellor to relive trauma-related emotions and

asked about emotional, cognitive, and behavioural reactions to achieve emotional habituation. The processing of experiences and transformation of the fragmented memories into a coherent narrative thus offers the client a new life perspective. At the end of therapy, the client gets either a physical or oral recording of their life story. As such, there are three core elements to this treatment: namely identity development (lifeline), counsellor support (guidance), and agency enhancement (lifeline, perspective change).

According to the manual, there are three parts to the structure of NET with different durations given as a guideline (Schauer et al., 2011). Part 1, which consists of a structured clinical interview to assess trauma spectrum disorders, event checklists, and psychoeducational introduction, typically lasts one to two sessions, each lasting about 90-120 minutes. Part 2, which is optional, concerns the creation of the lifeline with their autobiography, and lasts one session of 90-120 minutes as well. Lastly, part 3 is the core part and concerns the narrative exposure itself, with a duration of about four to 12 sessions, also of 90-120 minutes.

There were some deviations from the protocol. For duration, the shortest span the treatment was given in was 1-2 weeks (14) and the longest was 16-17 weeks (7; 9), with an average of 8.5 sessions. While duration of the treatment depends, three interventions were shortened to three weeks or less to fit the target groups' circumstances (1, 4, 14). Other deviations from protocol included cultural and lingual adaptation which was previously discussed with a focus group (2) and by focusing on a singular traumatic event more intensely (14). Moreover, the creation of the lifeline was nearly always explicitly included despite being optional in the original protocol (N = 12).

All 14 studies on NET interventions targeted people with trauma (1, 10, 14), posttraumatic stress disorder (PTSD; 2, 4 – 9, 11 – 13) or PTSD symptoms (3). Of these, five studies targeted refugees (2, 4, 8, 10, 11), two targeted survivors of natural disasters (6, 14), and one each targeted firefighters (1), COVID-19 patients (3), older patients (5), and people with severe mental illness (or serious mental illness, i.e., psychotic disorders, major depressive disorder, or personality disorders that severely impact the person's functioning; 7). Moreover, this intervention was also delivered to people with BPD (9, 12, 13). Interventions were carried out in different countries with different ethnicities being targeted, with three studies targeting people in Germany (9, 12, 13), two studies targeting people in the Netherlands (5, 7) two studies targeting people in China (3, 14), and one each targeting people in Saudi Arabia (1), Sudanese refugees in Cairo (2), Iraqi refugees in the USA (4), people in Iran (6), people in an African refugee settlement (8), North Korean refugee youth in South Korea (10), and Syrian refugees in Jordan (11).

In our sample, NET was always delivered individually and orally. Participants were guided through the intervention by a counsellor. Ten of the studies had their interventions carried out by a therapist or a counsellor previously trained in NET (4 – 13), three by the authors or researchers (1, 8, 14), two by doctors or nurses (3, 7), and one by lay counsellors without a background in mental health or counselling professions (2). The setting was unknown for three of the studies (1, 10, 14), while three implemented the intervention in an outpatient centre (5, 7, 9), three at inpatient centres (9, 12, 13), two at medical centres (6, 8), two in a refugee community (2, 8), one online (3), one in a designated room at the Jordanian Psychological Sciences Association building (11), and one in a private room to the client's preferences (4). One study (2) mentioned specific techniques that the counsellors were encouraged to use during the treatment which included active listening, empathy, congruency, and unconditional positive regard, which are in line with the original protocol for NET (Schauer et al., 2011).

Narrative Enhancement and Cognitive Therapy (NECT)

NECT is a manualised group therapy developed by Yanos and colleagues (2011) which is based on cognitive restructuring and narrative models, and is comprised of three different parts: psychoeducation, cognitive restructuring, and narrative enhancement. The recommended duration of each part in the manual is one session for the introduction, three sessions for psychoeducation, eight sessions for cognitive restructuring, and eight sessions for narrative enhancement, leading to a total of 20 sessions (Yanos et al., 2011). Groups are conducted by two facilitators to give more attention to an individual where needed and to be able to appropriately support group discussions. Psychoeducation teaches the participants about the stigmatising views and how they can lead to self-stigma, while cognitive restructuring builds the clients' skills to challenge their irrational beliefs.

The narrative enhancement part focuses on constructing narratives of the self, illness, and the connection of the two (Yanos et al., 2011). Participants either write or tell stories about the past or recent events which they share within groups of ideally four to eight members. Here, the intervention emphasises bringing together fragmented and isolated parts of the self by the participant being and having an audience to the story, exploring the way the story is told, responding to one's experienced difficulties with oneself, recognising the right to have and create one's own story, and reflecting on what stories one can tell. Moreover, participants can see the influence of one's cognitive distortions on their story. Additionally, three specific techniques are to be used by the facilitators. These include outlining and discussing group norms, encouraging group members to speak with and provide feedback to each other, and

outlining facilitation techniques that are listed in a fidelity rating scale. These elements are meant to integrate all parts of the intervention and thus lead to the participants' self-stigma being reduced. Thus, narrative enhancement reflects the three core elements, too: identity development (construction of narrative of self), counsellor/peer support and feedback (discussions), and agency enhancement (right to have and create one's story).

There were little deviations from protocol in our sample of studies. The duration of the intervention was always weekly one-hour sessions across the span of 20 weeks, except for one study where it was 19 weekly sessions (17). This study explicitly mentioned having seven sessions of narrative enhancement (17). Additionally, one study had groups of up to 14 members, which is nearly double the ideal size described in the protocol (16). Studies also emphasised that the stories are meant to underline personal strength, change, and success over adversity, thus leading to empowerment of the client. Lastly, the three techniques to be used by facilitators were not explicitly mentioned except by one (19) where the facilitators encouraged the participants to integrate empowering themes into their personal life stories. No other deviations were mentioned in the articles.

All five NECT-interventions in our sample targeted people with severe mental illness, with one study specifically focusing on people with schizophrenia (16). One study included people with PD in their sample (17). All studies took place in different countries, which were Sweden (15), Taiwan (16), the Netherlands (17), Israel (18), and the USA (19).

NECT was always carried out in groups of different sizes with the smallest being five (19) and the largest being 14 (16). In all interventions in our sample, two facilitators conducted the group sessions. NECT was delivered in a mixed format, with both oral discussions and written assignments and handouts.

Two of the five studies had their interventions carried out by trained mental health practitioners/clinicians (17, 18), while two studies did not further specify on the characteristics of the facilitators (15, 19), and one study had NECT carried out by psychiatric nurses (16; see Table 1.2). All studies were implemented at multiple treatment sites, with NECT being carried out at psychosis mental health services with in- and outpatient units (15), inpatient rehabilitation wards or day wards (16), unspecified different treatment sites (17), psychiatric rehabilitation agencies and a university community clinic (18), and in outpatient and comprehensive treatment settings (19).

Table 1.1 NET and NECT

	Authors (Year)	Target Group	Duration	Mode of Delivery	Tailored
NET					
1	Alghamdi et al. (2015)	Traumatised firefighters in Saudi Arabia	Four sessions of 60 to 90 minutes over a period of 3 weeks	Guided by researchers, setting unknown Delivered orally and individually	Yes, shortened
2	Ellis & Jones (2022)	Sudanese refugees in Cairo with PTSD	Six sessions over 2- 3-week period One session weekly over 6 weeks (? Inconsistent)	Delivered by lay counsellors without prior relevant background in refugee community Counsellor techniques: active listening, empathy, congruency, and unconditional positive regard Delivered orally and individually	Cultural and lingual adaptation which was aided through focus group
3	Fan et al. (2021)	COVID-19 patients with PTSD- symptoms in China	One or two sessions lasting 90-120 minutes over 8 weeks	Delivered by doctors and nurses with National Certificate of Psychological Counsellor online Delivered orally and individually	Not stated
4	Hijazi et al. (2014)	Iraqi Refugees with PTSD in the US	3 weekly sessions of 60-90 minutes	Guided by a therapist in a private room at the participant's preferred location Delivered orally and individually	Yes, shortened duration to fit
5	Lely et al. (2019)	Older patients with PTSD	~11 weekly sessions of 90 minutes	Outpatient specialised Dutch centres assessing and treating psychotrauma-related disturbances by different psychology professionals with NET training; phone calls as substitute Delivered orally and individually	No
6	Manesh et al. (2018)	Iranian Survivors of Mina Disaster with PTSD	12 weekly sessions for 90 to 120 minutes	At Hajj and pilgrimage medical centre of the Iranian Red Crescent, guided by a clinical psychologist Delivered orally and individually	No
7	Mauritz et al. (2021)	Patients with severe mental illness for comorbid PTSD	Up to 16 weekly sessions	Outpatient by different therapists the participants knew before Guided by either nurse practitioner or clinical psychologist Delivered orally and individually	No
8	Neuner et al. (2004)	People with PTSD in an African Refugee Settlement	Four sessions of 90 to 120 mins, three treatment sessions within two weeks	In huts or under trees around the refugee settlements' medical centre, guided by therapists with the help of interpreters Delivered by therapists with NET and supportive counselling training Delivered orally and individually	No
9	Pabst et al. (2014)	Patients with borderline personality disorder and comorbid PTSD	On average 17 sessions either once or twice a week lasting 90 minutes	In and outpatient setting guided by therapists in Germany Delivered orally and individually	No
10	Park et al. (2020)	Traumatized North Korean Refugee Youth	Five to ten (M = 8) sessions of 90-120 minutes each	By a clinical psychologist with NET training and treatment experience Supervision by documentation of cases and communications by e-mail or telephone	No (translation only)

	Authors (Year)	Target Group	Duration	Mode of Delivery	Tailored
				Delivered orally and individually	
11	Smaik et al. (2023)	Syrian refugees with PTSD in Jordan	Average of 10 weekly sessions lasting between 60 and 120 minutes	Designated room at Jordanian Psychological Sciences Association building in Amman guided by therapist Delivered orally and individually	No (translation only)
12	Steuwe et al. (2016)	Inpatient program to treat patients with comorbid BPD and PTSD	Same as below	Same as below	No
13	Steuwe et al. (2021)	People with posttraumatic stress disorder and borderline personality disorder	10 weeks of NET, before and after exposure phase weekly sessions of 50 min; during exposure two individual sessions of 90 min per week	At a ward for patients with BPD guided by therapists with NET training under supervision by experienced NET clinicians Delivered orally and individually	No
14	Zang et al. (2014)	Chinese earthquake survivors	NET-R: 3 or more sessions of 60-120min, sessions 1-2 days apart NET: 4 or more sessions of 60-90min twice weekly for two weeks	Guided by first author and one female counsellor who were both trained in NET and NET-R Delivered orally and individually	Yes, adapted to target group by making intervention shorter and more intensive as well as more focused on a singular traumatic event (the earthquake)
NECT					
15	Hansson et al. (2017)	People with severe mental disorders and self-stigma in Sweden	20 sessions of 1 hour	In- and outpatient at psychosis mental health services by two facilitators Delivered orally and in groups of 6-8 Guided by a manual for both facilitators and participants	No
16	Huang et al. (2023)	People with schizophrenia in Taiwan	20 weekly sessions of 1 hour	At inpatient rehabilitation wards or day words guided by two psychiatric nurses (investigator and coinvestigator) Delivered orally and written in groups of 6-14	No
17	Oudejans et al. (2022)	People with severe mental illness in the Netherlands	19 weekly sessions of four phases, of which the last phase is narrative enhancement which is comprised of 7 sessions	At different treatment sites by mental healthcare clinicians with NECT training Guided by one facilitator and one cofacilitator who were aided with a manual + handouts to guide group discussions Delivered orally (but writing is an additional option) and in groups of unknown size	No (translation only)
18	Roe et al. (2013)	People with severe mental illness in Israel	20 weekly sessions of 1 hour	Held at two psychiatric rehabilitation agencies and one University Community Clinic in Israel given by 35 NECT trained mental health practitioners, two of which were assigned to each NECT group as facilitators Guided by facilitators and NECT manual Delivered orally in groups of 8	No
19	Yanos et al. (2019)	People with severe mental illnesses	20 weekly sessions of 1 hour	At outpatient and comprehensive treatment settings guided by two facilitators who had a manual Facilitators gave feedback to participants and encouraged them to integrate empowering themes into narratives Delivered orally and written in groups of 5-8	No

Reminiscence therapies

This category of interventions encompasses multiple types of reminiscence therapy, which is said to have three modalities: simple reminiscence, life review, and life review therapy (Gaggioli et al., 2014), meaning that no one protocol can be described for this category. In our sample, three interventions were based on group reminiscence therapy (GRT; 21, 23, 24), three were based on life review (25 – 27), two were based on integrative reminiscence therapy (20, 22), one of which was a combination of integrative reminiscence therapy and narrative therapy (20), and the other was a comparison of integrative and instrumental reminiscence therapy (22). Details can be found in Table 1.2.

Despite reminiscence therapies having different modalities, all interventions had similar core elements. Each intervention incorporated a lookback on the participants' life, which was usually done through thematic sessions which revolved around, e.g., one's youth, difficult times, family history, values and strengths, among other things. These themes would either have a focus on positive events and/or the integration of negative events into a more meaningful and positive life story. Secondly, group discussions were held where participants share their memories and reflection of themes and discuss them with a focus on support and relatability. The last focal point to be found within reminiscence-type interventions is the development of alternative, more agentic/positive life stories that facilitate the (further) development of self-worth and strengths. Thus, the three core elements are apparent here as well: identity development (thematic dissection of one's life, exploring values), counsellor and peer support/feedback (open discussions), and agency enhancement (creation of meaningful stories, discussions of self-worth and strengths).

Some of the interventions also implemented other exercises, e.g., visualisation exercises (24) or creative expression (24, 25). Two interventions stood out as different from the core elements of reminiscence interventions, namely instrumental reminiscence therapy (22) and online life review therapy (27). Instrumental reminiscence therapy is based on a stress and coping framework that emphasises problem- and emotion-focused coping responses and resources, and primary and secondary appraisal strategies, different from the meaning-focused integrative reminiscence therapy and other reminiscence interventions. The online life review therapy was different in that it replaces the group discussion part with counsellor feedback only, which would be given through e-mail guidance.

Each intervention was tailored to their target group but one which offered participants a choice how much to write about traumatic life experiences (23). Three interventions adjusted

their length/intensity to fit the target group better (21, 24, 25), one was adjusted to the target group by facilitating alternative and thicker stories (20), one was adjusted to the reading and writing ability of the target group and was made more culturally suitable (22), and one was specifically designed for the target group (27).

Most reminiscence interventions targeted older adults, with the youngest age being 40 (27) and the oldest minimum age being over 70 years old (21). Seven of the studies targeted people with depressive symptoms/depression (20 – 23, 25 – 27) with one focusing on institutionalised older adults (22) and one on people in general practice (25), while one also targeted people with anxiety, PTSD, adjustment disorder, or other aging-related health or family stressors and those who could participate positively and appropriately in a group setting (23), and one targeted people with severe mental disorders (24). The studies were carried out in different countries, with five being in the Netherlands (20, 24 – 27), one in Taiwan (21), one in Iran (22), and one in the USA (23).

Intervention duration varied from 6 sessions (22) to 12 sessions (24), with an average of 8.4 sessions. One study had an additional make-up session (23). All interventions were given once a week except for one which gave sessions twice a week (21), and sessions were most commonly 1.5 hours long (22, 24, 25), but lasted from one hour (21, 23) to two hours (20, 26). Of the eight treatments, four assigned homework to the participants which were either thinking about the next session's theme or writing about it to be prepared (20, 22, 23, 26). Most interventions were delivered in a group format, with three having no defined number of members (21, 22, 25), one being delivered to groups of four (20), two in groups of four to six (23, 26), and one in groups of seven to eight (24). One intervention was delivered individually through a self-help book and online/at-home with written assignments and communication (27). Most interventions were delivered both orally and written (20, 23 – 26), whereas two interventions were delivered orally (21, 22). Two studies were carried out at nursing homes (21, 22), one at different community mental health centres (20), one at general practices (25), one at different mental healthcare services in urban and rural areas (26), one at an outpatient geriatric mental health clinic (23), and one at either a psychiatric hospital or a sheltered housing program (24). The interventions were mostly delivered by a counsellor who was either a psychologist, therapist, counsellor or clinician of some kind, while one intervention could also be delivered by a trained psychiatric nurse (20), and one was delivered by a mental healthcare nurse practitioner (25). Two studies (20, 27) described counsellor tasks, which were meant to facilitate group discussions and alternative reconstructions of negative story evaluations (20), which the other study also implemented, but without the group elements (27).

Table 1.2 Reminiscence

	Authors (Year)	Target Group	Duration	Mode of Delivery	Narrative Elements	Tailored
20	Bohlmeijer et al. (2008)	Older adults with depressive symptomatology in the Netherlands	Eight sessions weekly of 2 h + homework	At community mental health centres by one counsellor (psychologists or psychiatric nurses with experience in counselling and therapy with older adults who underwent training) per group Counsellor facilitates group discussions and asks questions Delivered orally and written in groups of four	Combination of integrative reminiscence + narrative therapy Guided Autobiography Systematic evaluation of one's life course with a focus on integrating negative life events of different themes Counsellor asked questions about evaluation and significance of the stories as well as encouraging develop alternative reconstructions and stories when they are evaluated as negative or meaningless Homework: answering questions about the themes at home which would then be read out	Yes, to target group by focusing on questions that facilitate alternative, thicker stories
21	Chueh & Chang (2013)	Male veterans with depressive symptoms in Taiwan	Eight sessions of 1 hour twice a week for 4 weeks	Guided by therapist in recreation room of nursing home facility Delivered orally in groups	Eight thematic sessions with different learning goals and memory recalling as well as sharing with the group with a focus on positive and future-focused aspects	Changed length/intensity of study and designed GRT to achieve catharsis, universality, increased hope, reconstruct meaning of veterans' life, and enhance self-integration among male veterans
22	Karimi et al. (2010)	Institutionalised older adults with depression symptoms in Iran	6 weekly sessions of 90 minutes + homework	By a master's level therapist at a nursing home Before a new session, participants were reminded by a nurse of the previously identified themes and related sessions Delivered orally and in groups	Integrative Cognitive re-attribution framework Disconfirmation of negative beliefs about the self and the future, alternatives to self-blame, internal guidelines for the evaluation of self-worth, and renewed sources of self-worth Instrumental Stress and coping framework Coping resources, primary and secondary appraisal strategies, and problem- and emotion-focused coping responses Both Thematic sessions Homework: thinking on topic for next session	Yes, by adjusting the intervention to their reading and writing ability: nurse reminded the participants of previously identified themes and related questions a day before the session Materials of manual were adjusted to be culturally suitable
23	King (2018)	U.S. veterans over age 65 with depression, anxiety, PTSD, adjustment disorder, or other aging related health or family stressors and those who could participate positively and appropriately in a group setting	Ten weekly 1-hour sessions with an additional eleventh make-up session + homework of preparing writing assignment for next week	An outpatient geriatric mental health clinic in a Veterans' Affairs Medical Centre guided by two clinicians per group with the help of worksheets Delivered written and orally in groups of 4-6	Reading from their writing and discuss what thoughts, feelings, and memories came up when reflecting on the topic Giving supportive and constructive comments, discuss what common themes they saw in each other's stories, avoiding unsolicited advice or criticism Worksheets described the topic and listed several questions to stimulate memory and reflection Warm-up exercises pertaining to thematic sessions	No, but personalised choice about how much to write about traumatic life experiences

	Authors (Year)	Target Group	Duration	Mode of Delivery	Narrative Elements	Tailored
					Homework: complete worksheet between sessions and/or write a short essay on theme	
24	Willemse et al. (2009)	Older adults with severe mental disorders	12 weekly sessions of 1.5 hrs	At either psychiatric hospital or sheltered housing program by two counsellors who were trained with a health psychologist and creative therapist Delivered orally and written in groups of 7-8	Thematic sessions Alteration of reminiscence (writing and being asked questions), dialogue (e.g., visualisation exercise), and creative expression (e.g., drawing) Focus on positive memories, assisting clients in developing a coherent, meaningful life story	Yes, to the target group by reducing the length of sessions and number of participants, and simplifying some assignments
25	Hendriks et al. (2019)	Older adults with depressive symptoms in general practice in the Netherlands	8 weekly sessions of 1.5 hr	Guided by mental health care nurse practitioner in general practices Delivered orally and non-verbal in groups	Thematic sessions Creative exercises (not further specified) Alternation of reminiscence, dialogue, and creative expression	Yes, to the target group by shortening the original Looking for Meaning intervention
26	Korte et al. (2012)	Older adults with moderate depressive symptomatology in the Netherlands	8 sessions of 2 hours each + homework	Delivered at different Dutch mental healthcare services in urban and rural areas by trained therapists who were supervised by a narrative and life review therapist Therapists had to have an attitude of curiosity and not-knowing while asking guiding questions Delivered orally and written in groups of 4-6 guided by therapist	Three core elements: Integration of difficult life events from the past, development of agentic life stories, & retrieval of specific positive memories as building blocks for new life stories Expression of values and past experiences Different life themes and sharing positive memory of each, thus exchange between participants Sharing difficult life event pertaining to theme and developing alternative stories to integrate these into the broader life story Focus on overarching themes in last 3 sessions and the future using metaphors, making an overview of the course of life, and a new beginning Homework: participants had to answer questions about theme for each session	No
27	Lamers et al. (2015)	Adults (40+) with moderate depressive symptomatology in the Netherlands	7 modules to be finished within 10 weeks	Self-help book with e-mail guidance by a counsellor Participants sent texts and questions to counsellor weekly which they would receive feedback on within 2 days Counsellors to respond to the e-mails from a narrative therapeutic framework, probing with questions to help participants construct alternative and agentic stories about the (negative) events written Delivered written and individually	Based on insights from autobiographical memory, life-review, and narrative therapy Participants answered questions about themes and described a specific positive memory and a difficult memory they were struggling with Four modules focused on different life themes, last three modules focused on creating an overview and on the near future Each of the modules also included a well-being exercise on an audio-CD in the book	Yes, newly designed

Other narrative interventions

This category comprises every intervention that was either newly developed or retested in a different setting. These interventions include two recovery-focused interventions (31, 32), two life story interventions (29, 36), two cognitive-narrative interventions (28, 35), two narrative therapy interventions (33, 34), and one self-concept focused intervention (30). The most important narrative elements of each intervention will be described separately, and further details can be read in Table 1.3.

The first division of treatments are recovery-focused interventions. While the interventions differ in structure, they are generally both about developing a more positive view of the self through a lens of recovery and being future-oriented. Moreover, both interventions employ discussions between participants where they share their stories and support each other. The first intervention, delivered to people with PDs (31), is built around a triptych in which participants write a 3-part biography concerning their past, a turning point toward recovery, and the present in relation to the future. The second intervention (32) has a thematic approach to building the life story, similar to reminiscence therapies. It also focuses on the deconstruction of stigma through discussions of stereotypes within the group, and facilitators are treated as equals to the participants by sharing their own stigma-related experiences.

The two *life story* interventions (29, 36) in our sample are based on the same intervention developed by the studies' authors but carried out with slightly different target groups. This 3-part intervention is similarly structured to the recovery-focused interventions with sessions about the past, the present (instead of a turning point), and the future with different themes being explored. The past is about who the participant is and is ended with a ritual closure of the past in form of 'good things and bad things' boxes. The present is about one's present situation, but also what one's strengths are, one's social network, life phases, current themes, values and norms among other things. The last part is about the future and explores the clients' goals, plans, and their future perspective. There were also other activities, such as creative exercises, and social exercises, among others.

Next are the *cognitive-narrative* interventions (28, 35). The first intervention is for people with complicated grief, which was based on cognitive narrative therapy. It focuses on recalling narratives the client shared with the deceased as well as loss episodes, which would later be explored on a cognitive and emotional level. Participants also use tools such as metaphorization and projecting, with the former being used to explore different meanings of a loss episode, and the latter being used as a foundation for meaningful, future-projecting narratives. The second cognitive-narrative intervention is continuous identity cognitive therapy

(CI-CT; 35). Here, the focus lays on creating one's most meaningful life story, to be mindful of one's present self, contextualise based on one's past self, and to move toward one's desired future self. Moreover, clients identify their life values and develop a self-growth perspective as well as possible future selves/timelines. They connect with their desired future self and move toward it and use the continuous-identity narrative as context for current problems.

The *narrative therapy* interventions are structured mostly the same except for a few differences. Both interventions employ the externalisation of problems which separates the issues one has from one's person, thus exploring moments where one was their best self (34) or identifying oneself with a more positive, alternative story (33). The intervention by Seo and colleagues (33) focuses more on this alternative story, whereas the intervention by Shakeri and colleagues (34) focuses more on discussions within the group about addiction and the clients' feelings, desires, and dreams about themselves. Another key difference is the implementation of different exercises (mind and body relaxation, training of skills; 34) versus the emotional focus and definitional ceremony that invites participants to bear witness to the new, positive identity (33).

The last intervention is called the *self-concept and engagement in life* (SELF; 30) intervention and contains four modules, three of which focus on narrative. The first module is about identity development and exploration of self-awareness, while the second module is concerned with one's personal narrative and the impact of mental health on their identity. The last module focuses on fostering a healthy self-concept and self-esteem. This intervention contains homework each week and some of the exercises include having to generate a list of words to describe oneself or bringing a photo of a meaningful memory to the session.

Again, the three core elements can be observed here: identity development through, e.g., thematic exploration of the self, values/strengths and lifeline, support/feedback by the counsellor and/or peers through, e.g., discussions and guidance, and agency enhancement through, e.g., perspective change/development, focus on the future, and self-growth.

Three interventions (28, 29, 36) were tailored to their target group by not performing a part of the original protocol due to increased risk of traumatic recall (28), and one intervention was adjusted to the target group's limitations in working memory, executive functions, and reflective power as well as using a more accessible workbook (29, 36). All other interventions were not explicitly tailored to their respective target group, and one intervention offered personalisation through a digital platform and printing of the life story book (31).

Target groups varied greatly across this category. Targeted twice were adults with intellectual disability and psychological problems, either trauma-related and depressive

complaints (29), or more general psychiatric problems (36). Two studies targeted people with severe mental illness (32, 35), one of which targeted US veterans (35). All other target groups only appeared once: bereaved elders with complicated grief, posttraumatic and depressive symptoms (28), people with schizophrenia and related psychoses (30), people with personality disorders (31), people with depression (33), and lastly people with amphetamine addiction (34). Two studies also included people with PD in their sample, but did not mainly target them (35, 36). Most studies were conducted in the Netherlands (29, 31, 36), with one each being conducted in Portugal (28), Canada (30), Chile (32), Korea (33), Iran (34), and the US (35).

The number of sessions varied from four (28, 35) to 17 (29, 36), with an average of 9.6 sessions. One study had two follow-up sessions of one hour each to reinforce effects (36). Six of the interventions had weekly sessions (28 – 32), while two had sessions an unspecified number of times a week (34, 36), and one was given twice a week (33). The shortest sessions were 50 minutes long (30), while the longest were three hours (35), and the most common duration of a session was one and a half hours (N = 4; 29, 31 – 33). Four of the interventions included a form of homework or (optional) at-home activity (30 – 32, 34), which included reflection through writing, bringing photographs, drawing, (30 – 32) or different tasks for each session (34).

The most common intervention setting was a hospital (N = 4), with two interventions being offered at psychiatric hospitals (29, 36), one at a residential hospital and day-hospital (both 31), and one at a non-specified hospital (34). Two interventions were held at specialised psychological centres, with one being for psychosis (30), and one for addiction treatment (34). One intervention each was delivered at various mental healthcare services (32), community health centres (33), and a medical centre (35). One study did not describe the setting (28). Interventions were usually delivered in a group format (N = 6; 31 – 36), with one being offered individually and in groups (29). Group sizes were most often unspecified (N = 4; 29, 31, 33, 34). The smallest group sizes started at six (35, 36) and the largest possible group size was twelve (35, 36). Two interventions were offered individually (28, 30). Seven interventions were delivered orally and written, in a mixed format (29, 30 – 32, 34 – 36) and two were delivered orally (28, 33). Most (N = 5) interventions were given by either psychologists, therapists, or counsellors (29 – 31, 35, 36), and one was given by a therapist alongside the first author (35). Four treatments were carried out by either the author or the research team (28, 32, 33, 35), with two interventions having an additional person for guidance, one being a professional from the mental health centre (32), and one a therapist (35). One study did not mention by whom it was carried out (34).

Table 1.3 Other

	Authors (Year)	Target Group	Duration	Mode of Delivery	Narrative Elements	Tailored
28	Barbosa et al. (2013)	Bereaved elders with complicated grief, post-traumatic and depressive symptoms in Portugal	4 sessions weekly of 1 hr each	Recruitment from three nursing homes in northern Portugal, setting not given but delivered by the first author of the article (Barbosa) who had undergone training and continued supervision in CNT Treatment was manualised and described in a detailed session-by-session protocol Delivered orally and individually	Recalling narratives Emotional and cognitive subjectivation Metaphorization: explore different meanings for the chosen episode and to choose a metaphor/title unifier Projecting: building and experimentation with other possible organisations of the episode, generating meaningful future projecting narratives	Yes, sensorial objectivation phase not performed due to increased risk of traumatic recall
29	Beernink & Westerhof (2020)	Adults with intellectual disability and depressive and trauma-related complaints in Netherlands	17 weekly sessions of 1.5-2 hr over a period of 4 months	In a psychiatric hospital guided by trained practitioners (licensed healthcare psychologists) Both inpatient and outpatient Delivered orally and written with help of a structured workbook and worksheets either in structured individual or group sessions	Three theme-structured parts: Past (9 sessions) + culmination in two boxes (one beautiful stories, one difficult). Future (2 sessions): life goal, presentation, what was learned Present (6 sessions): current life phase, social contacts, identity, focus on traits, talents, and values/norms	Yes, to target group by adjusting to limitations in working memory, executive functions, and reflective power Workbook written in accessible languages with short sentences
30	Konsztowicz et al. (2020)	People with schizophrenia and related psychoses	Weekly 50 min session (Mean sessions = 4.6) + homework	Guided by a therapist at Centre for Personalised Psychological Intervention for Psychosis in Canada Participants received handouts with summaries of the session and what to prepare for next session Delivered orally and written, individually	Four modules, three of which focus on narrative: 1. Identity development and exploration of self-awareness 2. Personal narrative and the impact of mental health on identity 3. Fostering a healthy self-concept and self-esteem Homework: e.g., generating list of words to describe oneself or bringing a photo of a meaningful memory)	No
31	Pol et al. (2023)	People with personality disorders in the Netherlands	12 weekly sessions of 1.5 hr + homework	Residential or day-hospital group treatment, guided by two counsellors Optional use of digital platform offered to upload assignments and limited number of photos, or other forms of expression (e.g., poems, drawings) as well as printing life story book Delivered orally, written, and in group	Triptych: Biographical writing concerning the past, a turning point toward recovery, and the present in relation to the future Homework: not specified, but most likely writing exercise	No, only personalisation
32	Schilling et al. (2015)	Adults with a diagnosis of a severe mental disorder	10 weekly 1.5hr sessions + optional, but recommended, home activity	At two out-patient mental health services in Chile, facilitated by two mental health professionals who were a member of the research team with clinical experience and a professional from the mental health centre Guided by Spanish intervention manual and handouts created by authors Facilitator instructions: be equals, share own experiences with obstacles and discrimination, as well as ensuring safe environment and promoting active participation Delivered orally and written in groups of max 10	Tree of Life approach: expansion of life narratives and generation of a more comprehensive, positive view of themselves by including childhood memories, interests and routines, strengths and abilities, goals, significant individuals, and available supports Connection of past to present activities and future goals Similarities between own experiences and goals and those of their peers while viewing themselves as part of society Discussions of stereotypes and stigma, with exercises to facilitate agency and externalisation Strength-based perspective focused on positive psychology values	No

	Authors (Year)	Target Group	Duration	Mode of Delivery	Narrative Elements	Tailored
					Homework: topic or question to reflect on or write/draw about in a journal between sessions	
33	Seo et al. (2015)	Patients with depression in Korea	8 90 min sessions, two sessions per week for 4 weeks	At four community health centres in South Korea guided by the primary researcher who is a practitioner of NTEA as well as a professor of family counselling Emotional approach of therapist through careful listening, validation, empathic response, reflection, evocation, reframing, and heightening Delivered orally in groups	Externalisation of the previously identified problems through separating person from problem Exploring unique outcomes where one was not overwhelmed by problems, talking about stories without problems, and knowing the differences between stories with/without problems Construction of an alternative story with a focus on positives which is compared to old story Definitional ceremony where the other participants bear witness to this positive identity	No
34	Shakeri et al. (2020)	People with amphetamine addiction in Iran	10 sessions of unknown length over unknown amount of time + homework	At hospital and private addiction treatment centres, not known by whom Delivered orally and written in groups	Combination of narrative focused sessions, exercises (e.g., mind and body relaxation) and training skills (e.g., eye contact skills) Telling life story to group, discussions of one's feelings, desires, and dreams about oneself Externalisation of problems Identification of the first self-assumption and basic assumptions about addiction Building a satisfying relationship with oneself while also making a story around one's best self, rewriting one's life story from past to future Homework: different objectives each session consisting of motivation, diary-keeping, relaxation and behavioural exercises, and writing a new story for oneself	No
35	Sokol et al. (2021)	U.S. Veterans with a serious mental illness	4 weekly 3-hr sessions	At VA Medical Centre in a partial hospitalisation program by first author and a master's level therapist under clinical supervision by a licensed clinical psychologist Guided by therapist manual and group workbook Delivered orally and written in groups of 6-12	Overarching theme is to create one's most meaningful life story, to be mindful of one's present self, contextualise based on one's past self, and move toward one's desired future self Construction of a continuous-identity narrative which is used as context for current problems and should be connected to a desired future self that will be moved toward Identification of life values Identifying life values, developing a self-growth perspective, and possible future selves/timelines	No
36	Westerhof et al. (2016)	Persons with intellectual disability and psychiatric problems	17 2-hour sessions with two 1-hour follow-up sessions	At Dutch psychiatric hospital guided by two therapists, one of whom is a licensed psychologist Comprehensive manual for therapists and structured workbook with exercises for participant Delivered orally and written in a group of 6-12	Same structure as 29, plus: Metaphorization, analysing photographs, telling stories, exercises with family, relaxation, listening, good things and bad things box, drawing, theme circles, lessons learned, sentence completion, quality games, letter about talents, planning	Yes, see 29, plus further details: Focus on good diagnostics, clear communication, experience-near exercises, simple structure, safe and positive environment, engagement of social network

Quality assessment of the evaluation studies

All 36 articles were critically appraised with the MMAT (see Appendix B)[1]. 17 studies rated 4-5 out of 5 points (1, 3, 5, 7 – 10, 12, 14 – 16, 20, 25, 26, 29, 30, 33), twelve studies rated 2-3 points (4, 13, 18, 19, 21, 22, 24, 27, 28, 32, 34, 35), and one study rated less than two points (6). Three mixed methods studies rated 10-13 out of 15 points (2, 11, 31), while three rated 14 points (17, 23, 36). Overall, most (N = 23; 63.9%) of studies met the criteria of appropriate methods and measures and reduction of bias sufficiently. Despite this, over a third of studies did not meet the criteria sufficiently, and many studies had small sample sizes, thus caution should be taken when looking at the following results.

Effects of the interventions: quantitative results

Studies varied in their designs and included 15 RCTs (1, 3 – 6, 8, 13 – 16, 19, 26 – 28, 34), 13 non-randomised study designs (7, 18, 21, 22, 24, 25, 30, 33), seven mixed-methods studies (2, 11, 17, 23, 31, 32, 36), although one only reported qualitative results (32), and one qualitative study (20). The studies used different outcome measures, mostly related to psychopathology (e.g., depression, trauma, anxiety, and BPD symptom severity), but also related to positive outcomes (e.g., hope, mental wellbeing, quality of life). Other studies included process-like outcomes, such as self-esteem, self-stigma, and coping. In total, 48 different variables were assessed.

Outcomes related to psychopathology

Of the 36 studies, 29 (81%) assessed changes in psychopathological outcome measures with 18 different variables. Details for the effectiveness of the interventions on each can be found in Table 2 (see Appendix C). Results are summarized below.

Depressive symptoms – The most assessed variable is depression or depressive symptoms in 25 studies, of which 18 found a significant reduction in depression or depressive symptoms (1, 4, 6, 9, 11-14, 21, 23, 26 – 29, 33 – 36), while three studies only found partially significant reductions (3, 10, 24), and three studies found no significant changes (2, 16, 30). One study had missing quantitative data which was requested by the authors but not received (22), and four

[1] For a more extensive understanding of the quality appraisal, please consult the supplementary materials.

studies did not list effect sizes (3, 23, 34, 36). Effect sizes varied greatly, with small to large effect sizes being found across studies.

Traumatic symptoms – 15 studies assessed changes in PTSD (symptoms or severity), trauma, or traumatic symptoms (1-14, 28). Of these 15 studies, all but three studies (5, 9, 13) found significant reductions in trauma, whereas the three other studies only found partially significant reductions. Similarly to depression, effect sizes varied greatly as well, with small to large effect sizes being found, and one study did not report effect sizes (5).

Anxiety – Ten studies assessed changes in anxiety (symptoms; 1-3, 11, 14, 25 – 27, 34, 36). Of these ten studies, five found significant reductions in anxiety (2, 11, 26, 34, 36), three found partially significant reductions in anxiety (1, 3, 14), and two found no significant reductions in anxiety (25, 27). Although two studies did not report on effect sizes (34, 36), they generally ranged from small to moderate.

Symptoms (Variety) – Five studies assessed symptom severity/presence which was significantly reduced in four studies (9, 13, 29, 36) of which one did not report an effect size (9), and a single study had no significant change (19). Somatic symptoms (3, 4, 10, 36) were assessed in four studies, of which they were significantly improved in one study (10), partially significantly improved in two studies (3, 36) with one of them not reporting on effect size (36), and one study found no significant improvement of somatic symptoms (4). BPD severity/symptoms and dissociation symptoms were assessed in three studies (9, 12, 13) and were both completely significantly improved in all studies. Comorbid symptoms were assessed in two studies and majorly improved in one study (6; no effect size) as well as partially significantly improved in one study (8). Assessed once in the studies each were the variables severe mental illness symptoms (7), internalising/externalising symptoms (10), complicated grief (28), hopelessness (35), suicidal ideation (35), agoraphobia (36), obsessive-compulsive symptoms (36), hostility (36), insufficiency (36).

Recovery – Recovery was assessed in two studies (17, 31) and partially significantly improved in one study (31) but not significantly improved in the other study (17).

Positive outcomes

Out of 36 studies, 23 (64%) assessed changes in positive outcomes with 15 different variables. Details for the effectiveness of the interventions on each can be found in Table 2 (see Appendix C). The main results are summarized below.

Quality of Life – The most assessed positive outcome was quality of life (QoL), which was assessed in nine studies (7, 12, 13, 15, 17, 18, 26, 30, 34) and was significantly improved in two studies (12, 13), partially significantly improved in two studies (7, 18), and not significantly improved in five studies (15, 17, 26, 30, 34).

Hope, Life satisfaction & Meaning in Life – Hope (16 – 18, 33) was next most common variables being significantly improved in two studies (17, 33), partially significantly improved in one study (18), and not significantly improved in one study (16). Effect size was not given for one study (33). Life satisfaction (24, 25, 29) was significantly improved in one study (29), and partially significantly improved in two studies (24, 25). Meaning in life (20, 26) was significantly improved in one study (26) and partially significantly improved in the other study (20).

Wellbeing (Variety) – Psychological wellbeing was assessed in three studies and significantly improved in one study (4), partially significantly improved in one study (27), but not significantly improved in one study (25). Further, wellbeing (26), emotional wellbeing (27), and social wellbeing (27) were assessed once.

Other positive outcomes – Social support, which was assessed in two studies (1, 14), was partially significantly improved in one study (1), but not significantly improved in one study (14). Assessed once in the studies each were the variables health (6), global functioning (7), psychological functioning (8), social functioning (19), evaluation of meaningful sources (20), evaluation of the past and future (20), and positive and negative affect (33).

Process-like outcomes

Out of 36 studies, 15 (42%) assessed changes in process-like outcomes across 13 variables. Details for the effectiveness of the interventions on each can be found in Table 2 (see Appendix C). The main results are summarized below. Of note is that moderator analyses were seldomly performed on these variables.

Self-Stigma & Self-Esteem – Most assessed was self-stigma with six studies assessing the variable (15 – 19, 30) of which two studies found a significant reduction (15, 17) and four found a partial significant reduction (16, 18, 19, 30). Self-esteem, which was researched in five studies (15, 16, 18, 19, 30), was significantly improved in one study (15), partially significantly improved in one study (18), and not significantly improved in three studies (16, 19, 30), with one of those not reporting an effect size (19).

Coping and Mastery – Coping and mastery were assessed by three different studies, with coping being partially significantly improved in all studies (1, 14, 19), and mastery not being significantly improved in any study (24, 25, 29).

Other process measures – Other process measures, assessed only once in the studies, were self-concept clarity (17), narrative insight (19), rumination (27), ego-integrity (27), illness engulfment (30), recovery style (30), self-awareness (33), future self-continuity (35), and interpersonal sensitivity (36).

Effectiveness for people with PD

Out of 36 studies, four directly targeted people with PD (BPD: 9, 12, 13; PD: 31) and three included people with PD in their sample (17, 35, 36). Three were NET interventions (9, 12, 13), one was a NECT intervention (17), one recovery-focused (31), one cognitive-narrative (35), and one life story intervention (36). Details can be found in Table 2 (see Appendix C).

All NET interventions significantly improved all variables assessed across the studies with medium to large effect sizes, which retained at 12-month follow-ups (FUs). Among the variables were PTSD severity/symptoms, BPD/borderline symptoms/severity, depression/depressive symptoms, symptom severity/presence, dissociation/dissociative symptoms, and QoL. Moreover, NET was equal in effectiveness to Treatment by Experts for BPD (TBE; 9) as well as dialectical behavioural therapy for people with BPD (DBT-bt; 13). NET was superior to DBT-bt in PTSD remission rates. The recovery-focused intervention (31) was effective at improving recovery at post-treatment with a medium effect size.

As for the interventions that included people with PD in their sample, the NECT intervention significantly improved self-stigma and hope with a small effect size, but did not improve self-concept clarity, recovery, or QoL (17). The cognitive-narrative intervention was

effective on nearly all variables including depressive symptoms, hopelessness (not sustained at 1-month FU), suicidal ideation, and future self-continuity (at 1-month FU) with large effect sizes (35). Similarly, the life story intervention was also effective on nearly all variables, most effects of which were maintained at the 3-month FU (36). Variables were total symptom severity which was improved with a large effect size and the subscales depression, anxiety, obsessive-compulsive symptoms, interpersonal sensitivity, hostility, somatisation, and sleep.

Thus, the different narrative interventions were effective on most variables assessed and improvement was long-term, especially for PD-focused interventions. There were small to large effect sizes, though most effect sizes were medium to large.

Adverse effects reported

Three studies explicitly mentioned either monitoring adverse effects (30) or reporting that no adverse events occurred during the study (7, 11), although one mentioned two patients dropping out during the study due to increased suicide risk and physical illness and increased severe mental illness symptoms as well as physical illness, but it is unknown whether this was caused by the intervention (7). No adverse effects were reported in any of the other studies. One study (24) assessed whether certain groups of participants would benefit more/less from the intervention and found that participants with a psychotic disorder had improved life satisfaction after the intervention, whereas the sample with depressive symptoms had a significant negative effect. Another study reported dropout during the study due to psychosocial problems and spontaneous remission (9). It is unclear whether these psychosocial problems were because of the intervention. No other adverse effects-related dropouts were reported in the remaining studies.

Attendance and participants' satisfaction with the interventions (quantitative data)

All but two studies sufficiently reported on attendance and ten studies measured satisfaction (4, 17, 24, 25, 27, 28, 30, 31, 35, 36). Overall, with small exceptions, interventions were evaluated as both feasible and acceptable to the target group it was delivered to. Details can be found in Table 2 (see Appendix C).

Attendance

Of 36 studies, 34 gave data on attendance, with two studies providing insufficient information (6, 22) and two studies having conflicting information (1, 13). Most (N = 21) studies provided exact numbers on dropouts, while five studies provided percentages (2, 25 – 27, 32), and seven provided both (4, 17 – 19, 24, 31, 35). Most commonly, session attendance was taken as an indicator for feasibility, which ranged from 63% (19) to 100% (2, 3, 11, 14). Notably, some studies assessed the intervention as feasible by looking at the mean session attendance (24), completion rate (4), exposure (17), or a mix (17). Dropout (excluding lost to FU) differed across interventions, with the lowest dropouts being in NET (no dropouts: 2, 3, 11, 14 to six: 5), and the highest in NECT (4 to 44; 16, 19). In reminiscence interventions, between no to 11 participants dropped out (21, 23). Dropout in other interventions ranged from one (28, 33) to six (29), and one study had a consistent attendance rate of 68%, meaning about 25 participants of 80 recruited did not participate consistently (32). Most studies with little dropouts (< 20%) had smaller samples (sample ≤ N = 50; 1, 2, 5, 7 – 12, 14, 21, 25, 28, 30, 33, 36), although some smaller sample studies had higher dropouts/little attendance (17, 23, 24, 35), and some larger scale studies had proportionally higher dropouts (sample > N = 50; 18, 19, 27 at T3). Four large scale studies had little dropouts (3, 4, 26, 29) and three small scale studies had high dropout (31, 34, 35). Overall, the trend for the studies was fewer dropouts (< 20%).

Satisfaction

Ten of the 26 studies measured satisfaction (4, 17, 24, 25, 27, 28, 30, 31, 35, 36) with either Likert scales (4) or evaluation questionnaires (Yes/No/Good etc.; 24). Details can be found in Table 2 (see Appendix C).

Studies that used Likert scales ranged from a satisfaction score of 3.0 on a 4-point Likert scale (27) to 7.3 (27) and up to 8.8 (4) on a 10-point Likert scale (4, 25, 27). One study used a different satisfaction scale with a possible score of 40 (clients) and 36 (counsellors), which were

scored 36 (range 30-39) and 30 and 35 (range 26 to 33) respectively (31). Overall, participants and counsellors were satisfied with the interventions.

Other forms of evaluation were questionnaires assessing how helpful a particular facet of the intervention was to the participants, either by rating them on a scale or by doing a qualitative analysis on them. Across the interventions that evaluated satisfaction with questionnaires (17, 24, 25, 28, 30, 35, 36), most respondents rated most facets of the interventions positively (17, 24, 25, 30, 35, 36), or respondents rated them with an average of 8.66 (28). Differences could be seen between the overall, psychotic disorder, and depressive care samples in one study (24), which showed that people with a psychotic disorder were more satisfied compared to the overall sample, and the depressive sample was the least satisfied. Some intervention facets were less liked, e.g., creative exercises and talking about memories (25) and group-related aspects (36). Moreover, respondents of two different interventions perceived skill gain differently, with one study showing that less participants felt they gained skills (30), while respondents in a different intervention often mentioned having gained skills among other things (36). Overall, respondents enjoyed most parts of each intervention and talked about them positively.

Thematic analysis of experiences and perceived changes (qualitative data)

Out of the 36 studies, eight reported qualitative evaluations in the form of participant and/or counsellor quotes (2, 17, 20, 23, 30, 31, 35, 36). One study (32) did not provide any quotes and despite the authors of this review requesting the qualitative data, none was received. Thus, author descriptions will be used for this. Each intervention category was investigated qualitatively at least once, and except for one study (2), all interventions that contained a qualitative analysis were carried out in group settings and delivered in a combination of written and oral exercises. There were 148 quotes collected across the eight studies from participants and nine from counsellors (17, 31), totalling to 157 remarks, of which 147 could be coded with subordinate thematic codes. Thematic analysis revealed that the comments could be divided into three main categories: appreciation of the intervention (N = 89), perceived outcomes or changes in identity (N = 40), and perceived outcomes or changes in recovery (N = 23). Table 3 shows the results of the thematic analysis, and the results are summarised below[2].

[2] For a more extensive understanding of the thematic analysis including codes, please consult the supplementary materials.

Table 3

Themes from qualitative reports

Themes with subordinate descriptive codes (N = 147)	Studies (N = 8)
Theme 1: Appreciation of intervention	
Wanting to do the therapy again/recommend to others, appreciation of help, positive, relaxing, surprised by benefits despite length, experiencing the intervention as one's 'own', happy despite being difficult, heavy/difficult, okay, liking acceptance and connection, positive feedback	2, 17, 30, 31, 36
Wishing longer/more sessions, adjusting material difficulty/load, not helping with one's problems, need further depth, focus less on illness and more on positives, intense to have to open up to others, abrupt start of sessions, information and speed of session related issues	17, 23, 30, 31, 36
Socialising appreciated, not feeling alone, supportive environment, vulnerability, discovering common problems and misconceptions, connection to counsellor, cosy even when difficult, beautiful memories, arguments, gossip, remarks about sex, annoyances, having to get used to	17, 23, 30, 31, 36
Appreciation of counsellor's views and shared experiences, even handling of members, receptiveness and empathy, good explanations, motivated, helpful, openness, compliments, structure, maintaining rules and not shielding people	17, 23, 30, 36
Handouts well prepared and good guidance, intelligent direction through assignments, resistance toward writing task, inspiring stories, good structure, positive reinforcement, good listening, focus on positivity, nice inclusion of photos, fun activities catalogue, good conversation and telling stories	23, 30, 31, 36
Theme 2: Identity changes and awareness, different perspective on life, and learned and appreciated skills	
Expressing oneself in feelings and problems, understanding oneself better, developing self-compassion/-respect, organising and describing the past, dealing with problems, acquisition of tools for the future, developing emotional control and coping mechanisms	20, 23, 30, 31, 36
Gaining self-confidence/-esteem, realising one's goodness, strengths, and qualities, being more than one's illness, gaining a new understanding of oneself, already knowing oneself well, connecting with one's old self, directed to the world	17, 20, 30, 36
Uniqueness of one's life, perseverance, recognising positive life experiences, reflection on past issues and how far one's come, finding one's roles, finding values that make for a better life, recognising one's life as arcs, life being worth living, future optimism	20, 23, 30, 31, 35
Theme 3: Perceived outcomes or changes in recovery	
Future optimism, seeing more possibilities, future-oriented perspective, goal setting	20, 31, 35, 36
Dealing better with the past emotionally, less affected by past events, perseverance, leaving past behind, reconnection with old self	2, 17, 20, 23, 36
Relief, generally feeling better, investment into oneself, focus on positives	2, 31, 36

1. Appreciation of the intervention

The most prevalent theme was appreciation of the intervention with a total of 89 remarks pertaining to it. This theme could be divided into five subthemes which were general evaluation of the therapy (N = 16), of therapy elements (N = 8), guidance (N = 20), group experience (N = 21), and points of improvement or criticism (N = 24). Detailed quotes can be found in Table 3 and supplementary material.

As for the *general evaluation* of the different narrative interventions, participants as well as counsellors experienced the interventions positively, enjoying the time they spent doing the intervention and appreciating how it helped them understand themselves better. Two quotes mention the intervention being either difficult or heavy, and one person evaluated the experience as generally okay (36).

Therapy elements that were liked by the participants include the materials (clear, good wording, good guidance; 23), the structure of the intervention (30), the positive nature of the intervention (30), learning about unhelpful self-talk (30), and sharing/discussing stories (36). No negative quotes of the participants were displayed in any of the articles, but in one article a counsellor mentioned that she encountered some resistance toward the writing tasks (31).

All quotes pertaining to *guidance* were positive in nature. The counsellor's views on writing and life, their handling of the group and structure, sharing of own experiences, and the empathy as well as explanations they provided were widely appreciated by respondents in different studies (17, 23, 30, 36). Moreover, not shielding specific people in the group was important to the clients of one study as well (36). No negative experiences were mentioned.

The *group experiences* varied more between the interventions and clients. While being able to socialise was greatly appreciated due to being able to hear other people's stories and feeling less alone in one's thoughts as well as getting positive feedback or support by one's peers (17, 23, 30, 31, 36), some people were also annoyed in this type of setting and some even had arguments or witnessed gossiping (36). Nevertheless, most comments were positive and togetherness, the positive environment, memories of people, and being vulnerable with each other was emphasised (17, 36).

Lastly, points of improvement and criticism were discussed in the quotes as well. Twelve quotes mentioned that the intervention was *too short* and should have been extended, most of which pertained to a single intervention of around 5 sessions (30), but also interventions of ten to 19 weeks (23, 17). Some clients expressed that there should have been *more homework* between sessions to incentivise clients and to also deepen certain aspects of the therapy (30). The same intervention was criticised for the focus on illness and that treatment was *not practical enough* (30). The content was said to be *difficult to understand* and that it *took time to make meaning* of the assignments (17) by clients, and one other person mentioned that parts of the early life were *difficult to relate to* (23). This was further underlined by people mentioning that giving *too much information* and *going too fast* should be avoided (36). One counsellor mentioned that, due to the novelty of the intervention, it was difficult to carry out the intervention as planned (31). Another client said that opening up to others was intense (17), and one person explicitly said that the intervention did not help them solve their problems (30).

2. *Perceived changes or effects in Identity*

Changes in identity was the most prevalent experienced change, with 40 remarks, which could be divided into the subthemes of identity changes or awareness (N = 15), different perspective on life (N = 9), and learned or appreciated skills (N = 16), which usually pertained to identity. Regarding *identity changes or awareness*, multiple clients mentioned that they realised they were a good person or possessed positive traits (20, 30, 36) and have gained (more) self-confidence (20, 30, 36). Developing a better sense of understanding oneself was also mentioned (30, 36) along with finding one's old self again, separated from one's illness (17, 30). Two people also mentioned that they are now more outwardly directed and social because of the intervention (20). Some explicated that they can now see the societal/relational roles they possess, while one mentioned that they knew themselves better than expected (30). Although no quotes were in the article and despite a request for qualitative material, improved confidence was also reported by participants in one study (32).

As for *life perspective*, multiple quotes focus on the fact that one's life is made up of unique and positive experiences, apart from negative memories (20). Similarly to the identity changes, roles were explicated and one's past and present were often compared which gave new perspective (23, 30, 35). Two people also mentioned that they can look at the positive sides of one's life and appreciate the future and possibilities to come (31), and that life is worth living (35). Finding one's values was noted, too (35). Notably, quotes in the identity theme often revolved around not just the client themselves, but also their relation to others (20, 30). This was also reported by authors in one study where participants felt more connected to their mental health community centre (32).

Skills learned or appreciated by participants included expressing oneself whether that be through writing or opening up about one's feelings (23, 36), which also helped in understanding oneself better (30). Moreover, the intervention helped in developing self-compassion, organising the past, and developing self-respect (31). Learning how to deal with problems, looking at oneself, and confidence was also emphasised (36). Additionally, one person mentioned that the tools given to them through the treatment will help them in the future (30) while another explained that they will now go to specialists with their problems (23). Changing childish behaviour from the past and time management skills were also explicitly mentioned (30, 23). Increased communication skills of the participants as well as other coping skills pertaining mostly to stigma as described by authors in one study (32).

3. *Perceived changes or effects in Recovery*

A second theme related to perceived effects of the treatments is recovery with 23 remarks, which could be divided into three subthemes: handling the past (N = 9), increased positive feelings (N = 5), and increased trust in the future (N = 9).

Handling the past was often reported to have become easier for clients as they became less sad about it (2) or thought about the past less due to the intervention (2, 36). Some also mentioned being able to handle the past better (20), with one saying that they recognise that you 'must bite the bullet' to get through rough times (23), or conversely, being able to remember one's old self (17). One intervention implemented a box with one's past, which one client mentioned to have thrown away the negative box and look at the positive box only (36).

As for *positive feelings*, nearly all quotes mention some sort of relief or better after the intervention (2, 31, 36) and appreciating the time one invested into themselves (31). Lastly, participants gained a more *positive outlook on their future* by being more optimistic and having a clear vision of what they want to do later, setting goals along the way and sticking to the plan (20, 31, 35, 36). Reflection on the participants' treatment and recovery plan was also reported by authors in one study (32).

Integration of quantitative and qualitative findings

The quantitative and qualitative findings of the studies show overlap as well as discrepancies between each other. One discrepancy found is the apparent lack of identity as a quantitative variable in the studies, as well as the little amount of evidence of improvement in studies that do assess identity. Despite changes in identity being an important theme for participants of the interventions and facets of identity (personal goals, values, roles) being mentioned as targets within treatment descriptions, only three studies assessed participants' identity directly. One study explored identity with self-concept clarity which was not significantly improved (17), another study with self-awareness (33) which was also not significantly improved, and one with future self-continuity (35) which was partially significantly improved. Other studies explored some facets of identity, e.g., through self-esteem (15, 16, 18, 19, 30) and ego-integrity (27), with ego-integrity being improved significantly, but self-esteem only being significantly improved in two studies (15; 18: partially). Thus, of 36 studies, only nine assessed (facets of) identity, although changes in identity was an integral part of the participants' experience. Moreover, despite the reported changes being overwhelmingly positive, only four studies found (partial) significant

improvements, meaning that the available quantitative evidence for this is contradicting the qualitative evidence.

Skills, although often mentioned by participants, were generally not assessed quantitatively in any of the studies. The only skills-related variables were coping (1, 14, 19) and mastery (24, 25, 29), with coping being partially significantly improved across all studies (1, 14, 19) and mastery not being significantly improved across any study. As such, because skills were seldomly assessed with little variety in types of skill, it is difficult to say whether skills were improved as participants reported.

This trend continues with recovery as it was frequently reported to have improved by clients in the qualitative results, yet it was quantitatively explored in only three of 36 studies (recovery: 17, 31; recovery style: 30), with one showing significant improvement (31), one showing partially significant improvement (30), and one showing none (17). Despite the importance of recovery to the clients' experience, most studies focused on reducing negative symptoms, e.g., depression, trauma, and anxiety. As a result of this, it is difficult to say that quantitative evidence reflected qualitative experiences.

Lastly, while the appreciation of the intervention by the participants gives insight into their experiences of the different elements, this was not quantitatively explored. No studies investigated which of the components make the interventions effective, although one study showed that internalised stigma was only improved after the narrative enhancement section of NECT was completed (16). Moreover, although guidance was frequently reported as positive by participants, it was seldomly explicitly measured within studies through assessment of counsellor treatment adherence, with most mentioning either supervision of treatment or that the counsellors were trained beforehand. Only two studies assessed treatment adherence/integrity, both reporting high protocol adherence (5, 31), which does reflect client experiences. However, most intervention elements remain quantitatively unassessed.

Overall, despite some overlaps between effectiveness of the intervention on participants' wellbeing and participants' experiences of the interventions, disparities between what participants observed within themselves and their experience of the intervention and what researchers assessed remained large. Due to the focus on psychopathological symptom reduction, variables such as (facets of) identity and recovery as well as skills were seldomly explored, with mostly mixed evidence on the interventions' effectiveness on them. Moreover, effectiveness of intervention elements was not quantitatively explored by researchers, although participants were asked to rate their experience of them.

Discussion

To our knowledge, this is the first review to investigate the characteristics, effectiveness, and participant and counsellor experiences of different narrative interventions targeted toward people with psychopathology and/or PD. Our findings show that, while narrative interventions have existed for two decades, over a third of studies have been published within the past five years, signifying the growing interest and development of such interventions which is further emphasised by a third of the studies included being initial evaluation, preliminary or pilot studies.

Four different categories of interventions were found: NET, NECT, reminiscence therapies, and other narrative interventions, with NET being the most common one that also has the most RCTs conducted within it. Consequently, interventions varied in their structure and elements, although all were at least one to two sessions long (3) and lasted up to 20 sessions (15, 16, 18, 19) with most taking place at least once a week. Although the interventions differed in their elements and methods used, the core elements that were present in every intervention were: [1] identity development, [2] counsellor/peer support and feedback, and [3] agency-enhancement. Most interventions targeted people with trauma, severe mental illness, and depression with differing types of people, e.g., refugees, firefighters, COVID-19 patients, elderly people, etc. Interventions were carried out in both individual as well as group settings, with most being delivered orally or in a mixed oral and written format, with only one intervention being delivered in a purely written format (27). Despite the opportunities that online interventions bring, such as accessibility, lower cost, and the opportunity to review older modules, only a single intervention was delivered online (27), which is a surprise considering the recent upsurge in narrative interventions coincides with the uptake of online psychotherapeutic interventions (Zale et al., 2021). All in all, narrative interventions differ mostly in their target groups and foci, although there are many similarities between their narrative elements and general structure.

The studies examined three types of variables: those pertaining to [1] psychopathological outcomes, [2] positive outcomes, and [3] process-like outcomes. Overall, the narrative interventions were shown to be mostly effective in improving psychopathological symptoms with small to large effect sizes as well as some positive, and process-like outcomes. Our review showed that a third of the included study were of insufficient quality according to the MMAT, meaning that evidence and interpretation should be viewed with caution. The insufficient quality was often due to lack of detail in the reporting of the studies, or the study

design was not robust. This was apparent in both randomised and non-randomised studies as criteria were often scored as ‘no’ or ‘can’t tell’. Preventative measures for data incompleteness should be implemented and procedures more clearly described.

80% of studies assessed psychopathological outcomes, which were almost always either significantly or partially significantly improved, with small to large effect size ranges. The focus on the reduction of psychopathological symptoms as a primary aim stands in direct contrast to the results of the thematic analysis, which showed most participants reporting a positive psychological change, specifically regarding identity and recovery. While psychological research is typically focused on the reduction of negative symptoms, e.g., depression, anxiety, trauma, or self-stigma, which are associated with the target group’s (main) diagnosis of mental illness, narrative psychology places emphasis on meaning-making and finding strengths within oneself as well as discovering values one might not have considered before (APA, 2018; Matos et al., 2009). These aims align themselves more with client-centred therapy as well as positive psychology, as they focus on the individual in a holistic way, with the therapist guiding the client through therapy and emphasising their experiences and strengths (APA, 2018; Chowdhury, 2024; Kirschenbaum, 2015; Matos et al., 2009). Therefore, it is uncharacteristic of the treatments to be assessed with mostly psychopathological variables, where positive outcomes are usually assessed as a secondary aim and not explored further. Future studies should assess more positive outcomes, such as recovery, meaning in life, self-esteem, hope, and QoL to more accurately capture the effectiveness of narrative interventions.

64% of studies assessed positive outcome measures. Our results show a trend that, except for QoL, most positive outcomes were significantly or partially significantly improved, regardless of whether the variables were assessed multiple times or once. This directly reflects the positive experiences reported by participants within the studies. QoL, on the other hand, was most often not significantly improved by the interventions. An explanation for this could be that the target groups for nearly all interventions that measured QoL were being delivered to people with serious mental illness (i.e., psychotic disorders, major depressive disorder, or personality disorders that severely impact the person’s functioning), schizophrenia/psychosis, and amphetamine addiction (15, 17, 26, 34). Despite these mostly promising results, positive outcomes should be assessed more consistently in future studies, perhaps alongside psychopathological outcomes, so that more concrete evidence can be shown for narrative interventions’ effectiveness on these variables.

42% of studies assessed process-like outcomes. These outcomes were both positive (i.e., self-esteem, coping) and psychopathological (i.e., self-stigma, illness engulfment) in nature and

varied more, but a trend could still be seen that these variables were either partially or significantly improved. Of note here is that self-esteem and mastery levels were mostly unchanged after the interventions, despite participants of studies reporting higher self-esteem and being able to deal with problems better. Coping was partially significantly improved, but often with small effect sizes. Nine of 13 variables were assessed in a single study, meaning that nothing definitive can be said for these variables, although the trend was noticeable here as well. Moreover, none of these studies assessed whether these processes were predictive for any effects, e.g., whether self-stigma levels affect levels of depression. In fact, overall, with little exception (20, 24, 27, 29), most studies did not take any moderators into account and assessed which subsections of their target group benefits most/least from the intervention. Pre-treatment levels of, e.g., depression or suicidality could potentially be a moderator in effectiveness of treatment, as implied by characteristics of participants who dropped out. Some of these reasons were being fear of increased stress after trauma exposure sessions, suicide risk, levels of severe mental illness symptoms, psychosocial problems, disciplinary problems, and lack of motivation, which could be studied pre-treatment to see how they affect effectiveness of treatment. As such, future studies should include process variables more often and conduct analyses on their effects on psychopathological and positive outcomes.

Our results showed that there are three main components of narrative interventions: [1] identity development, [2] counsellor/peer support and feedback, and [3] agency-enhancement. While most of the interventions differ in the *how* of these elements, these core characteristics were present across almost all interventions, reflecting the positive psychology and client-centred therapy aspects of narrative identity through the themes of recovery, empowerment, agency, and (self-)compassion being incorporated into narrative interventions (APA, 2018; Kirschenbaum, 2015; Matos et al., 2009). Moreover, these main methods of the narrative approach seem to align with the proposed forms of treatment by Lind and colleagues (2020). As previously mentioned, they suggested that treatment should address narrative identity disturbances through life story reconstruction [1; identity development], centring of therapist-client collaboration [2; counsellor support and feedback], and construction of agentic and redemptive stories [3; agency enhancement]. From our results, it becomes apparent that narrative interventions do implement these elements. Although these elements were present in nearly all interventions and indicated as helpful by participants as well as counsellors, it is not clear which of these elements are most important. Future studies could employ a factorial design to investigate which (added) elements in- or decrease effectiveness and to what extent, e.g., creative exercises influence effectiveness, as some participants did not enjoy these.

The interventions targeted an array of different conditions/complaints (e.g., trauma, severe mental illness, depression) and different types of people (e.g., refugees, firefighters, COVID-19 patients, elderly people, etc). Moreover, the interventions derived from a total of 16 different countries and cultures. The applicability to any cultural context could be a result of narrative interventions making use of storytelling, which is theorised to be a natural human activity that is integral to forming connections with others, conveying information, and empowerment (Bayer & Hettinger, 2019; Manesch et al., 2018). Furthermore, interventions seem to be helpful for people with complex psychological conditions that are usually difficult to treat, such as PTSD or BPD, with great success and some evidence for longevity as well (8, 12 – 14). This ties back into the importance of a coherent, whole identity to people with PD but also PTSD as they experience fragmentation of either themselves or their memories, respectively. Further, narrative interventions can also help people with depression or suicidal ideation as they may reflect on their life values and find meaning in their (new) life story that supports their psychological wellbeing and journey to recovery (30, 35).

One way in which the interventions differed was in the setting, either being delivered individually by a counsellor to a client or in groups supervised by (multiple) counsellor(s). Group interventions tended to make participants feel less alone in their experiences, which made them reflect on their own relationship to their mental illness (e.g., in NECT; 17). This motivated clients to work on misconceptions about themselves and give their own perspective to the group. However, there were also negative experiences within groups, e.g., people bringing up topics that were not welcomed by other participants or the experiences shared were difficult to process at times (36). Indeed, while the field of negative effects of group therapy is under-researched, negative experiences of group therapy can lead to a worsening of symptoms, with one of the most frequently reported effects being the resurfacing of unpleasant memories in the study of Pourová and colleagues (2023). This effect can be worse for participants with certain characteristics, e.g., higher levels of distress pre-treatment. Some ways to mitigate these effects were already implemented in the interventions, e.g., by the peer worker opening up about her own experiences and being vulnerable with the group (17) but could also be done by having participants fill out the Group Readiness Questionnaire (Pappas, 2023). It is important to note here that group therapy, despite these possible negative effects, tends to be equivalent to individual therapy in its effectiveness (Rosendahl et al., 2021), although this has not been explored in a meta-analysis for narrative interventions. However, our results show that both individual and group interventions have effect sizes ranging from small to large. The differences in group experiences could also be an explanation for the ranging effect sizes, especially since

few studies with group-based interventions qualitatively assessed participant experiences. On the other hand, no explicit comments were made regarding the individually delivered interventions, though participants stated that they felt relieved when having a session (2).

Duration varied greatly across interventions, and most comments made by participants regarding the duration of the intervention were pointing out how the intervention should have been longer, with more sessions and better time management (23, 30, 31). While participants pointed this out as criticism, except for one study (1), effects and effect sizes were comparable to those of longer duration. The longevity of effectiveness is assessed in only a few studies, though the effects seem to mostly retain at 3-month (14) and up to 12-month (8) FU assessments for NET, 3-month (19) and up to 6-month FU assessments (15) for NECT, 3-month and 6-month FU assessments for reminiscence therapies (21), and at 1-month (35) up to 12-month (30) FU assessments for other narrative interventions, regardless of duration and number of sessions. This longevity, regardless of intervention duration, could be due to the emphasis on processing one's life in an alternate way that enables long-lasting change. While these results are promising, future studies should implement FU assessments more often to see how effectiveness of their interventions changes with time.

Lastly, our results showed that interventions that were delivered to people with PD consistently improved participants' mental health with mostly medium to large effect sizes and were comparable to established treatments such as TBE and DBT-bt. While (facets of) identity were seldomly assessed by the studies, it is possible that narrative interventions work well for this target group because they aid in reworking a (positive) identity and integrate negative or traumatic events in a coherent manner. These mechanisms seem to be especially helpful for a population that struggles with unstable identity and oftentimes trauma (Lind et al., 2020). NET was most effective for improving the mental health of people with BPD, which may be because of the focus on processing events alongside creating a lifeline. But other approaches were promising as well, as most effectively reduced psychopathological outcomes. Of note is that interventions that were focused directly on identity and were positive in their approach (31, 35, 36) seemed to be more effective than those who had other foci, such as NECT with its focus on illness and stigma (17). Consequently, direct and focused treatment on identity with processing of past events and future-orientation seems to be an effective method of improving the mental health of people with PDs. Still, more studies targeted toward people with PD should be conducted in the future, preferably with a diverse sample since BPD was most present in our sample of studies. This would also enable comparison between PD types and who the interventions are most beneficial to.

Strengths and Limitations

This review had multiple strengths as well as limitations. On one hand, the mixed-methods approach strengthened the review by making it more comprehensive and allowing for the integration of qualitative and quantitative findings that could be compared with one another. Moreover, this comprehensiveness was further strengthened by using not only databases but forward and backward reference tracking which resulted in a large number of studies being included. On the other hand, despite discussing the search strategy extensively with an information specialist, we did not use the keyword "therapy" in the search string, which later became apparent as an issue during reference tracking since some articles used this keyword in conjunction with "narrative". However, this could be improved upon by future studies on narrative interventions terming them as such, e.g., with a unified term, such as "narrative psychology" or "narrative intervention". Moreover, the original aim of assessing narrative interventions for people with PDs was not possible as too little studies were conducted on this, thus we had to broaden our aim to people with psychopathology. Further, our search was limited to English studies and published data only, thus it is possible that studies conducted in other languages or countries were missed despite the large variety in countries in our selection of studies. As such, publication bias could have affected our results. Lastly, we were unable to assess interrater reliability since we relied on discussing until a consensus between researchers was reached.

Conclusion

To conclude, narrative interventions present an alternative treatment option to people with psychopathology and especially people with PD with promising effectiveness and longevity and are well-received by participants. While the field has been gaining interest recently, it is still in its infancy and continues to develop, especially regarding intervention characteristics, types of variables assessed, and target groups. Despite the variety of outcome measures, consistent improvements in depression, trauma, and anxiety could be seen across interventions. However, participant experiences do not reflect these outcome measures, as participants mostly valued changes in their identity and recovery, which were seldomly assessed by studies. Thus, future studies should more often include positive variables such as hope, QoL, identity, recovery, self-esteem, and meaning in life as these reflect participant experiences and aims of narrative psychology better. Further research is needed to examine the effectiveness of separate elements employed within interventions, whether online interventions are effective, longevity of effects, which target groups benefit most from narrative interventions, and explore participant experiences more often.

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Appendix A

(‘narrative intervention’ OR ‘narrative approach’ OR ‘narrative self’ OR ‘narrative identity’ OR ‘life stor*’) AND (‘personality disorder’ OR ‘personality pathology*’ OR psychopathology* OR ‘mental disorder’ OR ‘mental illness’ OR ‘psychiatric disorder’ OR ‘psychiatric illness’)

Appendix B

Article	*Criterium*	1.1	1.2	1.3	1.4	1.5	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4	3.5	4.1	4.2	4.3	4.4	4.5	5.1	5.2	5.3	5.4	5.5
1							1	1	1	2	1															
2		1	1	1	1	1						1	1	1	1	0						1	1	1	1	0
3							1	1	1	1	1															
4							1	1	1	2	2															
5							1	1	1	1	1															
6							2	2	2	2	2															
7												1	1	1	1	1										
8							2	1	1	1	1															
9												1	1	0	1	1										
10												1	1	1	1	1										
11		1	1	2	2	2	1	1	1	1	1											1	1	2	2	2
12												1	1	1	1	1										
13							2	1	1	1	0															
14							1	1	1	1	1															
15							1	1	1	2	1															
16							1	1	1	2	1															
17		1	1	1	1	1						1	1	0	1	1						1	1	1	1	1
18												1	1	0	0	1										
19							1	0	0	1	0															
20		1	1	1	1	1																				
21												1	1	0	1	2										
22												1	1	2	1	2										
23		1	1	1	1	1						1	1	0	1	1						1	1	1	1	1
24												1	1	0	1	2										
25												1	1	0	1	1										
26							1	1	1	2	1															
27							1	1	0	2	0															
28							2	1	1	2	1															
29												1	1	1	1	1										
30												1	1	1	1	2										
31		1	1	1	1	1						1	1	0	0	1						1	1	1	1	0
32		1	1	2	0	2																				
33												1	1	1	1	2										
34							1	1	0	2	0															
35												1	1	0	2	2										
36		1	1	1	1	1						1	1	1	1	2						1	1	1	1	1

Note. All screening questions were answered with yes. 0 = No, 1 = Yes, 2 = Can't tell.

Appendix C

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
NET						
1	Alghamdi et al. (2015)	RCT Experimental condition: NET Control: Waitlist Measurements were taken at baseline (T1), post treatment (T2), 3 weeks post treatment (T3), 3-months FU (T4), and 6-months FU (T5)	Population Traumatised firefighters in Saudi Arabia Sample N = 34 All male Intervention n = 17 Mean age = 28.7 SD = 4.1 Years of service 7.17 SD = 3.33 Traumatic events One time = 0 2 or 3 times = 3 > 3 times = 14 Control n = 17 Mean age 32.2 SD = 6.23 Years of service 11.0 SD = 7.44 Traumatic events One time = 3 2 or 3 times = 3 > 3 times = 11	Psychological PTSD symptoms Were significantly decreased within the NET group from T1-T2 (d = .75, p < .001) as well as between-group (d = 2.05, p < .001). Anxiety symptoms Were not significantly decreased within NET group from T1-T2 (d = .58, p > .05), but were significantly decreased between-group (d = 1.57, p < .001) Depression symptoms Were significantly decreased within the NET group from T1-T2 (d = .47, p < .01) as well as between-group (d = 1.15, p < .001). Coping Active Was not significantly increased within NET group (d = .16, p > .05) or between-group (d = .57, p > .05) from T1-T2 Passive Was significantly increased within NET group (d = .78, p < .001) but not between-group (d = .2.94, p > .05) from T1-T2 Social Support Family Was not significantly increased within NET group (d = .18, p > .05), but significantly increased between-group (d = .797, p < .05) from T1-T2 Friends Was not significantly increased within NET group (d = .13, p > .05) or between-group (d = .30, p > .05) from T1-T2 GO-NGO	Conflicting statements regarding attendance All participants completed the treatment in treatment adherence, but reportedly attrition and dropout at T4 and T5	Partially achieved Intervention was only effective for the short-term reduction of psychological outcome measures for within NET group (except for anxiety symptoms) as well as between-group from T1-T2 No longer-term improvement of psychological outcome measures within NET or between-group Active coping was not significantly increased by the study at any measurement point Passive coping was only significantly increased within NET group from T1-T2, but not between-group or any other measurement points No improvements in social support within- or between-group (except for family between-group from T1-T2) at any measurement point

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
				Was not significantly increased within NET group (d = .14, p > .05) or between-group (d = .39, p > .05) from T1-T2 No significant changes on any measures between pre intervention and 3-month FU or pre intervention and 6-month FU for NET group		
2	Ellis & Jones (2022)	Pre-post pilot study with 6-month focus group FU One condition only: NET Measurements taken at baseline (before intervention, T1) and post-intervention (T2)	Population Sudanese refugees in Cairo with PTSD Sample N = 7 F = 5 M = 2 Mean age = 31, range 28-39	Psychological n = 6 SPTSS Post-traumatic stress symptoms Were significantly reduced from T1-T2 (Z = -2.201, p < .028), and of 6 participants, 4 had a reliable change and 3 a clinically significant change HADS Total Was significantly reduced from T1-T2 (Z = -2.023, p < .043) HADS Anxiety Was significantly reduced from T1-T2 (Z = -2.032, p < .042), and of 6 participants, 4 had a reliable and clinically significant change HADS Depression Was not significantly reduced from T1-T2 (Z = -1.753, p = .080), and of 6 participants, 3 had a reliable and clinically significant change	Attendance 100% treatment completion rate	Mostly achieved While most psychological outcome measures show significant reduction post-intervention, depression was not significantly reduced, despite the clinically significant change in 3 participants Still, the participants were very satisfied with the intervention
3	Fan et al. (2021)	RCT (prospective, participant-blinded) Experimental condition: NET and personalised psychological treatment Control: Personalised psychological treatment of 40-60 min once a week Measurements at baseline (T1) and post-test (6-month FU, T2)	Population COVID-19 patients with PTSD-symptoms in China Sample N = 111 F = 69 M = 42 Mean age = 46.38 SD = 12.34	Psychological Time x group Post-traumatic stress symptoms Overall Was significantly more reduced in IG than CG from T1-T2, (d = .143, p < .001) Re-experience Was significantly more reduced in IG than CG from T1-T2, (d = .115, p < .001) Avoidance/Numbing Was significantly more reduced in IG than CG from T1-T2, (d = .037, p = .004) Hyper-arousal Was significantly more reduced in IG than CG from T1-T2, (d = .042, p = .002) Depression Was not significantly more reduced in IG than CG from T1-T2, (p = .329)	Attendance No dropout	Partially achieved While the primary goal of reducing posttraumatic stress symptoms more with NET in comparison to CG was fulfilled, none of the secondary outcome measures (depression, anxiety, sleep quality) were improved within the IG more than in the CG The secondary outcomes were improved from T1-T2 within IG

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
				Was significantly reduced in IG from T1-2 (p < .001) Anxiety Was not significantly more reduced in IG than CG from T1-T2, (p = .390) Was significantly reduced in IG from T1-2 (p < .001) Sleep quality Was not significantly more reduced in IG than CG from T1-T2, (p = .124) Was significantly reduced in IG from T1-2 (p < .001)	
4	Hijazi et al. (2014)	Preliminary RCT Experimental group: NET Control: Waitlist Measurements at baseline (T0), 2-month FU (T1), and 4-month FU (T2)	Population Iraqi Refugees with PTSD in the US Sample N = 63 F = 35 M = 28 Mean age = 48.2, SD = 8.9	Psychological Posttraumatic growth Was significantly more improved in IG compared to CG from T0-T1 (ES = .48, p < .05) Was significantly more improved in IG compared to CG from T0-T2 (ES = .83, p < .001) Psychological wellbeing Was significantly more improved in IG compared to CG from T0-T1 (ES = .56, p < .05) Was significantly more improved in IG compared to CG from T0-T2 (ES = .54, p < .05) Posttraumatic stress symptoms Were significantly more reduced in IG compared to CG from T0-T1 (ES = -.48, p < .05) Were significantly more reduced in IG compared to CG from T0-T2 (ES = -.46, p < .05) Depressive symptoms Were significantly more reduced in IG compared to CG from T0-T1 (ES = -.46, p < .05) Were significantly more reduced in IG compared to CG from T0-T2 (ES = -.27, p > .05) Somatic symptoms Were not significantly more reduced in IG compared to CG from T0-T1 (ES = -.32, p > .05) Were not significantly more reduced in IG compared to CG from T0-T2 (ES = -.13, p > .05)	Attendance NET Completion 95.1% Dropout N = 2, of which 1 due to job and 1 completed single session Assessments NET N = 1 lost to both FU General N = 53 completed both FU N = 9 only completed T1 FU N = 3 only completed T2 FU Satisfaction Satisfaction with treatment 1-10 M = 8.75, SD = 1.71 Significantly higher than benefit of treatment (t(37) = 4.57, p < .001) Benefit of treatment 1-10 M = 7.53, SD = 2.09	Almost fully achieved With small to large effect sizes, almost all outcome measures (except for somatic symptoms) were significantly improved in IG compared to CG at both FU points Participants were very satisfied with the treatment, but perceived their benefit of treatment to be less than their satisfaction with it

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
5	Lely et al. (2019)	RCT Experimental condition: NET Control: Present-centred therapy (PCT): 11 90-min sessions, includes PTSD psychoeducation and homework assignments about current maladaptive relational patterns by including problem-solving techniques that help patients focus on the 'here and now', also delivered by counsellor who followed protocol Focus on daily stress relief Measurements at baseline (T0), post-treatment (T1), and 4-month FU (T2)	Population Older patients with PTSD Sample N = 33 F = 9 M = 24 NET Mean age = 62.65, SD = 5.89 PCT Mean age = 62.47, SD = 6.24	Psychological PTSD severity Total score Was significantly less reduced in NET than PCT at T1 (M = 23.02, p = .008) Re-experience Was significantly less reduced in NET than PCT at T1 (M = 9.25, p = .000) Avoidance Did not differ significantly across time and treatment for T1 Arousal Did not differ significantly across time and treatment Continuous decline can be observed in NET compared to PCT, where decline was only observed at T1 PCT: Intrusion, avoidance, and mean scores showed an increase and PCT avoidance scores exceeded NET scores	Attendance Drop out Rates did not significantly differ Refusal to participate n = 3 Did not accept allocated intervention, not wanting to participate in assessments, and fear of stress increase following exposure sessions Left treatment prematurely n = 3 Two refused to continue the prescribed number of sessions and assessments, one altered personal circumstances Treatment adherence of therapist NET M = 89, SD = 11 PCT M = 87, SD = 14 Did not significantly differ Reliability Interrater reliability for PTSD was good (Cohen's k = .72)	Partially achieved Different to the hypothesis, using therapy, the rate of change of the outcome was not different across both treatments for any outcome measures As hypothesised, during FU, the rate of change of the outcome is different across both treatments on PTSD total, re-experience, and avoidance, but not arousal Different to the hypothesis, the rate of change of the outcome for NET was not equal during therapy and FU As hypothesised, the rate of change of the outcome for PCT was different during therapy and FU, except for arousal As hypothesised, the two conditions have different outcomes at T1 for PTSD total and re-experience, but not avoidance and arousal
6	Manesh et al. (2018)	Single case experimental design Experimental condition: NET Control: Waitlist Measurements at baseline (T0), at second (T1), fourth (T2), sixth (T3), eighth (T4), tenth (T5), and twelfth session (T6) in three two-week, one month, and three months following steps	Population Iranian Survivors of Mina Disaster with PTSD Sample N = 8 F = 4 M = 4 No further information	Psychological No significance level given, Hedges' g PTSD symptoms Severity Was significantly more reduced in NET than control at post-treatment (g = -2.91) and FU (g = -2.90) Intrusive subscale Was significantly more reduced in NET than control at post-treatment (g = -2.37) and FU (g = -2.73) Avoidant subscale Was significantly more reduced in NET than control at post-treatment (g = -4.12) and FU (g = -6.95) NACM subscale Was significantly more reduced in NET than control at post-treatment (g = -2.64) and FU (g = -1.89)	No information	Fully achieved NET significantly improved all outcomes measures in this target group at both post-treatment and FU compared to control Improvement percentages were higher in NET than control on all outcome measures

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
				Arousal and reactivity subscale Was significantly more reduced in NET than control at post-treatment (g = -2.05) and FU (g = -3.22) Depression symptoms Was significantly more reduced in NET than control at post-treatment (g = -2.38) and FU (g = -3.53) Patient health Was significantly more improved in NET than control at post-treatment (g = -.97) and FU (g = -1.44) PTSD symptoms improvement NET overall improvement in PTSD 68.25% vs 12% in control Intrusive symptoms 70.25% Avoidance symptoms 62.5% NACM symptoms 71.25% Changes in arousal and reactivity symptoms 65% Comorbid symptoms NET 63.25% improvement in overall depression vs 10.75% control NET 53.75% improvement in somatic symptoms vs 17% in control		
7	Mauritz et al. (2021)	Single-group pre-post test, repeated-measures design One condition: NET alongside FACT Measurements at baseline (T0), 1-month FU (T1), and 7-month FU (T2)	Population Patients with severe mental illness for comorbid PTSD Sample N = 23 F = 19 M = 4 Mean age= 49.9, SD = 9.81 Schizophrenia spectrum disorder N = 4 Bipolar disorder N = 4 Major depressive disorder N = 15 Duration SMI mean in years = 26.2, SD = 12.1	Psychological Intention-to-treat PTSD symptoms Total symptoms Were significantly decreased at T1 (LSMD = -2.5, p = .005) and T2 (LSMD = -4.83, p < .001) Total severity Was significantly decreased at T1 (LSMD = -6.01, p = .004) and T2 (LSMD = -13.37, p < .001) Intrusions Were significantly decreased at T1 (LSMD = -1.77, p = .026) and T2 (LSMD = -4.23, p < .001) Avoidance Was significantly decreased at T1 (LSMD = -1.49, p = .002) and T2 (LSMD = -2.13, p < .001) Cognition and mood Was significantly decreased at T1 (LSMD = -2.53, p = .014) and T2 (LSMD = -4.00, p < .001) Arousal and mood	Attendance Dropout 2 patients withdrew before inclusion because of somatic illness and family circumstances 2 patients dropped out during NET, one because of increased suicide risk and physical illness and the other because of increased severe mental illness symptoms and physical illness	Almost fully achieved NET significantly improved nearly all outcome measures except for care needs and contact per period NET did not significantly improve measures of arousal, SMI symptoms, or global functioning at T1 but did at T2 Conversely, Quality of Life was improved at T1 but not improved nor maintained at T2 While two participants dropped out due to increased symptoms, no serious events occurred during NET and FU, and none of the participants were admitted to hospital or needed crisis management

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
				Was not significantly decreased at T1 (LSMD = -.34, p = .664) but significantly at T2 (LSMD = -3.05, p < .001) Dissociation Was significantly decreased at T1 (LSMD = -5.38, p = .018) and T2 (LSMD = -6.83, p = .003) SMI symptoms Were not significantly decreased at T1 (LSMD = -2.27, p = .067) but at T2 (LSMD = -2.38, p = .047) Care needs Were not significantly improved at either measurement point Quality of life Was significantly improved at T1 (LSMD = 2.99, p = .048) but not at T2 (LSMD = .65, p = 660) Global functioning Was not significantly improved at T1 (LSDM = -.15, p = .915) but at T2 (LSMD = 4, p = .006) Care Care consumption Contact per period (number) Was not significantly improved at either measurement point Duration of contacts (minutes) Was significantly reduced at T1 (LSMD = 1728, p < .001) and T2 (LSMD = -750, p = .006)		
8	Neuner et al. (2004)	RCT Experimental condition 1: NET Experimental condition 2: Supportive Counselling (SC): 4 sessions, open to participants' needs with focus on current interpersonal problems, personal decisions, and plans/hopes for the future; problem-solving approach Control: Psychoeducation (PE): 3 sessions Measurements at baseline (T0), three to four weeks after	Population PTSD in an African Refugee Settlement Sample N = 43 F = 26 M = 16 NET Mean age = 31.9, SD = 6.7 SC Mean age = 33.8, SD = 7.9 PE Mean age = 34.2, SD = 6.9 One participant declined to participate in the NET group	Psychological PTSD symptoms Scale only Were significantly decreased at T1 (ES = .6) and T3 (ES = 1.6) in NET group Significant time x treatment interaction, favouring NET (η2 = .31, p = .01) Contrast analysis showed NET being superior to SC (p < .01) and PE (p < .01) Diagnostic interview Severity was significantly decreased at T3 (ES = 1.9) in NET group Significant time x treatment interaction, favouring NET (η2 = .21, p = .01) Contrast analysis showed NET being superior to SC (p = .01) and PE (p = .01)	Attendance Dropout EC1 N = 1 refusal to participate, pre-treatment EC2 N = 2 no reason given	Mostly achieved NET significantly improved all outcome measures at T1 and T3, and did so more than SC and PE for PTSD symptoms and severity, more than SC for psychological functioning, but not for PE, and was not superior to SC or PE for decreasing comorbid symptoms Moderate to large effect sizes Participants in the NET group had the best outcomes at 12-month FU

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
		first interview (post-treatment, T1), 4-month FU (T2), and 12-month FU (T3)		Comorbid symptoms Were significantly decreased at T1 (ES = .6) and T3 (ES = 1.1) in NET group No significant time x treatment interaction No significant difference shown in contrast analysis Psychological functioning Were significantly increased at T1 (ES = -.6) and T3 (ES = -1.1) in NET group No significant time x treatment interaction Contrast analysis showed NET being superior to SC ($p < .01$) but not PE ($p = .54$) NET group had significantly fewer participants with PTSD (PE $p = .02$, SC $p = .01$) after treatment (exact T unknown) Differences between treatment groups were significant $\chi^2(2, N = 38) = 9.48$, $p < .01$ Percentage of patients classified as mental health cases NET Pre 100 NET Post 73 NET 4-month FU 73 NET 1-year FU 50 SC Pre 100 SC Post 85 SC 4-month FU 85 SC 1-year FU 77 PE Pre 100 PE Post 92 PE 4-month FU 100 PE 1-year FU 91		
9	Pabst et al. (2014)	2 x 3 experimental design Open trial Experimental condition: NET Control: Treatment by Experts for Borderline Personality Disorder (TBE); outpatient treatment included DBT-elements and other CBT elements, psychoeducation, supportive counselling, strengthening participants'	Population **Patients with Borderline Personality Disorder and comorbid PTSD** Sample N = 22 All female Mean traumatic events = 5 NET N = 11 Mean age = 30.36, SD = 8.64, range 20-45	Psychological No significant group x time or group effect PTSD symptoms Were significantly reduced at T1 (g = 1, $p < .001$) and T2 (g = 1.6, $p < .001$) BPD symptoms Were significantly reduced at T1 (g = .9, $p < .01$) and T2 (g = .8, $p < .01$) Depression symptoms Were significantly reduced at T1 (g = .7, $p < .01$) and T2 (g = 1.3, $p < .01$)	Attendance Dropout NET N = 2 (1 in-, 1 outpatient) Psychosocial problems and spontaneous remission TBE N = 3 (all inpatient) Disciplinary discharge and lack of motivation	Fully achieved NET significantly reduced all outcomes long-term and is comparable to TBE on effect sizes, thus applicable to this target group

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
		individual resources, providing assistance in solving daily problems, improvement in coping skills and crises intervention; inpatient typical routine treatment program once admitted to ZIP, based on DBT and focused on BPD symptoms: weekly individual psychological therapy and group therapy and offered other optional therapies Measurements at baseline (T0), 6-month FU (T1) and 12-month FU (T2)	TBE N = 11 Mean age = 29.45, SD = 11.57, range 19-54	HSCL-25 Were significantly reduced at T1 and T2 (no g given, p < .01) Dissociation symptoms Were significantly reduced at T1 (g = .6, p < .05) and T2 (g = .6, p < .05)		
10	Park et al. (2020)	Experimental study with pre-FU design Experimental condition: NET Control: Treatment as usual: 10-15 individual sessions of 40-60min (supportive therapy or art therapy) as well as 1-hr sleep education sessions about sleep disorders Measurements at baseline (T0), 2-week FU (T1, NET only), 3-month FU (T2, both groups), 6-month FU (T3, both groups)	Population Traumatised North Korean Refugee Youth with PTSD, Depression, and Insomnia in Seoul Sample N = 20 No gender information NET N = 9 Mean age = 18.89, SD = 1.05 Number of traumatic events = 5.44, SD = 1.59 TAU N = 11 Mean age = 18.73, SD = 2.72 Number of traumatic events = 5.73, SD = 1.62 Mental health symptoms did not significantly differ between groups, except for depression symptoms which was significantly higher in the TAU group (p = .045)	Psychological Hedge's g PTSD Severity Significant main effect of time (ηp2 = .68, p < .001), treatment (ηp2 = .54, p < .001), and group x time interaction (ηp2 = .45, p < .001) Symptoms Were significantly reduced in NET group from T0-T3 (g = 3.57, p < .001), but not in TAU group (p = .382) All NET participants lost their PTSD diagnosis at T3 (Fischer's exact test p = .038) Depression symptoms Significant main effect of time (ηp2 = .49, p < .001), treatment (ηp2 = .41, p = .003), but not group x time interaction (ηp2 = .06, p = .322) Significantly reduced in NET group from T0-T3 (g = 1.50, p = .011) Compared to TAU, people in NET group reported significantly lower depression scores at T2 (p = .020) and T3 (p = .002) Internalising and externalising symptoms Time insignificant (?) Treatment insignificant(?) There was a significant group x time interaction effect (ηp2 = .21, p = .013)	Attendance Dropout N = 1 at 6-month FU	Almost fully achieved NET was superior to TAU on all outcome measures with large effect sizes except for depression symptoms, although there were significantly lower scores of depression reported by NET participants compared to TAU participants NET maintained these improvements at 6-month FU

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
				Were significantly reduced in NET group from T0-T3 (g = .99, p = .042), but not in TAU group (p = 1.00) Somatic Insomnia Significant main effect of time (ηp2 = .58, p < .001), treatment (ηp2 = .29, p = .014), and group x time interaction (ηp2 = .28, p = .008) Was significantly reduced in NET group from T0-T3 (g = 2.14, p = .001), but not in TAU group (p = .211) Sleep quality Significant main effect of time (ηp2 = .49, p < .001), treatment (ηp2 = .37, p = .004), and group x time interaction (ηp2 = .18, p = .027) Was significantly improved in NET group from T0-T3 (g = 2.16, p < .001), but not in TAU group (p = NA)		
11	Smaik et al. (2023)	Feasibility RCT Experimental condition: NET Control: Waitlist with educational lecture about positive child-rearing practices Measurements at baseline (T0) and post-intervention (T1)	Population Syrian refugees with PTSD in Jordan Sample N = 40 Mean age = 37.5, SD = 12, range 18-64 F = 30 M = 10 Depression symptoms were higher in IG than CG (p = .01)	Psychological PTSD symptoms Were significantly more reduced in IG than CG post-intervention (d = .73, p < .001) Anxiety symptoms Were significantly more reduced in IG than CG post-intervention (d = .97, p < .001) Depression symptoms Were significantly more reduced in IG than CG post-intervention (d = .79, p < .001)	Attendance No dropouts Adherence to study protocol, data completeness, cultural congruence, and participant satisfaction no further information in article, and the article cited is not available	Fully achieved All symptoms were significantly more reduced in the NET group than the control group with moderate to very large effect sizes Insufficient data on feasibility, so unsure whether this was truly fully achieved
12	Steuwe et al. (2016)	Effectiveness and feasibility pilot study Experimental condition: NET alongside standard (twice-weekly 30 min supportive talk sessions with primary nurse, twice-weekly sessions of art/music therapy, weekly sessions of body therapy; morning meetings, movement therapy, learned relaxation techniques)	Population People with posttraumatic stress disorder and **borderline personality disorder** Sample N = 10 M = 1 F = 9 Mean age = 34.9, SD = 9.71	Psychological Intent-to-treat N = 11 PTSD Was significantly reduced from T0-T1 (d = .7, p = .008) and T0-T2 (d = 1.5, p < .001), with a remission rate of 37.5% Borderline symptoms Were significantly reduced from T0-T1 (d = .6, p = .035) and T0-T2 (d = 1.0, p = .015) Depressive symptoms Were significantly reduced from T0-T1 (d = 1.2, p = .001) and T0-T2 (d = 1.0, p = .001)	Attendance Dropout N = 1 refusal to participate due to perceived instability, pre-treatment N = 1 discharged from treatment Assessments N = 2 lost to T2 FU	Fully achieved All outcome measures were significantly improved with moderate to large effect sizes

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
		Measurements at baseline (prior to admission, T0), post-treatment (T1), and 12-months FU (T2)		Dissociative symptoms Were significantly reduced from T0-T1 (d = .6, p = .035) and T0-T2 (d = .5, p = .025) Quality of life Was significantly improved from T0-T1 (d = .7, p = .006) and T0-T2 (d = 1.1, p = .007)		
13	Steuwe et al. (2021)	RCT Experimental condition: NET alongside standard (twice-weekly 30 min supportive talk sessions with primary nurse, twice-weekly sessions of art/music therapy, weekly sessions of body therapy; morning meetings, movement therapy, learned relaxation techniques) Control: DBT based treatment alongside standard: 50 min individual weekly sessions over 10 weeks and weekly group treatments (180min skills training, 45 min practicing mindfulness and psychoeducation on BPS and 60min patient-guided support group, also 10 sessions) Measurements at baseline (T0), post-treatment (T1), and 12-months FU (T2)	Population People with posttraumatic stress disorder and **borderline personality disorder** Sample NET: N = 29, Female Only, MAge = 30.82 (SD = 8.34) DBT: N = 29, Female only, MAge = 31.27 (SD = 8.24)	Psychological No significant group x time effects NET only, time effects, intent-to-treat N = 29 PTSD severity CAPS Was significantly reduced from T0-T1 (g = 1.3, p < .001) and T0-T2 (g = .8, p < .001) PDS Was significantly reduced from T0-T1 (g = .9, p < .001) and T0-T2 (g = 1.1, p < .001) Remission rates from the diagnosis of PTSD was significantly (p < .05) higher in NET (32%) than DBT-bt (9.1%) from T0-T2 BPD severity SCID-II-BPD Was significantly reduced from T0-T2 (g = 1.1, p < .001) BSL Was significantly reduced from T0-T1 (g = .8, p < .001) and T0-T2 (g = .7, p < .001) Dissociative experiences Were significantly reduced from T0-T1 (g = .4, p < .001) and T0-T2 (g = .5, p < .001) Depression Was significantly reduced from T0-T1 (g = 1.2, p < .001) and T0-T2 (g = 1.1, p < .001) Overall symptom severity Was significantly reduced from T0-T1 (g = .9, p < .001) and T0-T2 (g = .7, p < .001) Quality of life Was significantly improved from T0-T1 (g = -.4, p < .01) and T0-T2 (g = -.4, p < .01)	Attendance Dropout NET N = 1 protocol violation, pre-treatment N = 25 treatment completer N = 4 treatment dropouts (five in text) DBT-bt N = 1 protocol violation, pre-treatment N = 16 treatment completer N = 13 treatment dropouts Assessments NET N = 3 refused assessment 10 weeks after admission N = 2 refused assessment at T2 N = 1 lost to T2 FU DBT-bt N = 11 refused assessment 10 weeks after admission N = 3 refused assessment at T2 N = 4 lost to T2 FU	Partially achieved NET was only superior to DBT-bt in remission rates from PTSD diagnosis, but was not superior regarding reductions in PTSD symptom severity and symptom reduction over time All psychological measures were significantly improved with moderate to large effect sizes

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
14	Zang et al. (2014)	Pilot randomised controlled feasibility study Experimental condition 1: NET Experimental condition 2: revised NET; NET-R Control: Waitlist Experimental: Measurements at baseline (assessment of screening process; T1), post-treatment (T2), after 1 week (NET) or 2 weeks (NET-R; T3), and 3-month FU (T4) Control: Measurements at baseline (assessment of screening process; T1), 2 weeks after trial entry (T2), then given NET-R and assessed post-treatment (T3), and 3-month FU (T4)	Population Chinese earthquake survivors Sample N = 30 Mean age = 53.63, SD = 12.92; Age range 28 - 80 M = 3 F = 27 NET N = 10 M = 1 F = 9 Mean age = 53.50, SD = 1.24 NET-R N = 10 M = 2 F = 8 Mean age = 56.50, SD = 1.47 Control N = 10 F = 10 Mean age = 50.90, SD = 1.23	Psychological No significant time x group interaction effects for any of the measures (using T2 for control as baseline) PTSD severity Was significantly reduced from T1-T2 in NET (ES = 3.65, p < .001; to control: ES = 4.01, p < .001) and NET-R (ES = 4.62, p < .001; to control: ES = 4.31, p < .001) Decreased further at 3-month FU (compared to T1: NET ES = 3.61; NET-R ES = 4.79) Depression Was significantly reduced from T1-T2 in NET (ES = 1.22, p < .001; to control: ES = 1.04, p < .01) and NET-R (ES = 1.39, p < .01; to control: ES = 1.14, p < .01) Anxiety Was significantly reduced from T1-T2 in NET (ES = 1.44, p < .001; to control: ES = 1.42, p < .001) and NET-R (ES = 1.50, p < .01; to control: ES = 1.42, p < .001) General Health Questionnaire Was significantly reduced from T1-T2 in NET (ES = 1.04, p < .05; to control: ES = 2.26, p < .001) and NET-R (ES = 2.58, p < .001; to control: ES = 2.71, p < .001) Positive and negative posttraumatic changes Positive significantly increased in NET (ES = .84, p < .01; to control nonsignificant) and NET-R (ES = .91, p < .05; to control nonsignificant) from T1-T2 Negative significantly decreased in NET (ES = 1.11, p < .01; to control ES = .62, p < .05) and NET-R (ES = 1.98, p < .001; to control ES = .67, p < .01) Coping strategies Nonsignificant except for Active coping significantly increased in NET-R from T1-T2 (ES = 1.57, p < .01)	Attendance Dropout None	Almost fully achieved NET-R and NET both significantly improved almost all psychological measures from pre- to post-treatment and most were stable or improved further at 3-month FU As hypothesised, both treatments did not improve perceived social support in short-term, however, unlike hypothesised, both treatments, but mostly NET-R, improved some coping strategies in short-term post-treatment

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
				Reframing significantly increased in NET (ES = .54, p < .05) and NET-R (ES = 1.25, p < .05) from T1-T2 Planning significantly increased in NET from T1-T2 (ES = .84, p < .05) Religion significantly increased in WL from T1-T2 (ES = .22, p < .05) Self-distraction significantly increased in NET-R from T1-T2 (ES = 1.09, p < .001) All stable at 3-month FU Social Social support No significant changes T1-T2		
NECT						
15	Hansson et al. (2017)	RCT Experimental condition: NECT added onto TAU Control: Waitlist (6-month) Measurements at bseline (T0), post intervention (T1), and 6-month FU (intervention group only, T2)	Population People with severe mental disorders and self-stigma in Sweden Sample Intervention: N = 53 F = 28 (52.8%) M = 25 (47.2%) MAge = 45.1 (SD = 11.5) Psychosis = 24 (64.9%) Depression, anxiety = 6 (16.2%) Other = 7 (18.9%) Control: N = 53 F = 26 (49.1%) M = 27 (50.9%) MAge = 45.3 (SD = 10.9) Psychosis = 28 (71.8%) Depression, anxiety = 6 (15.4%) Other = 5 (12.8%)	Psychological Self-stigma Overall Was significantly more reduced in IG than CG from T0-T1 (d = .5, p =.013) Was significantly reduced from T0-T2 in IG (d = .58, p = .001 Subscales Awareness (p = .049), agreement (p = .028), and application (.042) were significantly reduced within IG from T0-T1, but not harm (p = nonsignificant) Self-esteem Was significantly more improved in IG than CG from T0-T1 (d = .5, p = .008) Was significantly improved from T0-T2 in IG (d = .44, p = .008) Quality of life Was not significantly more improved in IG than CG from T0-T1, nor was it significantly improved within IG from T0-T1 or T0-T2	Attendance Dropout NECT N = 12 N = 6 lost to T2 FU Control N = 7 14 dropouts during intervention phase N = 8 never participated in group phase N = 1 after a few sessions N = 2 moved N = 3 perceived worsening of mental health status	Mostly achieved The primary goal of decreasing stigma was nearly fully achieved (except for harm subscale) and the secondary goal of improving self-esteem was fully achieved at both measurement points Quality of life was not improved within-and-between group nor within-group Moreover, changes in self-stigma are correlated to exposure
16	Huang et al. (2023)	Multicentre RCT Experimental condition: NECT	Population People with chronic schizophrenia in chronic rehabilitation wards and day wards in Taiwan	Psychological Internalised stigma ISMIS Was not significantly more reduced in IG compared to CG from T0-T1 (ES = .098, p = .688)	Attendance Dropout NECT N = 1 discharged (before T1)	Partially achieved Only few of the outcome measures (internalised stigma and stopping self) were

Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
	Control: Treatment as usual and one-time psychosocial education on perceived stigma Measurements at baseline (T0), 12 weeks after start of the intervention/end of cognitive restructuring (T1), and at the end of the 20-week intervention (after narrative enhancement)	Sample N = 86 F = 45 M = 41 Mean age CG = 48.67, SD = 11.15 Mean age EG = 47.77, SD = 8.73	Was significantly more reduced in IG compared to CG from T0-T2 (ES = .453, p = .036) DISC unfair treatment Was not significantly more reduced in IG compared to CG from T0-T1 (ES = .115, p = .636) Was not significantly more reduced in IG compared to CG from T0-T2 (ES = .099, p unknown) DISC stopping self Was significantly more reduced in IG compared to CG from T0-T1 (ES = .557, p = .022) Was significantly more reduced in IG compared to CG from T0-T2 (ES = .455, p = .015) DISC overcoming stigma Was not significantly more reduced in IG compared to CG from T0-T1 (ES = .252, p = .233) Was not significantly more reduced in IG compared to CG from T0-T2 (ES = .410, p = .539) DISC positive treatment Was not significantly more improved in IG compared to CG from T0-T1 (ES = .164, p = .572) Was not significantly more improved in IG compared to CG from T0-T2 (ES = .198, p = .192) Hope Was not significantly more improved in IG compared to CG from T0-T1 (ES = .080, p = .703) Was not significantly more improved in IG compared to CG from T0-T2 (ES = .344, p = .454) Depressive symptoms Was not significantly more reduced in IG compared to CG from T0-T1 (ES = .061, p = .760) Was not significantly more reduced in IG compared to CG from T0-T2 (ES = .017, p = .770) Self-Esteem Was not significantly more improved in IG compared to CG from T0-T1 (ES = .080, p = .703) Was not significantly more improved in IG compared to CG from T0-T2 (ES = .344, p = .454)	N = 3 transferred to other wards (before T1) Control N = 2 discharged (1 before T1, 1 before T2) N = 1 absence from day care	significantly more improved in IG than CG, with internalised stigma only being improved after the narrative enhancement part of NECT was finished However, as NECT was compared to TAU, NECT seems to be similar in its effectiveness as TAU

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
17	Oudejans et al. (2022)	Pre-post pilot study One condition only: NECT Measurements at baseline (T0) and post-treatment (T1)	Population People with severe mental illness in the Netherlands Sample N = 41 F = 63.4% Mean age = 44.5, SD = 12 Years in treatment (N = 20) = 6.03, SD = 4.9 Diagnosis (N = 29) Mood disorder = 17.2% Bipolar disorder = 31.0% Schizophrenia spectrum disorder = 44.8% Trauma and stress-related disorders = 6.9% Anxiety disorder = 10.3% **Personality disorder = 24.1%**	Psychological Self-stigma Was signifcantly reduced T0-T1 (d = .10, p = .01) Hope Was signifcantly improved T0-T1 (d = .10, p = .03) Self-concept clarity Was not improved significantly (p = .93) Attended sessions Was significantly correlated to outcomes (r = .22, p < .05) Personal recovery Was not improved significantly (p = .50) Attended sessions Was significantly correlated to outcomes (r = .27, p < .01) Quality of life Was not significantly improved (p = .89)	Attendance M = 12.9 sessions, SD = 6.4 32 'exposed' participants (78%) attended at least six sessions or one part of the intervention Exposed participants session attendance M = 15.9 sessions, SD = 3.2 Dropout 12 participants, mostly during Part 1-2 Enhancing and impeding factors according to facilitators Intervention: two factors purely enhancing, attractiveness of the intervention manual and duration of the intervention was seen as impeding by 43% of facilitators and enhancing by 57% Conditional: all as purely enhancing except for time investment and available time to prepare/complete sessions which were seen as impending by 12% of facilitators	Partially achieved While feasible, the intervention only reduced negative psychological outcomes with small effect sizes and did not significantly improve any positive psychological outcomes
18	Roe et al. (2013)	Quasi-experimental pre-post Experimental condition: NECT Control: Treatment as usual Measurements at baseline (T1), and post-intervention (T2, average 6-month after baseline)	Population People with serious mental illness in Israel Sample N = 119 M = 54 F = 65 NECT N = 63 Mean age = 39, SD = 12.1, range 20-69 Significantly younger than TAU group, p = .038 Significantly less educated than TAU group, p = .009 TAU	Self-stigma Total Significant main effect of time (p = .004), and group x time interaction (ηp2 = .06, p = .006)but not group (p = .193) Alienation Significant main effect of time (p = .006), and group x time interaction (ηp2 = .04, p = .023) but not group (p = .417) Stereotype endorsement Significant main effect of group (p = .024), and group x time interaction (ηp2 = .08, p = .002) but not time (p = .239) Social withdrawal Significant main effect of time (p = .009), and group x time interaction (ηp2 = .04, p = .039) but not group (p = .433)	Attendance Dropout 28% (n = 39) attended no more than the first 3 sessions 95 participants attended most of the 20 NECT sessions, of which 63 (66%) completed T2 assessment	Mostly achieved While there was no significant time effect on stereotype endorsement, quality of life, and hope, most outcome measures were significantly more improved in NET group than TAU group with small to moderate effect sizes No group x time interaction effect was observed for discrimination experience, hope total or hope pathway Nearly a third of participants dropped out, and only 63 participants completed the post-intervention assessment

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
			N = 56 Mean age = 44, SD = 12.3, range 20-68 Participants at T2 included a larger number of people with academic degrees, p < .05 Most likely that most had a psychotic disorder	Discrimination experience Significant main effect of time (p = .004), but not group (p = .434) or group x time interaction (p = .205) Quality of life No significant main effect of time (p = .585) or group (p = .172), but significant group x time interaction (ηp2 = .04, p = .043) Hope Total Significant main effect of time (p = .029), but not group (p = .215) or group x time interaction (p = .190) Pathway No significant effects Agency Significant main effect of time (p = .009), and group x time interaction (ηp2 = .04, p = .043)but not group (p = .263) Self-esteem Significant main effect of time (p = .006), and group x time interaction (ηp2 = .08, p = .003) but not group (p = .136)		
19	Yanos et al. (2019)	RCT Experimental condition: NECT alongside treatment as usual Control: Supportive group therapy + TAU: 20 weekly meetings facilitated by two co-facilitators, followed manualised approach. Focus is on offering participants the opportunity to share recent experiences, problems, and concerns with the group and to receive feedback from facilitators and group members TAU was medication monitoring, case management, and psychotherapy	Population People with severe mental illnesses Sample N=170 Mean age = 45.5, SD = 11.7 NECT N = 85 M = 51 F = 32 T = 2 Control N = 85 M = 51 F = 34 T = 0	Psychological Self-stigma Total Was significantly more reduced in IG-outpatient compared to CG-outpatient at T1 (ES = .25, p = .04) maintained at T3 Alienation Was not significantly improved Stereotype endorsement Was not significantly improved Discrimination experience Was significantly more improved in IG-outpatient than CG-outpatient (p = .03, ES unknown) Social withdrawal Was significantly more improved in IG than CG at T1 (ES = .34, p = .03)	Attendance Dropout 44 of 170 participants who completed T0 did not complete T1 (26%), and those who dropped out were more likely to be assigned to SGT (p < .05) Treatment exposure 63% of participants attended 6 sessions or more and were thus exposed to treatment, NECT participants attended significantly more sessions than control (M = 10.8, M = 8.2, p < .05) and were more likely to be considered exposed (74%, 52%, p < .01)	Partially achieved Only some of the outcome measures were significantly more improved in IG than CG with small to moderate effect sizes Moderate to high feasibility due to low dropout and moderate exposure

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
		Measurements at baseline (T0), post-intervention (5 months after baseline, T1), 3-month FU (T2), 6-month FU (T3)		Self-esteem Was not significantly improved Hope Was significantly more improved in IG-comprehensive compared to IG-outpatient, CG-outpatient and CG-comprehensive (p = .01, no ES) Psychiatric symptoms Were not significantly improved Coping with symptoms Problem-centred coping Was not significantly improved Avoidant coping Was significantly more improved in IG than CG at T1 (ES = .08, p = .02) Functioning Social functioning Was not significantly improved Narrative insight Illness awareness Was significantly more improved in IG-comprehensive than IG-outpatient and CG-outpatient (p = .01, ES unknown)		
Reminiscence therapies						
20	Bohlmeijer et al. (2008)	Quasi-experimental pre-post study with two parallel conditions Experimental condition: The story of your life Control: Waitlist Measurements at baseline (week before intervention, T0) and after the intervention (T1)	Population Older adults with depressive symptomatology in the Netherlands Sample N= 106, mean age of 63.9 years (range 55-87), 61.4% were female.	Psychological Meaning in life Was significantly increased from T0-T1 within IG (d = .38, p < .05), but was not significantly higher than CG (p = .279) Evaluation of meaningful sources self and social relations Self Negative Was significantly reduced from T0-T1 within IG (66.7 to 40.4, p < .05) Social relations Positive Was significantly increased from T0-T1 within IG (24.6 to 43.9, p < .05) Evaluation of past and future Past Positive Was significantly increased from T0-T1 within IG (22.8 to 47.4, p < .05) Past Negative	Attendance Assessments IG N = 57 completed both T0 and T1 questionnaires CG N = 36 completed both T0 and T1 questionnaires No information on how many allocated to which group	Partially achieved While the intervention group improved on meaning in life from T0-T1, there was no significant interaction effect between group and time Only few of the evaluations of sources of meaning were improved (5 of 14) in the intervention group Women are only more positive about the self and past after the intervention compared to men, as opposed to more of the evaluation components

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
				Was significantly reduced from T0-T1 within IG (35.1 to 19.3, p < .05) Future Negative Was significantly reduced from T0-T1 within IG (40.4 to 15.8, p < .05) The IG nor the CG differed significantly within- or between-group for Self Positive, Social relations Negative, Physical integrity Positive and Negative, Activities Positive and Negative, General Positive and Negative, or Future Positive Women improved more than men on Self Negative (68.3 to 34.1, p < .05) and Past Positive (22.0 to 46.3, p < .05) & Negative (39.0 to 19.5, p < .05)		
21	Chueh & Chang (2013)	Quasi-experimental study with purposive sampling Experimental condition: GRT combined with routine care Control: Routine care (daily nursing home activities) for 1 month Measurements were taken at baseline (1 week before intervention, T0), post-treatment (a week after GRT, T1), 3-month FU (T2), and 6-month FU (T3)	Population Male veterans with depressive symptoms in Taiwan Sample N = 21 Intervention N = 11 Age 70-79 = 6 80-89 = 3 90-99 = 2 Control N = 10 Age 70-79 = 4 80-89 = 6 90-99 = 0	Psychological Depressive symptoms Were significantly more reduced in IG than CG from T0-T1 (Estimate = -8.69 z = 39.54, p < .001) Were significantly more reduced in IG than CG from T0-T2 (Estimate = -5.20 z = 7.96, p = .005) Were significantly more reduced in IG than CG from T0-T3 (Estimate -8.09 z = 11.18, p = .001) Geriatric depression Was significantly more reduced in IG than CG from T0-T1 (Estimate = -.83 z = 25.32, p < .001) Was significantly more reduced in IG than CG from T0-T2 (Estimate = -.68 z = 13.13, p < .001) Was significantly more reduced in IG than CG from T0-T3 (Estimate = -.55 z = 6.24, p = .013)	Attendance Dropout IG No dropouts during intervention N = 4 lost to T2 FU None lost to T3 FU CG N = 3 during 1-month waiting period N = 1 lost to T2 FU None lost to T3 FU All of those completing T3 FU completed intervention afterward	Mostly achieved Compared to the CG as well as baseline, depressive symptoms and geriatric depression reduced at all measurement points However, in the IG geriatric depression as well as depressive symptoms increased from T1-T2, and T2-T3, although still lower than baseline measurements.
22	Karimi et al. (2010)	Empirical pre-post-test study with random allocation Experimental Condition 1: Integrative reminiscence therapy Experimental Condition 2: Instrumental reminiscence therapy Control condition: social discussion Measurements at baseline (T0) and post-intervention (T1)	Population Institutionalized older adults with depression symptoms Sample N = 29 M = 12 F = 17 Mean age = 70.5 (SD unknown), range 64-87	Psychological Depression symptoms People in integrative RT had a mean score of 9.40 (SD = 3.02) pre-test, and a mean score of 4.55 (SD = 2.67) post-test People in instrumental RT had a mean score of 9.22 (SD = 2.72) pre-test, and a mean score of 7.017 (SD = 3.317) post-test People in social discussion had a mean score of 9.10 (SD = 2.60) pre-test, and a mean score of 8.125 (SD = 2.261) post-test Scheffé's test revealed that integrative RT is superior to social discussion, and social discussion	Attendance 39 randomly selected N = 10 excluded from study, e.g. due to illness or not attending at least 60% of the sessions No further information	Partially achieved While participants in the integrative RT group showed significantly fewer depressive symptoms compared to integrative RT and social discussion group participants, integrative RT was not superior to social discussion group although this was expected

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
				is equally as effective as instrumental RT (based on negative numbers: 1 < 3 = 2)		
23	King et al. (2018)	Single group pre-post-test design Condition: GRT with added Creative Writing Instruction Measurements at baseline (T0) and post-intervention (T1)	Population U.S. veterans over age 65 with depression, anxiety, PTSD, adjustment disorder, or other aging related health or family stressors. Client sample N= 34 (M=29, F=5) mean age of 70.89 (SD = 8.30).	Psychological Patient Health Questionnaire (PHQ-9): Mean pre-test score was 12.17 (SD = 6.07) Mean post-test score was 8.28 (SD = 4.52); moderate to minimal/mild depressive symptoms A paired t-Test revealed a statistically significant reduction in scores from pre-test to post-test (p = .005). On average, scores went down by nearly 4 points (M = −3.89, SD = 5.76).	Attendance Of 45 veterans screened, 34 participated in two or more group sessions	Fully achieved While no effect size is given, depressive symptoms significantly went down by an average of four points from T0-T1, which is a decrease from moderate to minimal/mild depressive symptoms Mostly positive feedback from clients to the researcher about the intervention
24	Willemse et al. (2009)	One-group pre-post design Single condition: Creative reminiscence program Measurements at baseline (T0) and post-intervention (T1)	Population Older adults with severe mental disorders Sample N = 46, 36 completed course F = 26 M = 10 Mean age = 67, SD = 9, range 51 – 83 Mean stay = 5 years, SD = 5, range 0 – 19 69% psychiatric hospital 31% sheltered housing Disorders Psychotic disorder 40% Mood disorder 25% Amnestic disorder 11% 6% substance-related disorder 18 participants had clinically relevant depressive symptoms	Psychological Depressive symptoms Were not significantly reduced in the overall sample (p unknown), but were significantly reduced in the sample of people with psychotic disorders (d = .41, p < .05) Life satisfaction of older people living in institutions Was significantly increased in the overall sample (d = .27, p = .02), psychotic disorder sample (d = .32, p < .05), and depressive cases (d = .60, p < .05), but not in non-psychotic or non-depressive sample (p unknown) Agitation Was not significantly improved in any sample Attitudes towards own aging Was not significantly improved in any sample but depressive cases (d = .056, p < .05) Life satisfaction Was only significantly improved in the overall sample (d = .20, p = .05) End-term mastery Was not significantly improved in any sample	Attendance Dropout 36 of 46 participants completed the course (78%) 3 left before course started, 2 experienced a difficult period and were not able to participate, some moved away, 3 did not like the course (either creative or verbal part), 2 probably lacked motivation 5 of 7 participants who dropped out during the course had a psychotic disorder Rates Mean attended sessions n = 11 (SD = 1.3) Evaluation Percentages Yes - Neutral - No Satisfied with the course Overall: 74 - 14 - 12 Psychotic disorder: 79 - 14 - 7 Depressive case: 66 - 17 - 17 Like reminiscing Overall: 68 - 11 - 21 Psychotic disorder: 69 - 0 - 31 Depressive case: 62 - 7 - 31	Partially achieved Only some outcome measures were significantly improved, with small to moderate effect sizes most notably in the depressive sample Despite the effectiveness, depressive cases generally evaluated the intervention more negatively/critically while the general sample and psychotic disorder sample evaluated it more positively High attendance and little dropout

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
					Benefit from course Overall: 51 - 19 - 30 Psychotic disorder: 58 - 17 - 25 Depressive case: 39 - 28 - 33 Recommend course Overall: 57 - 26 - 17 Psychotic disorder: 55 - 18 - 27 Depressive case: 47 - 29 - 24 Too short/little - Good - Too long/much Length of sessions Overall: 14 - 66 - 20 Psychotic disorder: 25 - 58 - 17 Depressive case: 17 - 56 - 28 Number of sessions Overall: 38 - 52 - 10 Psychotic disorder: 45 - 46 - 9 Depressive case: 27 - 66 - 7 Number of participants Overall: 15 - 74 - 11 Psychotic disorder: 9 - 73 - 18 Depressive case: 23 - 62 - 15	
25	Hendriks et al. (2019)	Pre-post pilot study One group: Life review therapy Measurements taken at baseline (one week prior to treatment, T0), and post-intervention (one week after treatment, T1)	Population Older adults with depressive symptoms in general practice in the Netherlands Sample 29 Post-test 21 female (72%), lived alone (79%), had children (90%) and a low educational level (62%) 19 had clinically relevant depressive symptoms (66%) MAge = 76.8 (SD = 8.37)	Psychological Depressive symptoms Were significantly reduced from T0-T1 (d = -.66, p = .012) Anxiety symptoms Were not significantly reduced from T0-T1 (d = -.27, p = .180) Psychological wellbeing Was not significantly improved from T0-T1 (d = .30, p = .080) Agitation Was not significantly reduced from T0-T1 (d = .21, p = .195) Lonely dissatisfaction Was significantly reduced from T0-T1 (d = .32, p = .041) Attitude towards aging Was not significantly improved from T0-T1 (d = .11, p = .433)	Attendance Completion: 81% Attendance: 7 of 8 sessions (SD = .68) Intervention evaluation (Percentages) Length of session: Too Long – 72 Exactly right – 28 Number of sessions: Exactly right – 72 Too many – 3 Too little – 24 Professional leading course Well-led – 93 Averagely – 7 Talking about memories Pleasant – 55 Neutral – 28 Unpleasant – 17 Creative exercises Pleasant – 69 Neutral – 18 Unpleasant – 14	Partially achieved While depressive symptoms were significantly reduced, most secondary outcomes were not significantly improved (except for lonely dissatisfaction) The intervention was evaluated mostly positively, but most participants did not like the length of each session, saying it was too long The evaluation of the parts of the intervention (creative exercises, talking about memories) were quite split, although the majority liked these parts, talking about memories was either assessed neutral or unpleasant. Moreover, four participants

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
				Mastery Was not significantly improved from T0-T1 (d = -.21, p = .245)	Recommend Yes – 72 Neutral – 14 No – 15 Satisfaction 1-10 Mean = 7.31 (SD = 1.63)	would not recommend this intervention to others
26	Korte et al. (2012)	Pragmatic multisite RCT Experimental condition: Life review therapy Control: TAU Measurements at baseline (T0), post-treatment (directly after, T1), 3-month FU (T2), and 6-month FU (intervention only, T3)	Population Older adults with moderate depressive symptomatology Sample N = 202 F = 76.7% M = 23.2% Mean age = 63.3, SD = 6.5, range 55-83	Psychological Depressive symptoms Were significantly reduced at T1 in IG (d = .60, p < .001) and maintained at T2 (d = .50, p < .001) Anxiety symptoms Were significantly reduced at T1 in IG (d = .28, p < .01) and maintained at T2 (d = .25, p < .05) Positive mental health Was significantly improved at T1 in IG (d = .29, p < .001) and maintained at T2 (d = .26, p < .001) Current major depressive episode (MDE) Participants in IG were more likely to not be in a current major depressive episode at T1 than participants in CG (OR = .57, n.s., p = .08) Quality of life Was not significantly improved at T1 or T2 in IG Means on all measurements were about the same T2-T3 in IG	Attendance Treatment adherence Of all participants, 85.1% filled out the questionnaires at all measurement times (80.4% intervention) Dropout Did not want to start n = 1 Discontinued n = 7 Lack of motivation n = 5 Health problems n = 2	Mostly achieved Almost all outcome measures were significantly improved in the IG with small to moderate effect sizes, although QoL and MDE were not significantly improved There was a low dropout, and the intervention may be particularly helpful for target groups with higher extraversion and lower levels of boredom reduction
27	Lamers et al. (2015)	RCT Experimental condition 1: Life-review Experimental condition 2: Expressive writing (adapted): 7 modules, 15-30 min writing about emotional experiences Duration unclear Psychoeducational text on emotion regulation and instructions in expressive writing Control: Waitlist (allowed to start psychological treatment);	Population Adults (40+) with moderate depressive symptomatology. Sample N=174 EC 1: N = 58 Mean age = 57.31, SD = 10.35 M = 14 F = 44 EC 2: N = 58 Mean age = 56.86, SD = 7.86 M = 13 F = 45	Psychological Depressive symptoms Were significantly more reduced in EC1 than in CG at T1 (d = .35, p < .01) Anxiety symptoms Were not significantly more reduced in EC1 than in CG at T1 (d = .31, p > .05), but were significantly reduced from T2-T3 in EC1 (d = -.25, p < .05) Emotional wellbeing Was significantly more improved in EC1 than in CG at T1 (d = .16, p < .05) Psychological wellbeing Was significantly more improved in EC1 than in CG at T1 (d = .27, p < .05)	Attendance Dropout Similar for all three conditions At T1 dropout-rate 10.3% At T2 (experimental only) dropout-rate 19.0% At T3 (experimental only) dropout-rate 22.4% Adherence EC 1: 24.1% discontinued due to occurrences of medical illness or life event as well as the intervention not meeting the expectations or was too demanding EC 2: 20.7% discontinued due to same reasons	Partially achieved Life-review was significantly more effective on depressive symptoms, anxiety symptoms, and wellbeing (excl. social wellbeing) at T1 than control with small effect sizes Life-review is not superior to effective writing and may even have adverse effects on psychological wellbeing compared to effective writing long-term As hypothesised, life-review was significantly more effective on ego-integrity and rumination at T1 than control with small

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
		received life-review with e-mail guidance directly after T1 Measurements at baseline (T0), 3 months (post-intervention; T1), 6-months (T2, experimental only), and 12-months (T3, experimental only)	Control: N = 58 Mean age = 56.64, SD = 9.08 M = 13 F = 45	Was significantly more improved in EC1 than in EC2 at T1 (d = .22, p < .05) Was significantly less improved in EC1 than in EC2 at T2 (d = -.32, p < .01), which was not significantly maintained at T3 (-.29, p > .05) Social wellbeing Was not significantly more improved in EC1 than in CG at T1 (d = .2, p > .05) Process Ego-Integrity Ego-despair Was not significantly more improved in EC1 than in CG at T1 (d = .04, p > .05) Ego-integrity Was significantly more improved in EC1 than in CG at T1 (d = .26, p < .001) Rumination Was significantly more improved in EC1 than in CG at T1 (d = .18, p < .05) No other significant differences between-group were found Emotional, psychological, and social wellbeing as well as anxiety effects remained stable at T2 and T3, but not T1-T2 for psychological wellbeing and in anxiety T2-T3	Participants of life-review condition spent more hours (M = 5.25, SD = 6.85) weekly on the intervention compared to expressive writing (p < .01) Satisfaction EC 1 Scale 1-4: 3.02 (SD = .53, N = 51) Scale 1-10: 7.3 (SD = 1.27, N = 53) EC 2 Scale 1-4: 2.99 (SD = .71, N = 53) Scale 1-10: 7.3 (SD = 1.59, N = 49)	effect sizes, and ego-integrity as well as rumination are mediating factors for the effectiveness of the intervention As hypothesised, age was not a moderator
Other						
28	Barbosa et al. (2013)	Longitudinal RCT Experimental condition: Cognitive narrative intervention based on cognitive narrative therapy Control: Waitlist Measurements were taken at baseline (T1) and 2-month post-intervention (T2)	Population Bereaved elders with spousal loss over six months ago in Portugal Sample N = 40 Mean age = 80.10, SD = 7.34, range 65-92 Intervention N = 20 M = 3 F = 17 One lost to FU due to death of participant Control	Psychological Complicated grief Compared to CG, was reduced significantly from T1-T2 (g = 2.41, p < .01) Depressive symptoms Compared to CG, was reduced significantly from T1-T2 (g = 1.57, p < .01) Traumatic symptoms Compared to CG, was reduced significantly from T1-T2 (g = 3.59, p < .01)	Attendance Dropout N = 1 lost to FU due to death Evaluation 0-10 N = 19 Importance of intervention M = 9.84, SD = .50 Help me decide better M = 8.11, SD = 1.56 To clarify thoughts and emotions M = 7.74, SD = 1.56 Additional support M = 9.32 SD = .82	Fully achieved Large and consistent decrease of symptoms on a longer term Significant time and interaction effect

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
			N = 20 M = 2 F = 18	There was a very positive time effect for IG from T1-T2 ($p < .01$) and a positive interaction effect ($p < .05$)	To live a better life M = 7.79, SD = 1.47 Importance of seeking help M = 9.16, SD = .96	
29	Beernink & Westerhof (2020)	Quasi-experimental with 2-month FU Experimental condition: My Lifestory intervention Control: Treatment as usual (CBT or problem-solving therapy once w week; assertiveness training once a week during 2 months) Measurements were taken at baseline (T1), immediately after intervention (4 months after baseline, T2), at 2-month FU (6 months after baseline, T3)	Population Adults with intellectual disability and depressive and trauma-related complaints in the Netherlands Sample IQ Range: 60 – 70 = 37.1% 70 – 85 = 62.9% Intervention: N = 32 F = 19 M = 13 Age: 18 – 24 N = 5 25 – 34 N = 6 35 – 44 N = 7 45 – 54 N = 11 55 – 64 N = 3 65 – 74 N = 0 Control: N = 30 F = 18 M = 12 Age: 18 – 24 N = 2 25 – 34 N = 7 35 – 44 N = 6 45 – 54 N = 8 55 – 64 N = 6 65 – 74 N = 1	Participants in control condition started with higher life satisfaction ($p = .042$), no significant differences besides this No significant main effects of condition Significant effect of time on all five measures, with decreases in psychiatric symptoms and increases in wellbeing, life satisfaction, mastery, and purpose in life Psychological Psychiatric symptoms Were significantly more reduced from T1-T2 in IG than CG (at FU: $d = .51$) Wellbeing Was significantly more improved from T1-T2 in IG than CG (at FU: $d = .57$) Life satisfaction Was significantly more improved from T1-T2 in IG than CG (at FU: $d = .62$) Mastery Not significantly more improved from T1-T2 in IG than CG (at FU: $d = -.02$) Purpose in life Was significantly more improved from T1-T2 in IG than CG (at FU: $d = .46$) Interaction effects showed at post-intervention and remained at FU No significant interactions between diagnosis (depression vs PTSD), time, and condition nor IQ, time, and condition	Attendance Dropout IG N = 6, of which 3 due to personal circumstances, two due to being discharged, one due to ward transfer CG N = 10, of which 2 due to care stopping and 8 due to refusal to complete assessments after first measurement	Almost fully achieved With moderate effect sizes, the intervention My Lifestory improved participants' psychiatric symptoms, wellbeing, life satisfaction, and purpose in life more than treatment as usual Only mastery was not improved more in comparison to the CG
30	Konsztowicz et al. (2021)	Pre-post pilot study Experimental group: SELF intervention on top of TAU Control: Waitlist / TAU	Population People with schizophrenia and related psychoses Sample N = 35 M = 18	Psychological Illness engulfment Was reduced significantly more in IG than CG ($\eta p2 = 0.15$, $p = .02$) Was reduced from T0-T1 in IG (ES = .48, p unknown)	Attendance Dropout IG N = 2, did not receive treatment CG	Partially achieved Only some of the outcome measures were significantly improved, and only one was significantly more reduced in

Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
	Measurements at baseline (T0) and post-intervention (1 week after, T1)	F = 17 Intervention: N = 18 F = 10 (55.6%) M = 8 (44.4%) MAge = 39.6 (SD = 12.7) Waitlist: N = 17 F = 7 (41.2%) M = 10 (58.8%) MAge = 41.1 (SD = 8.7)	Recovery style Was improved from T0-T1 in IG (ES = .37, p unknown) Was not improved more significantly in IG than CG (ηp2 = 0.02, p = .38) Self-esteem Was not improved more significantly in IG than CG (ηp2 = 0.06, p = .18) Was improved from T0-T1 in IG (ES = .35, p unknown) Internalised stigma Was not reduced more significantly in IG than CG (ηp2 = 0.04, p = .28) Was reduced from T0-T1 in IG (ES = .25, p unknown) Depression Was not reduced more significantly in IG than CG (ηp2 = 0.03, p = .33) Was reduced from T0-T1 in IG (ES = .10, p unknown) In participants who scored >6 at baseline ES = .50 Quality of life Was not improved more significantly in IG than CG (ηp2 = 0.02, p = .49) Was improved from T0-T1 in IG (ES = .03, p unknown)	N = 2 one of which did not meet inclusion criteria anymore and other dropped out, did not complete waitlist period N = 1 unable to complete evaluation during analysis period N = 6 of which 4 unable to contact and 2 discontinued intervention at FU after treatment Satisfaction (Percentages) Expectation and perception of progress Positive – 93.1 Neutral – 4.6 Negative – 2.3 Beliefs about CBT skills/knowledge gained Positive – 62.1 Neutral – 29.3 Negative – .5 Ratings of therapist attributes Positive – 98.5 Neutral – 1.0 Negative – .5 Perceived usefulness of between-session tasks Positive – 86.2 Neutral – 10.3 Negative – 3.4 General satisfaction Positive – 93.1 Neutral – 6.9 Negative – 0 Rating experience Positive – 96.6 Neutral – 0 Negative – 3.4 Recommending to others Positive – 93.1 Neutral – 0 Negative – 6.9	IG than CG with a small effect size However, participants were very satisfied with the intervention

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
					Feeling more positively about self Positive – 93.1 Neutral – 0 Negative – 6.9 Self-exploration Positive – 96.6 Neutral – 0 Negative – 3.4 Continuing therapy if possible Positive – 89.7 Neutral – 0 Negative – 10.3	
31	Pol et al. (2023)	Feasibility pre-post study Single condition: An Empowering Story Measurements at baseline (T0), 5 weeks (T1), and end of the intervention (T2)	Population **People with personality disorders** Client sample N = 13 M = 5 F = 8 At least one personality disorder (avoidant 38.5%, borderline 30.8%, not otherwise specified 38.5%) Most frequent comorbidities were depression and PTSD MAge = 33 (SD = 7.1, range = 23 – 48) MTreatment Years = 5 (SD = 2.4, range 1 – 10) Professional sample Two counsellors; One licensed clinical psychologist (female, age 50, 25 years of clinical experience, MSc, working at Scelta) and master-level psychologist (female, age 28, 4 years of experience with narrative research, MSc, working at Twente University); another psychologist (female, age 28, 4 years of clinical	Psychological Mental Health Recovery: Was not significantly improved from T0-T1 (d = -.30, p = .079), but was significantly improved from T0-T2 (d = -.58, p = .016) Content Part 1 Positive events: 39% Negative events: 42% Ambivalent events: 18% Neutral events: 2% Chronological arrangement: 98% Thematic arrangement: 2% Part 2 Explicit turning point: 97% Of which, innovative moments of reflection 38% action 26% protest 19% performing change 14% Part 3 Integration present and future: 89% Narrative processes Part 1 100% descriptive 47% emotional 60% reflective 40% combination Part 2 96% descriptive 40% emotional	Attendance Dropout Five out of 13 (38.5%) Decided not to come back after single session (1), many absences (1), process too fast, timing not right, too much investment (3) Client adherence 8 out of 13 finished life story books and were present at sessions 9-12 (62.5%) Satisfaction Clients M = 36 (range 30 – 39) out of 40 Counsellors 30 and 35 out of 36 Per session: M = 30.3 out of 36 (range 26 session 5 to 33 in sessions 11 and 12) Treatment integrity (counsellors) M = 89% (range 50 – 100)	Mostly achieved While client and counsellor satisfaction were high for this intervention, more than a third of participants dropped out of the study Despite this, the intervention had a significant improving effect on the mental health recovery of participants with a medium effect size at the end of the intervention The intervention helped to empower participants as seen in the increase of agency in the stories Absence of communion also decreased in the intervention writings

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
			experience, MSc, working at Scelta) recruited and involved as independent observer	72% reflective 32% combination Part 3 81% descriptive 50% emotional 99% reflective 44% combination Analysis on agency and communion Increase in agency across parts (50% - 65% - 81%) Communion relatively constant (58% - 55% - 57%) Absence of communion decreased (42% - 24% - 15%) Stories became more neutral		
32	Schilling et al. (2015)	RCT	Population Adults with a diagnosis of a severe mental disorder Sample N=80 no further information	Psychological Self-stigma Psychopathology Functional Quality of life Alcohol consumption	Attendance 68% rate of consistent attendance	Not able to be assessed
33	Seo et al. (2015)	Quasi-experimental pre-post study Experimental condition: Narrative therapy with emotional approach Control condition: Treatment as usual (antidepressants, regular medical treatment, social skills training, art therapy, medication education) Measurements at baseline (1 week prior to intervention, T0) and post-intervention (1 week after, T1)	Population Patients with depression in South Korea Sample N = 50 M = 23 F = 27 Mean age = 43.14, SD = 9.76	Psychological Self-awareness Was not significantly more increased in the IG compared to CG post-intervention Hope Was significantly more increased in IG compared to CG post-intervention ($p < .001$) Positive Affect Was significantly more increased in IG compared to CG post-intervention ($p = .002$) Negative Affect Was significantly more reduced in IG compared to CG post-intervention ($p = .010$) Depression Was significantly more reduced in IG compared to CG post-intervention ($p < .001$)	Attendance Dropout N = 1 due to job, no information when	Almost fully achieved While self-awareness was not significantly increased between-group after the intervention, all other outcome measures were significantly more improved with NTEA than TAU Effect sizes were not given
34	Shakeri et al. (2020)	RCT Experimental condition: Group narrative therapy	Population People with amphetamine addiction in Iran Sample	Psychological Depression Was significantly more reduced from T0-T1 in IG than CG ($p = .008$)	Attendance Dropout IG N = 5 at T1 N = 2 lost to FU	Mostly achieved Although depression and anxiety were significantly more reduced in IG than CG at T1,

	Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
		Control: Routine psychiatric care (not specified) Measurements at baseline (T0) and post-intervention (T1)	Intervention N = 13 Gender NA Age 20 – 30 = 3 (23.1%) Age 31 – 55 = 10 (76.9) Control N = 13 Gender NA Age 20 – 30 = 9 (69.2%) Age 31 – 55 = 4 (30.8%)	Anxiety Was significantly more reduced from T0-T1 in IG than CG (p = .02) Quality of Life Was not significantly more improved from T0-T1 in IG than CG, neither within-group (p = .48)	CG N = 4 at T1 N = 3 lost to FU	quality of life was not significantly improved within-group nor between-group Effect sizes were not given
35	Sokol et al. (2021)	Open-label within-group design Single condition: CI-CT Measurements at baseline (T0), post-intervention (T1), and 1-month FU (T2)	Population U.S. Veterans with a serious mental illness Sample N=17 M = 14 F= 3 Mean age = 59.7, SD = 9.5 **Most had borderline personality disorder (52.9%),** major depression disorder (52.9%), or schizophrenia type diagnosis (35.3%) 29.4% had posttraumatic stress disorder, 23.5% had substance abuse, and 11.8% had bipolar disorder	Psychological Depressive symptoms Were significantly decreased at T1 (drm = 1.26, p < .001), which did not significantly change from T1-T2 (drm = .08, p = .387) Hopelessness Was significantly decreased at T1 (drm = 1.12, p = .001), but significantly increased from T1-T2 (drm = .60, p = .031) Suicidal Ideation Was significantly decreased at T1 (drm = .81, p = .007), which did not significantly change from T1-T2 (drm = .39, p = .16) Functional Future-Self Continuity Significant increase in general future self-continuity at T2 (p =.031) Vividness of future self (p = .47) and similarity to future self (p = .90) did not increase significantly Improvement in positivity toward future self was significantly associated with decreasing suicidality (r = -.48, p = .049), depression (r = -.71, p = .004), and hopelessness (r = -.67, p = .005)	Attendance Dropout 4 participants after one-two sessions Research study time conflict (1), increased job requirements (1), transportation difficulty (1), and interpersonal conflict with a group member (1) Session 31% of contacted veterans completed treatment Most veterans attended all sessions, six missed one of four Satisfaction Most (n = 8) reported having enjoyed the experience	Partially achieved While depressive symptoms and suicidal ideation were significantly decreased at T1 and remained stable at T2, hopelessness did not remain stable at T2 despite the reduction present at T1 Future-Self continuity was not significantly increased T0-T1, but did at T2, and vividness of future self as well as similarity to future self did not increase significantly at any assessment point Effect sizes were large High levels of session attendance and patient completion was not achieved at the 70% level
36	Westerhof et al. (2016)	Evaluation study All conditions same intervention, different settings Setting 1: Intensive treatment of patients of the Dutch psychiatric hospital during a 10-day retreat in Spain Setting 2: Part-time clinic during 2 months	Population Persons With Intellectual Disability and Psychiatric Problems Sample N = 25 M = 11 F = 14 Mean age = 28, range 19-48	Psychological Intention-to-treat Groups did not differ significantly at pre- and post-treatment, nor at FU No ES given except for total SCL-90 Total Was significantly reduced from T0-T1 (PSdep = .76) and T0-T2 (PSdep = .76) Depression	Attendance Dropout N = 2 at T1 N = 3 did not complete questionnaires at FU Satisfaction Evaluation (237 statements, themes:) Explicit evaluation general (5.5% of statements) Positive n = 12	Almost fully achieved While effect sizes are only given for the total score on the SCL-90, which were large, most facets of the SCL (except for insufficiency and agoraphobia) were reduced from either both T0-T1 and T0-T2 or from only T0-T2

Authors (Year)	Design	Population and Sample	Outcome Measures	Attendance and Satisfaction	Study goal achievement
	Setting 3: Outpatient clinic during 8 months Measurements at baseline (T0), post-intervention (T1), and 3-month FU (T2)	IQ median = 70, range 60-90 Different diagnoses, including mood disorder, impulse disorder, posttraumatic stress disorder, and **problems related to personality disorders**	Was significantly reduced from T0-T1 (p = .003) and T0-T2 (p = .009) Anxiety Was significantly reduced from T0-T1 (p = .009) and T0-T2 (p = .005) Agoraphobia n.s. Obsessive-compulsive Was significantly reduced from T0-T1 (p = .012) and T0-T2 (p = .008) Interpersonal sensitivity Was significantly reduced from T0-T1 (p = .019, no effect size given) and T0-T2 (p = .007, no effect size given) Hostility Was significantly reduced from T0-T1 (p = .003) and T0-T2 (p = .026, n.s. for completers only) Insufficiency n.s. Somatisation Was not significantly reduced from T0-T1 (p = .100) but significantly from T0-T2 (p = .021, n.s. for completers only) Sleep Was significantly reduced from T0-T1 (p = .027) but not from T0-T2 (p = .175)	Negative/ambivalent n = 1 Personal learning points (36.3% of statements) Learned much n = 5 Insight n = 29 Skills = 27 Discover own strength n = 10 Trust in self and others n = 15 Intervention-specific aspects (22.4% of statements) Past positive n = 23 Past negative n = 6 Present positive n = 2 Future positive n = 10 Other intervention parts positive n = 12 Spain-specific aspects n = 11 Group-related aspects (15.6% of statements) Positive n = 25 Negative/ambivalent n = 12 Role therapist (12.7% of statements) Positive n = 30 Improvements n = 7	Most participants had a positive evaluation of the intervention