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Work-related Trauma Across Helping Professions.

A research portfolio consisting of two chapters including:

A Systematic Review of Evidence-based Interventions for the Treatment of Work-related Trauma in Helping Professions.

&

“Well, we’ve just got to keep going, I suppose”: An IPA Study into the Experiences of Adult Mental Health Workers and Trauma-Informed Care.

Jessica Woeginger

Doctorate in Clinical Psychology

The University of Edinburgh

May 2023

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Portfolio Lay Summary

Traumatic experiences can be debilitating and can affect people both physically and mentally. There is increasing recognition of trauma experienced through the work-place, especially following the Covid-19 pandemic where many front-line workers were faced with incredibly distressing incidents on a daily basis. Indeed, working within the helping professions, such as in healthcare, social care, and public services, gives rise to the risk of experiencing trauma at work due to the secondary impacts of witnessing or empathetically engaging with other people’s trauma. Professionals, such as mental health workers, may be frequently exposed to and engage with accounts of traumatic narratives and may begin to experience trauma symptoms themselves. Additionally, professionals such as emergency service personnel, may also be repeatedly exposed to traumatic events, such as attending multiple road traffic collisions, again leading to the potential development of traumatic symptoms. As such, those working in helping professions are at risk of developing work-related trauma. As work-related trauma is a distinct type of trauma, specific to someone’s occupation, more understanding of its treatment is needed and there is a need to identify evidence-based interventions.

Whilst there is growing evidence of this secondary traumatic impact from someone’s occupation, there is little direct evidence available of the impact of working within adult mental health settings, where contact with distress and trauma is likely. Additionally, in Scotland, there has been a recent move to introduce a Trauma-Informed Care approach into healthcare, using the National Trauma Training Programme. Trauma-Informed Care aims to meet the needs of survivors of trauma and prevent re-traumatisation. Trauma-Informed Care also aims to protect the workforce from any secondary impacts, prioritising staff wellbeing. Little is known currently about the impact of trauma-informed care on the workforce in adult mental health settings.

With this in mind, this research portfolio aimed to evidence treatment options for helping professionals experiencing work related trauma. Further, it aimed to explore the impact of working within adult mental health settings and the implementation of Trauma-Informed Care in this setting. Two research studies were conducted as follows.
**Systematic Review:** 13 studies were reviewed to assess evidence-based treatment options for treating work-related trauma in helping professionals. Treatment options evidenced from the review included: therapeutic models (i.e. Cognitive Behavioural Therapy, Narrative Exposure Therapy, Eye Movement Desensitisation Reprocessing), mindfulness-based interventions and psychoeducation. The helping professions included within the review included emergency service personnel, nurses, palliative care professionals and mental health workers. The review evidenced that there are various interventions that are effective in treating work-related trauma for helping professionals, helping to reduce traumatic symptoms. This is particularly important as it offers a choice to treatment. Additionally, the review evidenced that helping professionals can still benefit from treatment despite the potential of being repeatedly exposed to traumatic material in their roles. However, the review also assessed methodological quality of the included studies, and all were found to be either moderate or low in quality. As such, this review’s findings are limited by the quality of the papers.

**Empirical Project:** This research study aimed to explore the experiences of working within adult mental health settings, where contact with trauma and distress is likely. It further aimed to explore the impact of the National Trauma Training Programme that participants in this study attended. 11 participants were interviewed about their experiences and their accounts were analysed using Interpretative Phenomenological Analysis. The study found four Group Experiential Themes: ‘Role Identity’, “Well, we’ve just got to keep going, I suppose”, ‘Service Pressures’ and ‘The Implementation of Trauma-Informed Care’. The findings suggested that participants were committed and proud to work in their NHS service and that they were welcoming of trauma-informed approaches. However, it further evidenced that there are increasing service pressures, and this is threatening to staff’s wellbeing. There were barriers identified to implementing and embedding Trauma-Informed Care as a result.
Portfolio Abstract

Background: Through the nature of their roles, helping professionals are likely to be continually exposed to various traumatic events, narratives and/or situations. Recognition of work-related trauma across the helping professions is ever-growing, particularly following the Covid-19 pandemic and the increasing pressure on health, social and public care systems. However, the examination of interventions for treating work-related trauma is lacking. As such, there is a need for a clear-evidence base for treatment options for work-related trauma. Moreover, evidence has rarely accounted for the experiences of those working in adult mental health settings, which are under increasing strain and where contact with distress and trauma is likely. Finally, with the introduction of Trauma-Informed Care across Scotland, using the National Trauma Training Programme, little is known about the implementation of the approach in healthcare systems.

Method: To this effect, the current portfolio utilises two research methods to examine work-related trauma. Firstly, a systematic review of quantitative papers (N=13), assessed the efficacy and overall study quality of evidence-based treatments for work-related trauma in the helping professions. Results were presented using a narrative synthesis, detailing the type and duration of intervention. Secondly, an empirical paper employed a qualitative design to explore the experiences of NHS staff members (N=11) working in an adult mental health setting with distress and trauma, who had all attended the National Trauma Training Programme. Participants were interviewed using semi-structured interviews and Interpretative Phenomenological Analysis was applied to explore the impact of working in this setting and the impact of the National Trauma Training Programme.

Results: The systematic review indicated good efficacy for a variety of evidence-based treatment options for work-related trauma. This included therapeutic interventions, mindfulness-based interventions, and psychoeducation, providing different treatment options for helping professionals. Efficacy was further supported by large effect sizes. Interventions were generally found to be feasible and acceptable in relation to patient satisfaction. However, there was an overall limited quality of included studies which restricts the generalisability of this review. Findings of the empirical project yielded four Group Experiential Themes: ‘Role Identity’, “Well, We’ve Just Got To Keep Going I Suppose”, 
‘Service Pressures’ and ‘The Implementation of Trauma Informed Care’, each of which contained another two-four subthemes.

**Conclusion:** Work-related trauma represents a distinct type of trauma. Results from the systematic review contribute to the evidence base for clinicians who are actively engaged in trauma-work, providing favourable evidence for several different types of interventions for treating work-related trauma. The review highlighted that trauma-work can be commenced in helping professionals who are likely to be continually exposed to traumatic events and provide some longer-term protection from re-traumatisation. However, the review is limited by methodological quality and future reviews should expand to include qualitative studies and other professions that may be exposed to work-related trauma. Qualitative findings suggested that there is a passion and commitment amongst NHS staff members to working within adult mental health settings and there are benefits to trauma-informed approaches within these settings. However, the demands and pressures of the service are ever-increasing and threatening to staff wellbeing and thus antithetical to the implementation of Trauma-Informed Care.
Chapter 1: Systematic Review

A Systematic Review of Evidence-based Interventions for the Treatment of Work-related Trauma in Helping Professions.

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Review formatted for submission to the ‘Journal of Traumatic Stress’ (Appendix A – Author Guidelines)

Guidelines followed with the exception of journal word count limit for current thesis submission.
Abstract

**Background:** Despite its well-known incidence and prevalence, there is a lack of research concerning evidence-based interventions for treating work-related trauma. Global attention is being paid towards work-related trauma, especially in helping professions, following the Covid-19 pandemic. This has further highlighted the need for intervention options for helping professionals who are likely to be repeatedly exposed to traumatic events or experiences due to their occupation.

**Method:** A systematic review of quantitative studies was conducted using PsychINFO, PsychArticles, EMBASE and Medline. Studies were assessed for methodological quality, treatment effectiveness and other secondary and related outcomes.

**Results:** Thirteen studies were included in this review which were categorised into: therapeutic interventions, mindfulness-based interventions, and psychoeducation. All interventions demonstrated efficacy in treating work-related trauma across a span of helping professions at post-intervention. Secondary outcomes also demonstrated the intervention’s effectiveness in reducing symptoms of depression, anxiety and burn-out whilst increasing levels of compassion. Although limited to a few studies, the acceptability and feasibility of interventions in helping professions were also confirmed. Study quality was either weak or moderate, limiting some of the generalisability of this review.

**Conclusions:** This is the first review to consider evidence-based interventions in the treatment of work-related trauma in helping professions. The review provided favourable evidence for several different types of interventions and duration of treatment, thus increasing access to treatment models. As helping professionals are likely to experience a number of potentially traumatic conditions, with no period of safety post-incident due to their work, this review has highlighted that trauma-work can be commenced despite this. Moreover, that interventions may also provide some longer-term protection from traumatic responses. Future research should expand to include qualitative studies and also consider other professions that may be likely to experience work-related trauma.

**Keywords:** work-related trauma, psychological interventions, helping professions
Introduction

Professionals who work therapeutically with patients who have experienced trauma, or professionals who are repeatedly exposed to traumatic events through their occupation are at an increased risk for developing work-related trauma (Cavanagh et al., 2022). Whilst this was once regarded as a normal consequence of working in a helping profession, the negative impact of secondary trauma on an individual's mental and physical health has been increasingly recognised across the evidence-base and within clinical practice (e.g. Holmes et al., 2021; Rattray et al., 2020; Cocker & Joss, 2016). Work-related trauma may include being witness to acutely distressing events within the workplace, experiencing violence at work, or repeatedly hearing and empathetically engaging with other people’s traumatic narratives. Following the Covid-19 pandemic, global attention has been paid towards the experiences of helping professions, and there is increasing recognition of trauma from the workplace (Vagni et al., 2020; Orrù et al., 2020; Jones et al., 2021). However, the majority of research to date has focussed on identifying the prevalence and predictors of work-related trauma and identifying prevention strategies (Pellegrini et al., 2022; Greinacher et al., 2019; Vagni et al., 2020; Ogińska-Bulik et al., 2021). Whilst there is great utility to this, there has been little resulting focus on the treatment of work-related trauma. There is insufficient conclusive evidence as to the best way to treat this trauma, despite its known risk factors – exposure to other people’s traumatic events and narratives – that are inherent in the type of work that helping professionals undertake.

Several conceptual models have been developed to explain work-related trauma with vicarious trauma, secondary traumatic stress and compassion fatigue used interchangeably within the literature (Nimmo & Huggard, 2013). Vicarious trauma (Pearlman & Saakvitne, 1995) represents a shifting worldview concerning the self, others and the world, when professionals are exposed to indirect trauma and empathetically engage with their patients (Cohen & Collens, 2013; Moulden & Firestone, 2007). Whereas secondary traumatic stress (Stamm & Figley, 1995) describes the manifestation of symptoms that parallel those of PTSD when professionals are exposed to others’ trauma. Compassion fatigue (Joinson, 1992) describes the 'loss of ability to nurture'. It is often characterised by exhaustion, anger, a reduced ability to empathise, increased absenteeism and an impaired ability to make decisions and care for patients (Mathieu, 2007). Additionally, recent revisions to the fifth
edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) have made explicit that the repeated or extreme exposure to aversive details of a traumatic event (e.g. first responders collecting human remains) during the course of one’s professional duties may contribute to the development of PTSD (Allen & Ortlepp, 2000; Wise et al., 2015; Magnavita et al., 2021). Taken together, these are all forms of occupational hazards that those in the helping professions may experience, and whilst nuances differentiating the constructs have been asserted (Beck, 2011; Figley, 1995; Sabin-Farrell & Turpin, 2003), there is no clear evidence that the concepts are conceptually distinct (Craig & Sprang, 2010). Thus, the cluster term of ‘work-related trauma’ encapsulates the experience of trauma experienced as a result of job roles.

Specific prevalence rates of work-related trauma vary across helping professions (Greinacher et al., 2019; McKinley et al., 2017; van Mol et al., 2015). This is due in large part to the inconsistency in how the constructs used to define work-related trauma are operationalised and measured (Holland et al., 2022). Zhang et al., (2018) reported a 52.6% prevalence rate of compassion fatigue amongst nurses in a global meta-analysis, suggesting a far-reaching span that is not unique to one country. Additionally, Roden-Foreman et al., (2017) reported secondary traumatic stress rates of 12.7% among emergency medicine clinicians, and 21.4% of oncology nurses were found to have some level of compassion fatigue (Yu et al., 2016). Moreover, rates of compassion fatigue and secondary traumatic stress were found to be between 15%-49% in various helping professions such as child protection workers, veteran mental health workers, social workers, rescue workers and substance abuse therapists (Conrad & Kellar-Guenther, 2006; Cieslak et al., 2013; Chatzea et al., 2018; Bride, 2007; Johansen et al., 2019).

Mathieu (2012) estimates that anywhere between 40-85% of helping professionals will develop vicarious trauma, compassion fatigue and/or high rates of traumatic symptoms with widespread physical, psychological, and organisational consequences. Additionally, comorbid symptoms of anxiety and depression have been found to be present following the development of work-related trauma (Carmassi et al., 2022; Duncan et al., 2021; DeBoer et al., 2011). Carmassi et al., (2022) found an association between depressive and anxious symptoms and work-based PTSD in front-line Covid-19 healthcare workers. All three were major predictors of impaired functioning at work, in relationships and in someone's personal life. The impact of work-related trauma also has consequences for the quality of patient care.
Dasan et al., (2015) reported that emergency medicine consultants in the NHS, with higher levels of compassion fatigue, reported higher levels of irritability with patients and colleagues. Consequently, this reduces standards of care; with one third of the sample reporting that stress at work had led them to make a mistake that could have harmed a patient. Additionally, over half the sample intended to retire early, showing the wide-ranging effect on the workforce. Moreover, in a qualitative study, Perez-Garica et al., (2021) reported that nurses with compassion fatigue identified repercussions on their family and private life, high levels of anxiety and stress and again, a desire to resign from the profession. Various physical symptoms such as sleep disturbances, appetite changes and hypervigilance have been reported within the research (Figley, 2002; Hesse, 2002), alongside an increase in absenteeism and an increased desire to leave the current position or the whole profession entirely (Arimon-Pages et al., 2019; Jakimovicz et al., 2018). Thus, the consequences of work-related trauma are extensive and represent a clear threat to the individual, their significant others, patients, and the organisation to which they belong.

*How is work-related trauma measured?*

Given the variability in defining work-related trauma, there is an inconsistency in assessing the impact. This has led to a significant research gap in the interventions on offer as it is difficult to accurately assess work-related trauma. Various measures are currently being used to assess and outcome work-related trauma (Nimmo & Huggard, 2013), which include the use of specific measures for vicarious trauma, compassion fatigue and secondary traumatic stress alongside the use of validated PTSD scales to assess symptomology. This adds to the complexity within the literature and little agreement on how best to measure work-related trauma when providing treatment (Nimmo & Huggard, 2013). However, the Professional Quality of Life Scale version 5 (ProQol-V; Stamm, 2010), is often the most cited measure for compassion fatigue and secondary traumatic stress disorder. The scale measures the 'quality one feels towards their work as a helper' (Stamm, 2010, pg. 8), focusing on compassion satisfaction and compassion fatigue. Within this measure, compassion fatigue is comprised of two concepts: secondary traumatic stress and burn-out, each measured by a ten-item scale. Good alpha reliabilities have been established for the measure (Heritage et al., 2018; Geoffrion et al., 2019) amongst various professional groups. Hemsworth et al., (2018) have suggested that the compassion fatigue scale may lack
convergent validity; however, they further highlighted that the measure demonstrates reasonable psychometric properties beyond this and is fit for purpose.

**Interventions for work-related trauma**

Given the prolonged and far-reaching consequences on the individual, patient and organisation of work-related trauma, treatment interventions are crucial. Whilst there is recognition that repeated exposure to traumatic material at work may contribute to the development of PTSD, work-related trauma is not currently recognised within diagnostic classifications, and there are no guidelines for intervention and treatment as a result.

The British Medical Association have released advice and support on their website (BMA, 2019), identifying strategies for reducing the risk of vicarious trauma. Additionally, the United Nations Human Rights Office of the High Commissioners published the *Manual on Human Rights Monitoring* (2011), which includes a chapter providing information about the possible consequences of working with trauma survivors. This manual outlines stress management techniques, such as breathing exercises, physical exercises, and good nutrition. Moreover, the prevention of each of these conditions has been well studied, with recommendations given concerning organisational support and the use of self-care (Sutton et al., 2022; Bell et al., 2003; Flint et al., 2018; Harrison et al., 2009; Trippany et al., 2004).

Although published reports contain information about the prevalence and prevention of work-related trauma, they lack information about the delivery and efficacy of practical intervention programmes (Ebren et al., 2022), particularly concerning psychological evidence-based treatments. Historically, the specification of diagnostic algorithms has led to a new problem of so-called 'subthreshold disorders' (Helmchen & Lindon, 2000), whereby the distress and symptoms experienced do not fulfil criteria for diagnoses, and therefore there is not a recommended course of treatment. Work-related trauma represents a distinct type of trauma, with similarities to PTSD; however, with unique features not covered by diagnostic manuals, as mentioned. Consequently, a lack of treatment pathways has become apparent, despite the significant impact on professionals.
The Current Review

To date, there has been no review which considers psychological, evidence-based treatment options for work-related trauma in helping professions. Given the above literature, which has identified the impact of work-related trauma on helping professionals, their patients, and the organisation, yet the lack of treatment guidelines, there is a need to identify research which has been conducted on interventions targeting this trauma. As such, given this impact, the current review chose the term ‘helping professionals’ to allow for there to be a comprehensive review into interventions for the treatment of work-related trauma and keep the review broad given the lack of previous reviews. The term ‘helping professionals’ was also chosen to take into account the range of professionals that may experience the impact of psychological trauma and draw together learning from different settings and professional groups. There has also been a shift in focus to these professional groups following the Covid-19 pandemic (e.g. Suo et al., 2021; Li et al., 2020). The lasting impact felt by helping professionals and front-line workers during this time, who were tasked with caring for others, whilst risking their own health (e.g. Holmes et al., 2021; Norhayati et al., 2021) is becoming increasingly recognised.

In order to retain and protect the wellbeing of helping professionals, there is a need to better understand work-related trauma and how best to treat the resulting impact. Additionally, since there is no current guidance for clinicians in the treatment of work-related trauma, it is hoped that this review will serve as a guiding point for treatment options when helping professionals present to psychological and/or mental health services.

This review will synthesise quantitative studies focussed on evidence-based interventions for work-related trauma across the helping professions. The review will aim to:

i. Identify existing psychological evidence-based interventions in the treatment of work-related trauma.
ii. Synthesise the intervention(s) efficacy.
iii. Narratively detail the intervention(s) procedure(s).
Method

Prior to the initiation of the review, a scoping search was performed across various databases (MEDLINE, PsychInfo, EMBASE, Cochrane and Google Scholar), to ensure that no previous systematic reviews in this area had been published. A search of Prospero was also completed to ensure that other researchers were not currently in the process of conducting the same review. A review protocol was submitted and processed through PROSPERO (registration number: CRD42023400829) as per recommended guidelines. Please see Appendix B for the registered protocol.

Search Strategy

The final search was conducted across four databases between November 2022-January 2023: PsychInfo, PsychArticles, EMBASE and MEDLINE. Given there were no previous reviews on the topic found, a decision was made not to apply a time limit to relevant papers to ensure that all research in the area could be considered.

Three primary search areas were considered for this review (psychological intervention, work-related trauma, helping profession), each of which was supplemented by a relevant range of terms. To maximise search sensitivity, truncation (*) was applied to the terms. See Table 1 for a breakdown of search terms. Following the removal of duplicate papers, titles and abstracts were initially screened using the elected review criteria, followed by a screening of the remaining full text articles, which resulted in the final selection of papers. This process was conducted using the COVIDENCE review management software.
Table 1

<table>
<thead>
<tr>
<th>Search Term Strategy</th>
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<tbody>
<tr>
<td><strong>Psychological Intervention</strong></td>
<td>psycho* intervention* OR therap* OR CBT* OR EMDR* OR eye movement desent* OR reprocess*</td>
</tr>
<tr>
<td><strong>AND</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Work-related trauma</strong></td>
<td>vicarious* traum* OR secondary stress* OR compassion fatigue* OR secondary traum*</td>
</tr>
<tr>
<td><strong>AND</strong></td>
<td></td>
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<tr>
<td><strong>Helping Profession</strong></td>
<td>clinic* OR work* OR team member OR staff* OR firefight* OR police OR employe* OR keywork* OR nurs* OR counsel* OR psychol* OR allied health prof* OR therap*</td>
</tr>
</tbody>
</table>

**Inclusion and Exclusion Criteria**

To meet inclusion criteria, each relevant article had to: i) include adult participants aged 18 or over who worked with in helping or front-line professions, ii) involve evidence-based psychological interventions, e.g. CBT, EMDR, Mindfulness-based therapy etc, iii) involve a definition of work-related trauma, iv) include at least one outcome measure of vicarious trauma, compassion fatigue, secondary traumatic stress, traumatic stress, work-based or psychological distress, v) have a quantitative element (if within mixed-methods studies).

Articles were excluded if they were: i) solely qualitative in nature, ii) only investigated the prevalence of work-related trauma in professions, iii) only investigated the prevention of work-related trauma in professions, iv) solely used pharmacological based interventions, v) studies that have not been published in English, vi) book chapters, vii) bulletins or opinion pieces, viii) individual case studies.
Data Extraction

The extraction and reporting of data were informed by PRISMA guidelines (Moher et al., 2009). Items included in extraction were as follows: i) Study Design, ii) Aims and Objectives, iii) Participant Population (professional group), iv) Sample Size, v) Relevant Participant Demographic Details, vi) Country the study took place in, vii) Intervention Format (model, number of sessions, length of intervention), viii) Type of Outcome Measure, ix) Main Study Outcomes, x) Secondary Study Outcomes.

A narrative synthesis was chosen as the appropriate form of review for the current paper. The use of a narrative synthesis provides a thorough and critical overview of studies, enabling an investigation into studies' similarities and differences, assessing the strength of the evidence and results in a summary of knowledge (Lisy & Porritt, 2016).

A meta-analysis was considered; however subsequently excluded due to a number of factors. Firstly, studies had varying degrees of treatment dosages, in terms of duration and intensity, which may limit the validity of an overall measure of effect. Secondly, there was a lack of homogeneity relating to the intervention and various models utilised, such as cognitive, behavioural, mindfulness-based, psychoeducation and group therapy, alongside different professional groups, which again would limit any findings. Thirdly, the review focussed on work-related trauma, and whilst there is overlap in the literature between constructs, they are inconsistent, and analysis between these constructs would not be reliable.

Quality Appraisal Tool

Studies were assessed using the Effective Public Health Practice Project (EPHPP) Quality Assessment Tool (National Institute for Health and Clinical Excellence, 2006; Appendix C). The EPHPP has been designed to assess the quality of studies across various quantitative designs. The tool uses six items of methodological standards to provide an overall rating of strong, moderate, and weak quality evidence as follows:

1. Selection bias
2. Study design
3. Confounders
4. Blinding
5. Data collection method

A second reviewer was employed to reduce the risk of bias within this systematic review and was provided with a randomised set (N=5) of included papers to rate their quality. This was to ensure inter-rater reliability using Cohen's kappa analysis. For studies to be given a strong rating within the data collection section, validity and reliability had to be explicitly stated or described within the article. Additionally, 'drop-out' was evaluated based on the first post-intervention follow-up, rather than the end of data collection to allow for variation in time-points across studies. Following the EPHPP guidance, a study could only be classified with a global rating of 'strong' if it had no weak ratings. Studies were classified with a global rating of 'moderate' if they had one weak rating and as 'weak' if they had two or more weak ratings.
Results

Study Selection

The search resulted in 1814 papers, of which 720 were duplicates. This left a final set of 1094 papers to review. Titles and abstracts were screened in line with the above inclusion and exclusion criteria, and here, 1004 papers were removed. This left a total of 90 papers to be full-text reviewed. Studies were excluded here due to wrong study settings and/or design, being clearly unrelated to this review's aims or not wholly meeting inclusion criteria. A final 13 studies met the inclusion criteria for this review. Figure 1 represents the PRISMA flow diagram of the study selection process (Page et al., 2021).

Studies are presented in tables below in an intentional order, grouped by the intervention used (therapeutic models, mindfulness-based interventions, psychoeducation). An initial exploration of study characteristics (Table 2) provides an overview of the study background and methodology. This is then followed by the quality appraisal of the methodology (Table 3). Finally, the main findings are presented (Table 4) in relation to treatment efficacy, considering both primary and secondary outcomes in each study.

Included Studies

Table 2 displays a breakdown of the 13 included studies and the respective characteristics. The studies were predominantly based in the United States of America (N=4), with other countries including the United Kingdom (N=2), India (N=1), Saudi Arabia (N=1), Mexico (N=1), Israel (N=1), Portugal (N=1), Spain (N=1) and Australia (N=1). The total sample size across the studies was 764, with sample sizes ranging from 15-162 participants and a mean age of 39.3 years. The largest professional group represented within studies were Nurses (N=6), followed by Emergency Service Personnel (N=5), with Palliative Medical Professionals (N=1) and Mental Health Workers (N=1) also being represented. Secondary traumatic stress represented the focus of treatment in the greatest number of studies (N=6), followed by Occupational PTSD (N=5) and, finally, compassion fatigue (N=2).

The most common design within the studies was Randomised Control Trials (N=5), followed by single-group designs (N=2) and cohort studies (N=2). This was followed by quasi-
experimental (N=1), non-randomised pre- and post-test designs (N=1) and 2x2 mixed group designs (N=1). Interventions included within studies included EMDR, CBT, Mindfulness-based interventions, Narrative Exposure Therapy (NET) and psychoeducation. All of the interventions included were designed for trauma-related presentations and the studies were designed to specifically target occupational PTSD, Secondary traumatic stress and / or compassion fatigue. Studies employed a variety of in-person sessions and online sessions in both individual and group therapy formats. Studies further varied in terms of assessing one treatment model, combining and/or comparing multiple models at once.

Figure 1
PRISMA (2020) Flow diagram of the review process
<table>
<thead>
<tr>
<th>Author, Design, Year</th>
<th>Design</th>
<th>Cohort</th>
<th>Country</th>
<th>Area of Treatment</th>
<th>Sample Size</th>
<th>Mean Age</th>
<th>Intervention used</th>
<th>Intervention delivered by</th>
<th>Primary Outcome Measure</th>
<th>Secondary Outcome Measures</th>
<th>Time Points</th>
<th>Duration of Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jarero, Amaya, Givaudan &amp; Miranda (2013)</td>
<td>RCT</td>
<td>First Responders</td>
<td>Mexico</td>
<td>Occupational PTSD</td>
<td>39</td>
<td>Not reported</td>
<td>EMDR PROPARA (paraprofessional) vs Supportive Counselling</td>
<td>EMDR Therapists</td>
<td>SPRINT</td>
<td>N/A</td>
<td>Pre, post, 1 month, 3 month</td>
<td>Two 90-minute sessions.</td>
</tr>
<tr>
<td>Alghamdi, Hunt &amp; Thomas (2015)</td>
<td>RCT</td>
<td>Firefighters</td>
<td>Saudi Arabia</td>
<td>Occupational PTSD</td>
<td>34</td>
<td>28.7</td>
<td>NET vs Waitlist</td>
<td>Authors (NET Therapy trained)</td>
<td>SPTSS</td>
<td>HADS</td>
<td>Pre, post, 3 month, 6 month</td>
<td>4 sessions total between 60-90 minutes each.</td>
</tr>
<tr>
<td>Beaumont, Durkin, McAndrew &amp; Martin (2016)</td>
<td>2x2 mixed group</td>
<td>Firefighters</td>
<td>UK</td>
<td>Occupational PTSD</td>
<td>17</td>
<td>41.3</td>
<td>TF-CBT or TF-CBT + CFT</td>
<td>EMDR and BABCP accredited therapists</td>
<td>IES-R</td>
<td>HADS SCS</td>
<td>Pre, post</td>
<td>12 weeks total. 60-minute weekly sessions (first and last session – 90mins).</td>
</tr>
<tr>
<td>Bryant et al., (2018)</td>
<td>RCT</td>
<td>Emergency Service Personnel</td>
<td>Australia</td>
<td>Occupational PTSD</td>
<td>100</td>
<td>43.6</td>
<td>CBT-prolonged (CBT-L) vs CBT-brief (CBT-B) vs Waitlist</td>
<td>Clinical Psychologists</td>
<td>CAPS</td>
<td>BDI</td>
<td>Pre, post, 6 month</td>
<td>12 weekly sessions. Imaginal exposure: CBT-L: 40 minutes per session CBT-B: 10 minutes per session.</td>
</tr>
<tr>
<td>Author</td>
<td>Design</td>
<td>Cohort</td>
<td>Country</td>
<td>Area of Treatment</td>
<td>Sample Size</td>
<td>Mean Age</td>
<td>Intervention used</td>
<td>Intervention delivered by</td>
<td>Primary Outcome Measure</td>
<td>Secondary Outcome Measures</td>
<td>Time points</td>
<td>Duration of Intervention</td>
</tr>
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<tr>
<td>Deblinger, Pollio, Cooper and Steer (2020)</td>
<td>Cohort</td>
<td>Mental Health Clinicians</td>
<td>USA</td>
<td>STS</td>
<td>115</td>
<td>37.35</td>
<td>TF-CBT with Practice what You Preach (PWYP)</td>
<td>TF-CBT expert trainer</td>
<td>ProQOL-V</td>
<td>COPE</td>
<td>Pre, post</td>
<td>8-9 months training. 18 calls with 4 hours total focussed on PWYP (10-20mins per call).</td>
</tr>
<tr>
<td>Biggs, Tehrani &amp; Billings, (2021)</td>
<td>Cohort</td>
<td>Police Officers</td>
<td>UK</td>
<td>Occupational PTSD</td>
<td>162</td>
<td>42</td>
<td>TF-CBT or EMDR or Combined</td>
<td>Clinical or Counselling Psychologist</td>
<td>IES-R</td>
<td>GADS</td>
<td>Pre, post</td>
<td>9-12 hours in total. 60-90-minute weekly sessions.</td>
</tr>
<tr>
<td>Duarte &amp; Pinto-Gouveia (2016)</td>
<td>Nonrandomised</td>
<td>Nurses</td>
<td>Portugal</td>
<td>STS</td>
<td>48</td>
<td>41</td>
<td>Mindfulness-based group vs Waitlist</td>
<td>Clinical Psychologist</td>
<td>ProQOL-V</td>
<td>DASS-21, FFMQ, SCS, AAQ-II</td>
<td>Pre, post</td>
<td>6 weekly, two hour sessions.</td>
</tr>
<tr>
<td>Hevezi (2016)</td>
<td>Nonrandomised pre-post</td>
<td>Nurses (oncology)</td>
<td>USA</td>
<td>STS</td>
<td>15</td>
<td>Not reported</td>
<td>Mindfulness Meditation</td>
<td>Authors</td>
<td>ProQOL-V</td>
<td>N/A</td>
<td>Pre, post</td>
<td>Five days a week for four weeks.</td>
</tr>
<tr>
<td>Owens et al., (2020)</td>
<td>Single group</td>
<td>Nurses (acute care)</td>
<td>USA</td>
<td>CF</td>
<td>32</td>
<td>40</td>
<td>3-minute mindfulness intervention</td>
<td>Authors (trained in mindfulness)</td>
<td>ProQOL-V</td>
<td>N/A</td>
<td>Pre, post</td>
<td>Three minutes x three times per day over four weeks.</td>
</tr>
<tr>
<td>Copeland (2021)</td>
<td>Quasi-experimental</td>
<td>Nurses</td>
<td>USA</td>
<td>STS</td>
<td>23</td>
<td>44.4</td>
<td>Brief Intervention: Meditation</td>
<td>Mobile Application</td>
<td>ProQOL-V</td>
<td>N/A</td>
<td>Pre, post</td>
<td>Six weeks</td>
</tr>
<tr>
<td>Author, Year</td>
<td>Design</td>
<td>Cohort</td>
<td>Country</td>
<td>Area of Treatment</td>
<td>Sample Size</td>
<td>Mean Age</td>
<td>Intervention used</td>
<td>Intervention delivered by</td>
<td>Primary Outcome Measure</td>
<td>Secondary Outcome Measures</td>
<td>Time points</td>
<td>Duration of Intervention</td>
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</tr>
<tr>
<td>Perez et al., (2022)</td>
<td>RCT</td>
<td>Nurses (dementia)</td>
<td>Spain</td>
<td>CF</td>
<td>74</td>
<td>37</td>
<td>Online mindfulness training</td>
<td>Nurse and Psychologists trained in mindfulness</td>
<td>ProQOL-V</td>
<td>N/A</td>
<td>Pre, 6 weeks, three months</td>
<td>6 weekly sessions. 60 minutes per session</td>
</tr>
<tr>
<td>Berger &amp; Gelkopf (2011)</td>
<td>Quasi-random control</td>
<td>Nurses (well-baby clinic in war and terror areas)</td>
<td>Israel</td>
<td>STS</td>
<td>80</td>
<td>48.5</td>
<td>Psychoeducation group with self-maintenance tools vs Waitlist</td>
<td>Authors</td>
<td>ProQOL-V</td>
<td>N/A</td>
<td>Pre, 3 months</td>
<td>12 weeks total. 6-hour sessions (N.B. study details unclear if each session was six hours, or if a total of six hours of intervention was provided).</td>
</tr>
</tbody>
</table>

Please note: RCT = randomised control trial, TF-CBT = Trauma focussed cognitive behavioural therapy, CFT = Compassion focussed therapy, EMDR = Eye movement desensitisation and reprocessing, NET = Narrative exposure therapy, IES = Impact of events Scale (Horowitz et al., 1979), GADS = Goldberg Anxiety and Depression Scale (Goldberg et al., 1988), HADS = Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983), ProQOL-V = Professional Quality of Life version 5 (Stamm, 2010), COPE = coping scale (Carver et al., 1989), SPTSS = Screen for Post-traumatic Stress Symptoms (Carlson, 2012), SPRINT = Short post-traumatic stress disorder rating interview (Connor & Davidson, 2001), DASS-21 = Depression and Anxiety Stress Scale (Lovibond & Lovibond, 1995), AAQ-II = Acceptance and Action questionnaire (Hayes et al., 2004), CAPS = Clinician Administered PTSD Scale for DSM-5 (Blake et al., 1990), BDI = Beck Depression Inventory (Beck, 1987), PWS = Psychological Wellbeing Scale (Ryff, 1989), FFMQ = Five Facet Mindfulness Questionnaire (Baer et al., 2006).
Cohen's Kappa ($\kappa$) was used as a measurement of inter-rater reliability, and a moderate rate of agreement ($\kappa = 0.55$) was calculated. The workings can be seen in Appendix D. Both raters clarified and agreed on any discrepancies between ratings. A summary of quality assessment ratings can be seen in Table 3.

Of the 13 studies, none received an overall 'strong' global rating of quality. Six studies received a 'moderate' rating of global quality, with the final seven studies being deemed 'weak' in overall global quality. All studies received either a strong (N=8) or moderate (N=5) rating for their study design. In terms of strengths, 'Strong' ratings for study design were given for studies using randomised control designs or clinical control designs (where randomisation wasn't explicit or the method of allocation into groups wasn’t explicit). Therefore, all cohort studies received a moderate design rating and could not be rated higher due to assessment tool guidelines. All 13 studies received a 'strong' rating for Data Collection due to using reliable and valid measures, contributing to the validity of the overall results reported.

Methodological weaknesses were noted within the Blinding category, with every study but one receiving a weak rating here. Twelve studies included in this review, did not use a method of blinding participants or assessors to the intervention, although this is not surprising given the population(s) being studied and the ethical nature of participants needing to know about their treatment and what they were experiencing. One study (Bryant et al., 2018) was rated as moderate for blinding, as the authors note that assessors were blinded to treatment conditions, and this was optimised by having assessors trained and managed separately from treating clinicians. Fidelity of blinding was also measured in this study by having assessors guess the condition of each participant, and assessors correctly guessed at chance rate, demonstrating that blindness was maintained. Five studies were rated as 'weak' for confounders, whereby they did not specify or control for demographic or relevant confounder variables at baseline. Selection bias was apparent throughout the studies, with only one study receiving a 'strong' rating. Additionally, four studies were deemed 'weak' in quality due to their self-referral nature of participants and a further eight studies were deemed 'moderate' quality as their participants were referred from a source in a systemic manner (e.g. referred from clinics).
### Table 3

*Quality Assessment of included studies*

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Selection Bias</th>
<th>Design</th>
<th>Confounders</th>
<th>Blinding</th>
<th>Data Collection</th>
<th>Drop-Out</th>
<th>Global Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jarero, Amaya, Givaudan &amp; Miranda (2013)</td>
<td>Weak</td>
<td>Strong</td>
<td>Weak</td>
<td>Weak</td>
<td>Strong</td>
<td>Strong</td>
<td>Weak</td>
</tr>
<tr>
<td>Alghamdi, Hunt &amp; Thomas (2015)</td>
<td>Moderate</td>
<td>Strong</td>
<td>Strong</td>
<td>Weak</td>
<td>Strong</td>
<td>Strong</td>
<td>Moderate</td>
</tr>
<tr>
<td>Beaumont, Durkin, McAndrew &amp; Martin (2016)</td>
<td>Moderate</td>
<td>Strong</td>
<td>Strong</td>
<td>Weak</td>
<td>Strong</td>
<td>Strong</td>
<td>Moderate</td>
</tr>
<tr>
<td>Bryant et al., (2018)</td>
<td>Strong</td>
<td>Strong</td>
<td>Strong</td>
<td>Moderate</td>
<td>Strong</td>
<td>Strong</td>
<td>Moderate</td>
</tr>
<tr>
<td>Deblinger, Pollio, Cooper and Steer (2020)</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Strong</td>
<td>Weak</td>
<td>Strong</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Biggs, Tehrani &amp; Billings, (2021)</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Strong</td>
<td>Weak</td>
<td>Strong</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Selection Bias</td>
<td>Design</td>
<td>Confounders</td>
<td>Blinding</td>
<td>Data Collection</td>
<td>Drop-Out</td>
<td>Global Ratings</td>
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</tr>
<tr>
<td>Duarte &amp; Pinto-Gouveia (2016)</td>
<td>Moderate</td>
<td>Strong</td>
<td>Strong</td>
<td>Weak</td>
<td>Strong</td>
<td>Weak</td>
<td>Weak</td>
</tr>
<tr>
<td>Hevezi (2016)</td>
<td>Weak</td>
<td>Moderate</td>
<td>Weak</td>
<td>Weak</td>
<td>Strong</td>
<td>Strong</td>
<td>Weak</td>
</tr>
<tr>
<td>Owens et al., (2020)</td>
<td>Strong</td>
<td>Moderate</td>
<td>Weak</td>
<td>Weak</td>
<td>Strong</td>
<td>Moderate</td>
<td>Weak</td>
</tr>
<tr>
<td>Copeland (2021)</td>
<td>Moderate</td>
<td>Strong</td>
<td>Weak</td>
<td>Weak</td>
<td>Strong</td>
<td>Strong</td>
<td>Weak</td>
</tr>
<tr>
<td>Kaur, Sharma &amp; Chaturvedi (2021)</td>
<td>Weak</td>
<td>Moderate</td>
<td>Weak</td>
<td>Weak</td>
<td>Strong</td>
<td>Strong</td>
<td>Weak</td>
</tr>
<tr>
<td>Perez et al., (2022)</td>
<td>Strong</td>
<td>Strong</td>
<td>Strong</td>
<td>Weak</td>
<td>Strong</td>
<td>Strong</td>
<td>Moderate</td>
</tr>
<tr>
<td>Berger &amp; Gelkopf (2011)</td>
<td>Weak</td>
<td>Strong</td>
<td>Strong</td>
<td>Weak</td>
<td>Strong</td>
<td>Strong</td>
<td>Weak</td>
</tr>
</tbody>
</table>
**Treatment Efficacy**

Table 4 provides a summary of primary (work-related trauma) outcomes, and secondary outcomes across studies.

**Outcome Measures**

The majority of studies (N=8) utilised the Professional Quality of Life Scale Version 5 (ProQOL-V) as a pre- and post-assessment of work-related trauma. In particular, for studies using the ProQOL-V, this systematic review reported on results concerning the Secondary Traumatic Stress Scale as primary outcomes. The other subscales of the ProQOL-5 (burn-out and compassion satisfaction) were considered within the secondary outcomes of Table 4.

Four studies utilised measures of PTSD symptomology across interventions; these measures were Impact of Events Scale (IES; both revised and extended used), the Short PTSD Rating Interview (SPRINT) and the Screen for Post-traumatic Stress Symptoms (SPTSS). Again, when these measures were used, they were considered within the primary outcomes of this review.

Other secondary outcomes included measures of anxiety, depression, wellbeing and compassion, as detailed in Table 4.
Table 4

**Study Outcomes**

<table>
<thead>
<tr>
<th>Author</th>
<th>Intervention Used</th>
<th>Outcome Measures</th>
<th>Primary (work-related trauma) Outcome(s)</th>
<th>Secondary Outcome(s)</th>
<th>Measure of effect *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jarero, Amaya, Givaudan &amp; Miranda (2013)</td>
<td>EMDR PROPARA (paraprofessional) vs Supportive Counselling</td>
<td>SPRINT</td>
<td>SPRINT: EMDR PROPARA was superior to supportive counselling at post-intervention: t(37) = 6.35, p&lt;0.001, at one-month follow-up: t(37) = 8.77, p&lt;0.001, and at three-month follow-up: t(37) = 14.98, p&lt;0.001. EMDR PROPARA demonstrated a further significant interaction of time x group: F(1,35) = 524.87, p = 0.001.</td>
<td>N/A</td>
<td>Not reported</td>
</tr>
<tr>
<td>Alghamdi, Hunt &amp; Thomas (2015)</td>
<td>NET vs Waitlist</td>
<td>SPTSS HADS</td>
<td>SPTSS: NET showed superiority in reducing PTSD symptoms compared to the waitlist control: F = 102.5, p&lt;0.001. Reductions in symptomology were not maintained at three- or six-month follow-ups. Further, within group significant decreases in PTSD symptomology were reported only in the NET group: t = 10.01, p&lt;0.001; again, these gains were not maintained at three- or six-month follow-up.</td>
<td>HADS: There were significant reductions in the NET group compared to the Waitlist concerning anxiety: F = 31.42, p&lt;0.001, and depression: F = 32.8, p&lt;0.001.</td>
<td>NET vs Waitlist: SPTSS: d = 2.05 HADSanxiety: d = 1.57 HADSdepression: d = 1.15</td>
</tr>
<tr>
<td>Beaumont, Durkin, McAndrew &amp; Martin (2016)</td>
<td>TF-CBT or TF-CBT + CFT</td>
<td>IES-R HADS SCS</td>
<td>IES-R: No significant differences were found between TF-CBT and TF-CBT+CFT in reducing trauma. Trends in estimated marginal means point to a greater reduction in trauma symptoms in the TF-CBT+CFT group: M(SD) = 15.5 (2.5) compared to the TF-CBT group: TF-CBT: M(SD) 19.9(2.6).</td>
<td>SCS: A significant increase in self-compassion was reported in the TF-CBT+CFT group compared to the TF-CBT group: F'(1,14) = 7.014, p = 0.05.</td>
<td>The authors state that effect sizes were 'large' for both groups post-therapy. Numerical data was not provided to substantiate this.</td>
</tr>
<tr>
<td>Author</td>
<td>Intervention Used</td>
<td>Outcome Measures</td>
<td>Primary (work-related trauma) Outcome(s)</td>
<td>Secondary Outcome(s)</td>
<td>Measure of effect *</td>
</tr>
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</tbody>
</table>
| Bryant et al., (2018)         | CBT-prolonged (CBT-L) vs CBT-brief (CBT-B) vs Waitlist. | CAPS, BDI        | CAPS: Both CBT-L and CBT-B reported significantly greater reductions in PTSD symptomology than the waitlist control: $F(47, 25) = 20.04, p < 0.001$. A non-significant difference between CBT-L and CBT-B was reported: $F(49,00) = 0.20, p < 0.85$. | BDI: A significant main effect for time in reducing depression symptomology was reported: $F(159,15) = 108.63, p < 0.001$. | CBT-L vs WL: $d=1.7$  
CBT-B vs WL: $d=1.6$  
CBT-L vs CBT-B: $d= 0.1$ |
| Deblinger, Pollio, Cooper and Steer (2020) | TF-CBT with Practice What You Preach (PWYP) | ProQOL-V, COPE   | ProQOL-V: A significant decrease in secondary traumatic stress was reported: $t(114) = 3.98, p<0.001$. | COPE: Significant increases in the use of social support, active coping and humour was reported (p<0.01). | STS: $d = 0.34$  
Social support: $d = 0.26$  
Active coping: $d = 0.32$  
Humour: $d = 0.26$ |
| Biggs, Tehrani & Billings, (2021) | TF-CBT or EMDR or Combined TF-CBT+EMDR | IES-E, GADS      | IES-E: TF-CBT, EMDR or combined interventions significantly reduced PTSD symptomology across time: baseline $M(SD) = 63.62 (15.51)$, follow-up $M(SD) = 33.49$, $p<0.001$. 77% no longer met criteria for PTSD after treatment.  
(N.B. the authors reported on interventions as a whole and did not distinguish between type of intervention in the outcomes). | GADS: A significant reduction in depression symptomology was reported: baseline $M(SD) = 6.5 (1.95)$, follow-up $M(SD) = 3.3 (2.5)$, $p<0.001$.  
A significant reduction in anxiety was reported: baseline $M(SD) = 7.4 (1.8)$, follow-up $M(SD) = 4.4 (2.7)$, $p<0.001$.  
50% of cases no longer met criteria for depression and anxiety after treatment. | Not reported |
<table>
<thead>
<tr>
<th>Author</th>
<th>Intervention Used</th>
<th>Outcome Measures</th>
<th>Primary (work-related trauma) Outcome(s)</th>
<th>Secondary Outcome(s)</th>
<th>Measure of effect *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duarte &amp; Pinto-Gouveia</td>
<td>Mindfulness-based group vs Waitlist</td>
<td>ProQOL-V, DASS-21, FFMQ, SCS, AAQ-II</td>
<td>ProQOL-V: A significant decrease in compassion fatigue was reported between groups at post-intervention with significant reductions observed in the mindfulness group compared to the Waitlist: $F(1, 46) = 7.9$, $p = 0.01$. A significant decrease in compassion fatigue from pre to post-test was reported in the mindfulness group: $F= 18.60$, $p&lt;0.001$.</td>
<td>AAQ-II: A significant decrease in experiential avoidance reported from pre- to post-intervention in the mindfulness group: $F =13.15$, $p = 0.001$</td>
<td>CF: partial $\eta^2 = 0.29$ Experiential avoidance: partial $\eta^2 = 0.22$</td>
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<td>FFMQ: A significant increase in mindfulness skills reported from pre- to post-intervention in the mindfulness group: $F=5.26$, $p=0.026$</td>
<td>SCS: A significant increase in self-compassion reported pre- to post-intervention in the mindfulness group: $F=5.79$, $p=0.020$.</td>
<td>Mindfulness: partial $\eta^2 = 0.1$</td>
</tr>
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<td></td>
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<td></td>
<td>DASS-21: No significant changes reported for anxiety and depression in the mindfulness group.</td>
<td></td>
<td>SCS: partial $\eta^2 = 0.11$</td>
</tr>
<tr>
<td>Hevezi (2016)</td>
<td>Mindfulness Meditation</td>
<td>ProQOL-V</td>
<td>ProQOL-V: A significant decrease in secondary trauma stress pre- to post-intervention was reported for mindfulness meditation: $t(14) = 2.174$, $p = 0.047$.</td>
<td>ProQOL-V: A significant increase in scores of compassion satisfaction from pre- to post-intervention was reported for mindfulness meditation: $t(14) = -2.48$, $p = 0.027$. A significant decrease in burn-out scores from pre-to post-intervention was reported: $t(14) = 3.581$, $p = 0.003$.</td>
<td>STS: $d = 0.56$ CS: $d = 0.63$</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>BO: $d = 0.92$</td>
<td></td>
</tr>
<tr>
<td>Author</td>
<td>Intervention Used</td>
<td>Outcome Measures</td>
<td>Primary (work-related trauma) Outcome(s)</td>
<td>Secondary Outcome(s)</td>
<td>Measure of effect * (Cohens d, hedges g, partial $\eta^2$)</td>
</tr>
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<td>-------------------------</td>
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<tr>
<td>Owens et al., (2020)</td>
<td>3-minute mindfulness intervention</td>
<td>ProQOL-V</td>
<td>ProQOL-V: A significant decrease in secondary traumatic stress scores from pre- to post-intervention was reported: baseline $M(SD) = 23.63(5.36)$, follow-up $M(SD) = 21.28(4.26)$, $p = 0.0053$. Levels of secondary traumatic stress moved from the average range to the low range.</td>
<td>ProQOL-V: Significant decreases in scores of burn-out were reported pre- to post intervention: baseline $M(SD) = 23.34(6.25)$, follow-up $M(SD) = 21.72(6.15)$, $p = 0.011$.</td>
<td>STS: $g = -0.4795$ BO: $g = -0.2581$</td>
</tr>
<tr>
<td>Copeland (2021)</td>
<td>Brief Intervention: Mindfulness Meditation</td>
<td>ProQOL-V</td>
<td>ProQOL-V: A significant decrease in secondary traumatic stress was reported from pre- to post-intervention: $t(3) = 3.178$, $p = 0.05$.</td>
<td>N/A</td>
<td>Effect sizes reported to range from 0.495 to 0.757</td>
</tr>
</tbody>
</table>
| Kaur, Sharma & Chaturvedi (2021) | Mindfulness Integrated Behavioural Intervention | ProQOL-V | ProQOL-V: A significant decrease in secondary traumatic stress from pre- to post-intervention was reported: $Z = -4.21$, $p<0.001$. This significant decrease was maintained at three-month follow-up: $Z = -4.02$, $p<0.001$. | ProQOL-V: A significant decrease in burn-out scores pre- to post-intervention and at three-month follow-up was reported: $p<0.001$. A significant increase in compassion satisfaction scores from pre- to post-intervention and at three-month follow-up was reported: $p<0.001$. | Post Intervention and three-month follow-up:  
STS: $d = 1.09$; $d = 1.17$  
BO: $d = 0.89$; $d = 0.96$  
Mindfulness Skills:  
d = 1.67; d = 1.94.  
PWS & FFMQ: A significant increase in psychological wellbeing and mindfulness skills from pre- to post-intervention was reported: $p<0.001$; however this effect was not maintained at three-month follow-up. |
<table>
<thead>
<tr>
<th>Author</th>
<th>Intervention</th>
<th>Outcome Measures</th>
<th>Primary (work-related trauma) Outcome(s)</th>
<th>Secondary Outcome(s)</th>
<th>Measure of effect *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perez et al., (2022)</td>
<td>Online mindfulness training</td>
<td>ProQOL-V</td>
<td><strong>ProQOL-V:</strong> A significant decrease in scores of compassion fatigue from pre- to post-intervention was reported: $F(1,65) = 8.15, p = 0.011$. This significant decrease was maintained at three-month follow-up: $F(1,28) = 18.14, p = 0.003$.</td>
<td><strong>ProQOL-V:</strong> A significant decrease in scores of burn-out from pre- to post-intervention was reported: $F(1,65) = 11.05, p = 0.02$. This significant decrease was maintained at three-month follow-up: $F(1,28) = 7.25, p = 0.040$.</td>
<td>CF: $d = 0.32$; $d = 2.34$.</td>
</tr>
</tbody>
</table>
| Berger & Gelkopf (2011) | Psychoeducation group with self-maintenance tools vs Waitlist | ProQOL-V         | **ProQOL-V:** A significant decrease in compassion fatigue post-intervention was reported in the psychoeducation group compared to the waitlist control: $F(1, 79) = 12.8, p < 0.001$. | **ProQOL-V:** A significant decrease in burn-out scores and a significant increase in compassion satisfaction were reported in the psychoeducation group: $p < 0.001$. | CF: $d = 0.14$  
CS: $d = 0.35$  
BO: $d = 0.22$ |

* Please note: STS = Secondary traumatic stress, WL = Waitlist, BO = Burn-out, CF = Compassion Fatigue, CS = Compassion Satisfaction, SCS = Self-compassion scale
**Intervention Design**

Eight out of thirteen studies provided an individual intervention, with three studies using a group intervention. Two studies provided a mix of group and individual intervention. Individual interventions were mostly utilised in studies that employed therapy, i.e. CBT or EMDR, whereas group interventions were used for psychoeducation and/or mindfulness-based interventions. Of the thirteen included studies, nine were conducted within a face-to-face setting, two used pre-recorded methods and a final two used remote methods, i.e. online or telephone. The majority of studies (N=12) employed trained clinicians, therapists and/or psychologists to deliver the intervention to participants. This included using author’s dual skills as researchers and clinicians to implement the intervention. One study (Copeland, 2021) utilised an already established mobile application to deliver the intervention, which was self-managed and accessed by participants.

For studies that used individual therapy (N=6) in the treatment of work-related trauma, treatment duration varied between two and twelve individual sessions lasting 60-90 minutes each. One study (Deblinger et al., 2020) utilised a practice-what-you-preach (PWYP) element within a TF-CBT training course and this included 18 phone calls with 10-20 minutes per call, focussing on the PWYP element. PWYP involves clinicians utilising the skills that they teach their patients in session.

Mindfulness-based studies (N=6) employed designs over a period of four to six weeks, and participants engaged in mindfulness anywhere from nine minutes per day to 2.5 hours a week. Indeed, the mindfulness-based studies employed a variety of methods, including group mindfulness sessions (Kaur et al., 2021; Duarte & Pinto-Gouveia, 2016; ), pre-recorded mindfulness meditations (Copeland et al., 2021; Hevezi et al., 2021; Owens et al., 2020) and online group therapy (Perez et al., 2022).

Finally, one study (Berger & Gelkopf, 2011) utilised a psychoeducation intervention, which consisted of 12 weekly, 6-hour sessions. However, it is unclear whether each session was six hours or if the total time in the intervention was six hours, with issues around reliability and validity rising as a result.
The above suggests variability in the duration of interventions offered for the treatment of work-related trauma. Indeed, individual therapeutic interventions appeared to have longer durations, with the exception of Jarero et al., (2013), who reported the effectiveness of two sessions of EMDR using a specific protocol developed for the use with paraprofessionals experiencing work-related trauma. Studies that used a therapeutic model in their treatment had a focus on occupational PTSD- symptoms among participants. In comparison, the mindfulness-based studies and psychoeducation studies considered levels of secondary traumatic stress and/or compassion fatigue as their main area of treatment. As work-related trauma encapsulates a range of trauma symptoms and presentations, as evidenced here, the different intervention designs in this review may help to inform clinical decision-making and treatment options for clinicians.

**Therapeutic Interventions Efficacy (CBT, EMDR, NET)**

Six papers out of thirteen used a therapeutic model and/or process in the treatment of work-related trauma (Biggs et al., 2021; Beaumont et al., 2016; Deblinger et al., 2021; Alghamadi et al., 2015; Jarero et al., 2013; Bryant et al., 2018). The most common model used was CBT; with brief and long, trauma-focussed and compassion-focussed variations included (N=3), followed by EMDR (N=1) and Narrative Exposure Therapy (N=1) and combined CBT and EMDR (N=1). All studies reported on significant within group changes from pre- to post-work-related trauma symptoms, noting a decrease in work-related trauma symptoms at the end of treatment. All studies using a waitlist control, further reported the superiority of the intervention over no treatment at post-intervention.

Effect sizes were reported in four of the six studies, using either hedges g or cohens d, and therefore effect sizes were categorised into small (0.2), medium (0.5) and large (>0.8) (Brydges, 2019). The majority of studies (N=5) reported medium or large effect sizes, with effect sizes of trauma outcomes appearing numerically stronger than secondary outcomes indicating the intervention was successful in targeting the trauma. One study did not report on effect sizes, and another study stated 'large' effect sizes within text, however data was not available to corroborate this. Of the studies that reported on their effect sizes, estimates of power calculations were only stated in one study (Bryant et al., 2019), which also demonstrated sufficient power at post-treatment (although this was marginally reduced with
drop-out rates). Two further studies (Biggs et al., 2021; Jarero et al., 2013) reported that power calculations had been considered within their analysis but provided no further detail.

Three studies of the six (Alghamdi et al., 2015; Jarero et al., 2013; Bryant et al., 2018) reported on longer-term effects of interventions, with follow-ups between one and six months. Two studies (Jarero et al., 2013; Bryant et al., 2018) reported significant decreases in symptoms at follow-up, within intervention groups and a superiority of the intervention vs a waitlist control. One study using NET (Alghamdi et al., 2015), did not report significant long-term benefits. However, the authors identified that participants went on to face many more challenging and potentially traumatic incidents within this time, following a large-scale natural disaster that occurred in between follow-up timings.

One study utilised non-inferiority analyses (Bryant et al., 2018), comparing ‘CBT-brief’ to ‘CBT-long’. This study reported that a brief CBT intervention was no less efficacious than a long CBT intervention and that 10 minutes of imaginal exposure was just as effective in reducing symptoms as 40 minutes of exposure.

Five out of the six studies reported secondary outcomes concerning anxiety and depression. All five studies reported significant reductions in symptoms of depression and anxiety at post-intervention.

**Mindfulness-based Interventions Efficacy**

Six studies out of thirteen reported on the use of mindfulness-based interventions in the treatment of work-related trauma (Kaur et al., 2018; Copeland, 2021; Hevezi, 2016; Duarte & Pinto-Gouveia, 2016; Perez et al., 2022; Owens et al., 2020). Studies utilised a variety of mindfulness-based techniques, including group and individual sessions. All studies reported a significant decrease in secondary traumatic stress scores as measured by the ProQOL-V post-intervention. Three studies utilised a within-groups design (Kaur et al., 2021; Hevezi, 2016; Owens et al., 2020), reporting significant reductions from pre- to post-intervention. A further three studies conducted between groups analyses (Copeland, 2021; Duarte & Pinto-Gouveia; Perez et al., 2022), with two reporting a superiority of mindfulness vs a waitlist control (Duarte & Pinto-Gouveia; Perez et al., 2022). One study (Copeland, 2021) reported
superiority of five minutes of mindfulness meditation in reducing symptoms of secondary traumatic stress vs other holistic five-minute brief interventions.

Effect sizes were reported in all six studies, using Cohens $d$, hedges $g$, or partial eta squared. Five studies (Kaur et al., 2018; Copeland, 2021; Hevezi, 2016; Duarte & Pinto-Gouveia, 2016; Owens et al., 2020) reported medium to large effect sizes on secondary traumatic stress scores, with one study (Perez et al., 2022) reporting a small effect size of the intervention. Effect sizes for the trauma-related outcomes appeared numerically bigger than secondary outcomes in all but one study. One study (Duarte & Pinto-Gouveia, 2016) reported on their power calculations, noting that power had been met for analysis; however, five studies either noted that they had not met power or there was no mention of power within the papers.

Two studies (Kaur et al., 2021; Perez et al., 2022) reported on the longer-term effects of mindfulness interventions, with follow-up occurring at three months. Each of the two studies reported a sustained decrease in secondary traumatic stress scores at three months, and secondary outcomes were also maintained at three-month follow-up, indicating treatment efficacy.

Secondary outcomes were considered in all six studies, and since all studies utilised the ProQOL-V outcome measure, changes in compassion satisfaction and burn-out scales were reported. Again, all six studies noted a decrease in burn-out and an increase in compassion satisfaction post-intervention.

**Psychoeducation Intervention Efficacy**

One study (Berger & Gelkopf, 2011) utilised psychoeducational group therapy as its intervention in the treatment of work-related trauma. This study reported a significant effect of psychoeducation vs a waitlist control in reducing secondary traumatic stress, as measured by the ProQOL-V. However, this study reported a small effect size, and there are no indications of power calculations mentioned within the study. Significant improvements were also reported in increasing hope, a sense of mastery and compassion satisfaction with a decrease in burn-out scores. A superiority of the psychoeducation intervention was reported over the waitlist control for all primary and secondary outcomes.
Acceptability and Feasibility of Interventions

Six studies out of the thirteen (Biggs et al., 2021; Kaur et al., 2021; Deblinger et al., 2020; Copeland, 2021; Duarte & Pinto-Gouveia, 2016; Owens et al., 2020) reported on the acceptability and feasibility of their interventions in helping professions. All six reported that the intervention had been well received by participants. Each of the six studies reporting on acceptability and feasibility had low attrition rates and high retention rates, indicating the viability of interventions targeting work-related trauma. Participants directly reported high levels of satisfaction and/or usefulness of the intervention in three studies (Biggs et al., 2021; Kaur et al., 2021; Duarte & Pinto-Gouveia, 2016). Participants in one study (Copeland, 2021), reported that the interventions were brief enough to fit in with work schedules and demands, and again acceptability and feasibility were confirmed here.
Discussion

To our knowledge, this is the only systematic review to date which considers evidence-based treatment options for work-related trauma in helping professions. This review aimed to identify existing psychological evidence-based interventions in the treatment of work-related trauma and synthesis their efficacy, alongside detailing the intervention(s) procedure. Work-related trauma has been well studied in terms of prevention and prevalence, particularly following the increase in its occurrence following the Covid-19 pandemic (e.g. Hydon et al., 2015; Morrison & Joy, 2016; Jones et al., 2021; Cole et al., 2021; Billings et al., 2021). Whilst attempts to prevent the development of work-related trauma are useful and much needed, for those in the helping professions for whom prevention has not been effective, there are extensive consequences to developing work-related trauma. Indeed, the impact on the individual, their significant others, patient care, and the organisation is evident (Sutton et al., 2022; Finklestein et al., 2015; Middleton & Potter, 2015). This review, therefore, provides an up-to-date synthesis of the available literature on treatment options for helping professions, reporting on the delivery and efficacy of the interventions. This review has further addressed methodological weaknesses and gaps within the available research.

Summary of Findings

Thirteen studies were included in this review and the results demonstrate the effectiveness of several interventions in the treatment of work-related trauma. All of the studies included reported significant reductions in work-related trauma across time from pre- to post-intervention. Additionally, for studies that used a waitlist control condition, trauma interventions were significantly superior in reducing trauma symptoms over no treatment. For studies that considered secondary outcomes, the interventions were also found to be effective across time and superior between conditions in reducing depression, anxiety, burn-out and increasing levels of self-compassion. Asnaani et al., (2020) state that around 10-15% of those who experience trauma will develop secondary mental health difficulties, including anxiety and depression. As such, the applicability of the interventions in not only the treatment of work-related trauma but any subsequent difficulties are implied.
The review categorised studies into three types of intervention: therapeutic, mindfulness-based and psychoeducation. The inclusion of various interventions is highly relevant, as it offers choice for treatment options within clinical settings. As a result, the findings provide ecological validity to the field of work-related trauma. The inclusion of several intervention models is comparable to previous trauma-specific reviews which also encompass a variety of models across populations (Gameon & Skewes, 2019; Lewis et al., 2020; Roberts et al., 2015) and contributes to expanding the evidence for trauma interventions.

Considering the therapeutic models, this review included studies using cognitive behavioural therapy (trauma-focused, brief and long, integrated compassion-focussed therapy, PWYP), eye movement desensitisation and reprocessing, and narrative exposure therapy. All of these models have been successfully evidenced in the treatment of trauma across general adult populations (Mavranezouli et al., 2020; de Jongh et al., 2019; Siehl et al., 2021; Lewis et al., 2021). This review has evidenced that these models can also successfully target repeated, secondary exposure to trauma in helping professions and reduce trauma symptomology, showing their efficacy.

Traditionally, trauma-focused work would be conducted when there has been a period of post-trauma safety for memory consolidation (Jarero & Uribe, 2011, 2012). However, as is the nature of their roles, helping professionals are likely to be continually exposed to further potentially traumatic events. As such, the findings have also demonstrated that the undertaking of trauma-focused therapy for work-related trauma can reduce symptoms despite the ongoing threat and danger of further trauma being experienced. This is particularly important and shows that therapy can still be commenced and subsequently effective when related stressful events may be ongoing and when a post-trauma period of safety is not possible.

When considering the mindfulness-based intervention findings within this study, the interventions were successful in reducing levels of secondary traumatic stress and compassion fatigue in helping professions. As such, there is an implication that the tendency to focus on the present moment rather than on intrusive memories of traumatic events alongside a capacity for non-judgemental reflection may buffer the negative impact of traumatic events (Follette et al., 2006). Indeed, previous research has suggested that greater trait mindfulness is associated with fewer symptoms of PTSD in high-risk groups such as
firefighters, survivors of natural disasters and victims of sexual abuse (Smith et al., 2011; Hagen et al., 2016; Daigneault et al., 2016). Mindfulness interventions may serve as a means of aiding emotional regulation and increasing distress tolerance in helping professionals, as evidenced in previous reviews with traumatised individuals (Follette et al., 2006). Indeed, the inclusion of mindfulness-based interventions offers a timelier approach to the treatment of work-related trauma. Mindfulness approaches are relatively well-integrated into healthcare systems (Banks et al., 2015) and subsequently, these interventions may be relatively easy to implement into services using existing resources. Indeed, the use of pre-recorded and brief mindfulness sessions that were well-incorporated into a professional's working day and had favourable outcomes suggests the practicality of the treatment.

Finally, the efficacy of psychoeducation in the treatment of work-related trauma was evidenced in this review. Whilst only one study used psychoeducation, its inclusion parallels the use of psychoeducation with survivors of trauma (Whitworth, 2016; Wessely, 2009). Psychoeducation has been described as a way of giving traumatised individuals a 'psychological map' (Krupnick & Green, 2008) to comprehend traumatic reactions. Psychoeducation may be delivered at different time-points in treatment, including during the 'impact phase' when trauma is still occurring (Phoenix, 2007). Again, this is useful for helping professionals who are likely to be continually exposed to trauma as a result of their work. Psychoeducation appears helpful in reducing traumatic responses in helping professionals and also in normalising traumatic reactions (Howard & Goelitz, 2004).

Taken together, this review has provided a number of options in the treatment of work-related trauma using different psychological models, detailing their procedure as outlined in the aims of the review. This increases the accessibility of treatment options for the helping professions. As therapeutic interventions may not be as readily available due to the need for skilled therapists to conduct them (The Psychological Therapies Matrix, 2019), mindfulness-based interventions and psychoeducation may be timelier and more convenient yet still offer relief and protection from work-related trauma.

Interestingly, there was a variability in the duration of treatment across interventions offered. For example, one study showed significant changes within a short period of time (two sessions of EMDR; Jarero et al., 2013) whilst other studies utilised up to twelve sessions of therapy (Biggs et al., 2021; Beaumont et al., 2016; Berger & Gelkopf, 2011; Bryant et al.,
2018) or daily sessions of mindfulness (Hevezi, 2016; Owens et al., 2020). There is an implication of the potential effectiveness of brief interventions for helping professionals as a result. This contradicts previous guidance and recommendations for longer phased-based treatment approaches for trauma (The Psychological Therapies Matrix, 2019; Galovski et al., 2012). Whilst it may not be generalisable across populations, brief interventions for helping professionals provide a time-efficient and flexible option in treating work-related trauma. Brief interventions have been used successfully in the US Military, where they offer access to timely but appropriate treatment and the increased identification of PTSD symptoms in troops (Engel et al., 2008; Wong et al., 2015). However, it must not be assumed that brief interventions can resolve work-related trauma due to the low number of studies included and the methodological quality of the studies included. As such, more research is needed to further understand this phenomenon. Nevertheless, the variability in interventions here may be useful when considering treatment options.

The effectiveness of all studies was generally shown to maintain at follow-up time points which is a promising finding for the interventions. Given that helping professionals are likely to be repeatedly exposed to traumatic and stressful conditions, as mentioned - interventions may provide longer-term protection from traumatisation through the workplace. Indeed, the results imply that the skills and techniques learnt within interventions may enhance a person's ability to cope with traumatic conditions and increase their confidence in the ability to deal with difficulties, thus building a more resilient workforce. This also further complements developing research and theory on post-traumatic growth (Haagenars & van Minnen, 2010; Maitlis, 2020).

Finally, examinations of feasibility and acceptability of interventions showed favourable evidence for work-related trauma interventions. This is particularly relevant given that paradoxically, helping professionals often avoid seeking the help they may offer to others (Putnik, de Jong & Verdonk, 2011; Ledingham et al., 2019) and if interventions are well-received, in line with working demands, uptake and attrition remain high.

**Evaluation of Studies**

Comparison between studies was difficult given the heterogeneity of the interventions themselves and the lower level of methodological quality for the studies, which were all rated
either moderate or weak in quality. Whilst RCTs or Clinical Controlled Trials (N=8) made up the majority of studies, indicating a strong design rating, all studies received a moderate or low-quality rating in selection bias and the blinding category, bringing overall global ratings down. However, it must be noted that studies utilised specific populations for interventions and as previously mentioned, it would have been unethical to blind participants to their type of intervention, and thus, lower ratings in terms of study quality were therefore expected. The majority of studies employed a pre-post design, most of which included variable longer-term follow-up times, again making comparison difficult and further limiting any conclusions that can be drawn from this review. Finally, most studies (N=10) had small sample sizes, with less than 100 participants, which reduces the statistical power, and increases the likelihood of type II errors occurring.

The review aimed to detail interventions efficacy. Effect sizes across studies were generally large or moderate, and whilst it is tempting to assume this means a strong practical applicability of the research, there are a number of concerns around this. Firstly, the lack of stated power calculations may limit the overall statistical power of findings. Secondly, the papers reviewed employed cohens $d$, hedges $g$ and partial eta squared to account for the effect, making cross-comparison difficult. Thirdly, two studies (Beaumont et al., 2016; Jarero et al., 2013) did not report numerically on their effect sizes, with one study (Beaumont et al., 2016) reporting that large effect sizes were found, however providing no statistical evidence for this. As a result, there are concerns over studies replicability, reliability and validity. Finally, large effect sizes were reported in five studies ($d>0.8$) and these effects may be an overestimation of the strength of the intervention. Funder and Ozer (2019), have noted that large effect sizes are often misinterpreted and that a large effect size in the context of psychological research is likely to be a gross overestimate that will rarely be found in a large sample in a replication study. However, previous research on trauma interventions have reported on moderate to large effect sizes of interventions across populations (e.g. Morina et al., 2018; Lambert & Alhasoon., 2015; Malik et al., 2021), so whilst caution must be applied to these findings, they are in keeping with the field.

Considering study characteristics, nurses were over-represented within this review (N=6), representing 35.6% of the total sample. This disproportionate representation limits the generalisability of the findings to other at-risk occupations. Whilst this review did intend to include a span of helping professions, there appears to be limited expansive research across
the helping professions. None of the identified research focussed on disaster and aid workers, who are likely to be repeatedly confronted with traumatic experiences in their roles. Mental health workers were also vastly underrepresented despite being more likely to experience vicarious trauma (McNellie & Rose, 2020). Older workers were also disproportionately represented within this review. Again, this limits the applicability of findings, as research has indicated that younger workers may be more prone to experiencing compassion fatigue and in particular those with less work experience (Adams et al., 2001). Since all studies reported on successful outcomes, it would be prudent to research these interventions on younger helping professionals to see if the benefits are maintained.

Finally, studies used different definitions of work-related trauma, and thus, again it is increasingly difficult to generalise as a result. Whilst this is an expected finding, given the interchangeable terms within the literature and the scope of the definition this study used, it does highlight an inconsistent approach to operationalising this phenomenon. There are multiple factors that underlie work-related trauma, as highlighted by this review, and this is perhaps a starting point for defining work-related trauma.

Strengths and Clinical Implications

The findings of this review have direct relevance to service provision. This review has identified and detailed psychological interventions and their procedures for work-related trauma, alongside reporting on the efficacy of each intervention. The inclusion criteria employed within this review was intended to capture evidence-based treatments. The intention here was not to discount the utility of indirect or guided forms of interventions but rather to provide the most direct and accessible evidence base for clinicians to utilise. As such, this review provides evidence of interventions in treating work-related trauma, highlighting successful outcomes through therapeutic interventions, whilst also providing practical applications around length of duration and outcome measures to use across a range of professions. This not only provides immediate guidance to clinicians working with helping professionals in the treatment of work-related trauma, but it also ensures that clinicians have access to evidence on the effectiveness of different therapeutic modalities. This can help to aid in clinical judgement when selecting interventions and further increases treatment options for patients.
Given the increased global attention towards work-related trauma, following the Covid-19 pandemic (Benfante et al., 2020; Marvaldi et al., 2021; Liu et al., 2023), this review provides a valuable, up-to-date evidence of trauma-specific interventions for helping professions. Specifically, over half of the studies included in this review, were published within the last five years, highlighting the increasing attention in this area. Moreover, this review is made more robust by the inclusion of several trauma models, as well as using a wide range of trials and analyses. This review also highlights the nuances between different notions of work-related trauma. Clinicians must use clinical judgement in assessing presenting referrals and consider how work-related trauma may differ from other trauma presentations.

This review indicates that there is some promising evidence emerging about interventions to reduce work-related trauma, however, given the small number of published studies to date, it is difficult to determine the wider impact of this.

**Limitations and Future Research**

Whilst some limitations have been considered in the interpretation of the findings, there are some specific gaps in this review, which restrict the generalisability of this paper. Firstly, qualitative material was excluded from this review. Qualitative accounts may provide further context to the observed findings, particularly around the acceptability and feasibility of the interventions. A previous qualitative review has provided conceptual frameworks for work-related trauma and provided recommendations for the prevention of this trauma across occupations (Rauvola et al., 2019). This includes building interventions into earlier career stages for helping professionals. Despite the value and importance of prevention, more research is required to qualitatively explore the experience of work-related trauma and assess the impact of psychological interventions on helping professionals who experience acute trauma in the work-place.

Additionally, other individual and organisational factors which may give rise to the incidence of work-related trauma, such as gender, adverse childhood experiences and average work hours (Boscarino et al., 2004; Creamer & Liddle, 2008) were not considered within this review and again, this limits the generalisability of the review. Surprisingly, none of the studies identified within the search accounted for vicarious trauma in helping professions. This is a phenomenon which may be experienced disproportionately by therapists and mental
health workers (Devilly et al., 2009; Pearlman et al., 1995; Kadambi & Ellis, 2004), and its exclusion in the available research is an anomaly. Further research considering interventions for the shifting schemas that present in vicarious traumatisation would complement this review and the overall understanding of work-related trauma.

Studies included within the review, measured the severity of work-related trauma symptoms via outcome measures, however, the context of the trauma i.e. what the participants experienced, or what their trauma was in relation too, was not captured or included within studies. Going forward, it would be useful to record the context of helping professionals work-related trauma e.g. physical aggression experienced, empathetically engaging in trauma narratives, attending road traffic collisions, in relation to the interventions on offer to further contribute to the field of work-related trauma which is continuing to develop.

Grey literature was not included within this review. Whilst this decision was applied to ensure methodological rigour of the included studies, given that this is the first review of its kind, and due to pragmatic expectations of the review it provides specific limitations. As a result of not including grey literature, there is a risk of a publication bias being present within the review. There is a known bias to publishing favourable research pieces (Paez, 2017) in peer-reviewed journals and indeed, all studies included here showed significant findings. Thus, the exclusion of grey literature is problematic for the conclusions of this review and including grey literature in future research would help to provide a balanced view of the evidence.

Future research should focus on the effectiveness of interventions in a more diverse range of at-risk occupation groups. Recent research has identified that there are a number of other at-risk professions for vicarious trauma including journalists, documentary-film makers, and researchers (Specht & Tsilman, 2018; Melzer, 2018; Moran & Asquith, 2020) due to exposure to distressing material. Further research which considers wider populations for work-related trauma would be useful in expanding the field.

Finally, whilst this review considered evidence-based interventions, which are highly relevant, there is a known barrier to helping professionals seeking psychological support initially (Edwards et al., 2021; Carpenter et al., 2020; Siebert & Siebert, 2007). Therefore, a review which considers more holistic interventions for work-related trauma would provide
more supportive options for the helping professionals who may not wish to engage in an evidence-based intervention. If non-psychological interventions can be reviewed and appropriately scrutinised, this would expand the current evidence base and complement the interventions currently available and offer more patient choice.
Conclusion

This is the first systematic review to identify and evaluate evidence-based psychological interventions in the treatment of work-related trauma across helping professions. Results revealed promising effects of interventions in the reduction of symptoms of work-related trauma. Interventions included: therapeutic, mindfulness-based and psychoeducation and practical applications around these, including duration and use of outcome measures, have also been provided through this review. Additionally, the review noted good acceptability and feasibility of evidence-based interventions amongst helping professionals. However, these findings are limited by the methodological quality of the included studies and the relatively low number of research papers investigating this phenomenon. As such, future research into the area must be more robust to evidence the effectiveness of work-related trauma interventions. Furthermore, whilst this review has provided a starting point, there is a crucial need for more research into the area which expands across working populations. As the effects of work-related trauma become ever-apparent on helping professionals, this review represents an important evidence base which will continue to grow in significance for both research and clinical practice.


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Chapter 2: Empirical Project

“Well, we’ve just got to keep going, I suppose”: An IPA Study into the Experiences of Adult Mental Health Workers and Trauma-Informed Care.

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Guidelines followed with the exception of journal word count limit for current thesis submission.
Abstract

**Background:** There is little qualitative evidence available on both the impact of working in adult mental health settings, whereby contact with distress and trauma is likely and the field of Trauma-Informed Care, which is a developing area. However, there is a growing recognition of the vicarious impact of working within mental health services. Adult Mental Health NHS workers are underrepresented within the literature, and little is known about the effects and impact of their work on them. Additionally, with the recent introduction of the National Trauma Training Programme in Scotland, little is known about its impact on staff and whether Trauma-Informed Care is a useful approach within the NHS.

**Aim:** To explore the impact of working in adult mental health settings with distress and trauma and to further explore the impact of the national trauma training programme on adult mental health workers.

**Method:** NHS staff members working in an adult mental health setting who attended the National Trauma Training Programme were recruited for a 1:1 semi-structured interview (N=11). This was to explore individual experiences of working within adult mental health with distress and trauma, and their experiences of Trauma-Informed Care following the training that they attended. Accounts were analysed using Interpretative Phenomenological Analysis (IPA).

**Findings:** Four Group Experiential Themes were found within the data: ‘Role Identity’, “Well we’ve just got to keep going, I suppose”, ‘Service Pressures’ and the ‘Implementation of Trauma-Informed Care’. Each theme contained another 2-4 subthemes within them.

**Conclusion:** Findings suggest that NHS Adult Mental Health workers experience various challenges and opportunities within their roles. This is often impacted by wider systemic pressures from the service they belong to; however, there is a resounding pride and passion in their roles. Further, whilst Trauma-Informed Care and approaches have been warmly welcomed by staff, implementing the approach into the NHS organisation remains a challenge.

*Keywords: trauma, work-related trauma, adult mental health, NHS, trauma-informed care*
Introduction

Trauma

Trauma is a pervasive problem resulting from exposure to an incident or series of events that are emotionally disturbing or life-threatening (Trauma Informed Care Implementation Resource Centre, 2021), with lasting effects on the individuals functioning and wellbeing. Type 1 trauma includes single incident or unexpected adverse events (e.g. road traffic accidents, natural disasters, terrorist incidents), and is commonly associated with Post-traumatic Stress Disorder (PTSD). Symptoms may include re-experiencing and hyperarousal. Kessler et al., (2017) report a lifetime prevalence of single-event trauma of 70.4% across populations; however, a resulting diagnosis of PTSD may be as low as four percent.

Type 2 trauma is defined as repeating or enduring experiences that are often interpersonal in nature, such as childhood abuse, interpersonal violence, and neglect (NHS Education for Scotland; NES, 2017). Type 2 trauma is commonly referred to as complex trauma and may manifest as dissociation, self-harming behaviours, and relational difficulties. Given the duration of complex trauma, an individual’s basic functioning and capacity for coping are usually significantly disrupted. Maercker et al., (2022) report a population prevalence of 1-8% for complex trauma and 50% within mental health services. However, the prevalence is likely higher than any reported figure due to underreporting and the stigmatising nature of complex trauma (Coleman et al., 2021). Complex trauma has significant psychological and physical impacts on survivors (World Health Organisation, 2013), including mood difficulties, anxiety and use of substances (Molnar et al., 2001), and it has been connected to serious psychiatric problems both in childhood and adulthood (Teicher & Parigger, 2015). Further, experiencing complex trauma has been associated with high use of health services, functional impairment, and poor subjective health across the lifespan (Cohen et al., 2008; Leserman, 2005; Spataro et al., 2004). Given the prevalence and significant impact of complex trauma, working with trauma survivors is a critical issue in healthcare settings.

Working with trauma in healthcare settings

Complex trauma is a worldwide public health concern (Strand et al., 2016; Lee et al., 2021), and survivors often present across the healthcare system (Oral et al., 2020), with a large
impact on health resources. Annual healthcare costs worldwide are significantly higher for those with complex trauma (WHO, 2013), and many trauma survivors experience multiple barriers to accessing healthcare (Reeves, 2015).

Services that fail to consider trauma inadequately address underlying health issues and can be experienced as re-traumatising and disempowering to patients (Lovell et al., 2022). In a mixed methods study, Farro et al., (2011) reports that patients are less likely to trust services and their healthcare professionals if re-traumatisation happens. Whilst this study used an organisational case study, and thus its generalisability must be questioned, it highlights the consequences for ongoing care for those who have been re-traumatised. Indeed, Chaudhri et al., 2019 note that if re-traumatisation happens patients will often disengage with services and seek care via more anonymous, transactional systems instead, such as A&E departments. Subsequently, this disengagement exacerbates health issues and may result in multiple re-presentations over a lifetime and poorer overall health outcomes (Farro, 2011). Trauma can therefore be present across the continuum of care, and anticipating the possibility that someone may have a trauma history from the initial contact can be protective of patients. Furthermore, being trauma aware does not stop with the recognition that trauma only affects patients; instead, it encompasses a broader awareness that the impact of trauma may extend beyond the patient to significant others, family members and health professionals working with patients.

**Work-related trauma; the impact of working with distress and trauma**

For health professionals, working with trauma survivors can impact on their own health and wellbeing and may even be confronting of their own traumatic experiences (Boxall et al., 2020). There is a 'cost to caring' (Figley, 1995) whereby professionals who listen to reports of trauma, human cruelty and extreme loss can be overwhelmed and exhibit a range of traumatic stress reactions. Vicarious trauma, secondary traumatic stress, and compassion fatigue (Pearlman & Saakvitne, 1995; Stamm & Figley, 1995; Joinson; 1992) are occupational hazards for those providing trauma therapy (Jankoski, 2022; Figley, 1995; Mathieu, 2012) or vicariously witnessing traumatic events. The terms have been used interchangeably within the literature, which has caused some confusion (e.g. Chouliara et al., 2009; Devilly et al., 2009; Dunkley & Whelan, 2006b; Sabin-Farrell & Turpin, 2003). As such, vicarious trauma describes a profound shift in worldview, whereby indirect exposure to trauma changes
clinicians' cognitive schemas about the self, others, and the world (Cohen & Collens, 2013; Moulden & Firestone, 2007). Secondary traumatic stress describes the development of trauma symptoms that parallel those of PTSD (Stamm & Figley, 1995) and compassion fatigue refers to the profound 'loss of ability to nurture' due to multiple environmental stressors (Joinson, 1992).

The range of secondary reactions that manifest in healthcare professionals can be, but are not necessarily always, similar to those presented by patients who have experienced the trauma. Symptoms of work-related trauma may vary in intensity and duration and can include: avoidance behaviours during patient interactions, limited emotional expression, including during supervision, somatic complaints, insomnia and heightened arousal, low mood and detachment from friends and family (Maschi & Brown, 2010). Additionally, the policies, procedures and practices that staff, and in particular mental health staff, may be required to perform may be at odds with their own personal values and beliefs (e.g. the use of restraint or covert medications; Sweeney et al., 2015) and against the reason that they entered into the profession initially. Staff who experience conflict between job duties and their moral code may perceive that they are under chronic stress for which they must learn to cope and adapt too and may develop moral injury (Jinkerson, 2016). Work-related trauma is, therefore, not only influenced by exposure to traumatic content but also the context in which a person belongs.

It is well recognised that mental health workers can experience poor mental health and general psychological distress due to the demanding nature of their work (Koinis et al., 2015). Additionally, studies point to the elevated rate of trauma amongst therapists working with traumatised individuals and the number of trauma cases on a clinician's caseload influences the level of work-related trauma experienced (Brady et al., 1999; Ortlepp & Friedman, 2002; Chouliara et al., 2009). However, in a meta-synthesis on the impact of trauma work on trauma clinicians, Cohen and Collens (2013) report that whilst there are schematic changes associated with working in complex trauma, these are not necessarily always negative. These changes can be positive if clinicians are exposed to their client's progress. This is in line with theories of post-traumatic growth, which outline positive changes to schemas on relationships, appreciation for life, new possibility, and a sense of personal strength (Tedeschi & Calhoun, 2008; Cohen & Collens, 2013). Additionally,
therapists with adequate training in complex trauma have a reduced sense of hopelessness (Ortlepp & Friedman, 2002).

Sabin-Farrell & Turpin (2003) report that the concept of vicarious trauma has been so welcomed by mental health professionals that the publication of remediation and self-help strategies has preceded the performance of empirical research investigating the occurrence and aetiology of the phenomenon. Indeed, the available evidence often lacks scientific rigour due to the interchangeable use of terms and different structural measures employed; therefore, the validity must be viewed with caution. Although the literature currently lacks consistency, the demands of providing care to trauma survivors cannot be ignored, lest the provider becomes increasingly impaired and less effective (SAMHSA, 2014), which can harm their patients. An organisational environment of care for the health and safety of staff will enhance the ability to provide the best care for patients whilst promoting staff wellbeing.

**Trauma-Informed Care**

Trauma-Informed Care aims to meet the unique needs of trauma survivors (Rosenberg, 2011) across organisations and systems. Five principles have been proposed within the research; safety, trust, collaboration, choice and empowerment (Fallot & Harris, 2009; Goodman et al., 2016; Knight & Borders, 2018) and there is an emerging consensus that these principles, when ingrained into organisations can benefit both trauma survivors and staff. Trauma-Informed Care can help close the gap between the people who use services and the people who provide them (Filson & Mead, 2016), making services safer.

Where Trauma-Informed Care has been implemented into organisations, there is less chance of re-traumatisation, and both staff and patients report feeling more empowered (Bryson et al., 2017; Sullivan et al., 2017). Conversely, where trauma-informed policies are not applied, staff experience higher rates of secondary trauma symptoms and a sense of reduced competency (Frey et al., 2017).

A more recent focus has been on 'culture' as an important principle within Trauma-Informed Care as it incorporates gender and historical issues relevant to organisations (SAMHSA, 2014b). Permitting flexibility is key to ensuring the successful implementation of Trauma-Informed Care. Indeed, implementing Trauma-Informed Care may be seen as occurring on a
continuum, where the practice is the journey and not the destination (Alive and Well Communities Educational Leader's Workgroup, 2014). This allows for continuous evolution and adaptation of Trauma-Informed Care based on new understandings and considerations as the field continues to develop and be researched.

**Trauma-Informed Care in Scotland and the National Trauma Training Programme**

Scotland became the first country to recognise and respond to the need for trauma-informed services by implementing a National Trauma Training Programme (NTTP), led by NHS Education for Scotland (NES; NES, 2021). The NTTP provides training resources to help raise awareness, knowledge, and confidence amongst the Scottish workforce to embed Trauma-Informed Care throughout services.

The NTTP use the five principles as outlined in subsection *Trauma Informed Care* (safety, trust, collaboration, choice, and empowerment; Fallot & Harris, 2006) and has five key drivers for organisational change, which include:

1. Leadership and Management
2. Workforce Wellbeing
3. Workforce Knowledge and Skills
4. Experts by Experience
5. Data and Information

Indeed, NES has recognised that for organisations to become trauma-informed, there must be an emphasis on staff skills, knowledge, and wellbeing (NES, 2021). As such, NES has developed a framework for implementing Trauma-Informed Care across Scotland, and this is based on trauma survivors and staff's views of what this practice looks like in a real-world Scottish setting. There was, and still is, an overarching vision to develop a trauma-informed and responsive nation and workforce that:

- is informed by people with lived experience,
- recognises the importance of wellbeing in the workforce,
- recognises where people are affected by trauma and adversity,
- responds in a way that prevents further harm,
- supports recovery,
- and can address inequalities and improve life chances (NES, 2021).

There are four levels of training for staff within the NTTP, with an emphasis on trauma being 'everyone's business'. NTTP recognises that not everyone needs to be a trauma expert and instead has created the following levels:

1. Level 1 – Trauma-Informed
2. Level 2 – Trauma Skilled
3. Level 3 – Trauma Enhanced
4. Level 4 – Trauma Specialist

Levels 1 and 2 of the training programmes aim to get every staff member trauma-informed, regardless of their role, and skilling up staff members in trauma-informed working. Whereas Levels 3 and 4 focus on trauma specialist work. The NTTP acknowledges that "all workers, in the context of their own role and work remit, have a unique and essential trauma-informed role to play in responding to people who are affected by trauma" (NES, 2021). Thus, implementing trauma-informed practice into Scottish organisations is ever-evolving and remains a priority at both a local and national level.

The current social context, the lasting impact of Covid-19, and the evolving NHS crisis

When considering Trauma-Informed Care and work-related trauma in healthcare professionals, it would be remiss not to acknowledge the impact of the current social climate in the United Kingdom. This includes the lasting effects felt from the Covid-19 pandemic and the emerging crisis across the NHS.

In a quantitative study, Gilleen et al., (2021), note that poor mental wellbeing was prevalent among healthcare workers during the Covid-19 pandemic. Indeed, nearly a third of their participants reported moderate to severe levels of anxiety and depression with high levels of PTSD symptomology, which was more than quadruple the rates in staff pre covid-19.

However, this study recruited from only 19% of UK NHS trusts limiting the generalisability
of the findings. Nevertheless, this is further supported by Greenberg et al., (2021), who noted that 45% of their sample of healthcare workers experienced mental health difficulties during the Covid-19 pandemic whilst they were working within Intensive Care departments. The impact of the pandemic has been apparent throughout healthcare settings, and Aafjes-van Doorn et al., (2020) in their survey, reported that psychotherapists experienced moderate levels of vicarious trauma on average with a further 15% of their sample experiencing high levels during the first wave of Covid-19. Despite their study mainly focusing on female therapists, it shows the breadth and depth of the impact of the pandemic and how it affected healthcare workers across services. It appears that negative experiences felt during the pandemic, such as feeling more distressed and overworked whilst feeling less connected to patients, is associated with poorer mental health and a higher vicarious impact on staff members.

As a recent drop in public satisfaction with the NHS becomes apparent (Buzzelli et al., 2022), staff are left feeling undervalued, and yet under huge pressure to maintain and improve services with little extra investment. Deakin (2022) notes high levels of burn-out associated with working within NHS Systems and the workforce shortages, which are affecting staff wellbeing and patient care. In an opinion piece based on the NHS Staff Survey (2021), Waters (2022) reports that the morale and wellbeing of NHS workers have been dented as a result of a lack of investment into services, with only 1 in 4 NHS staff members reporting that there are enough employees in their organisation to allow them to do their job properly. There are further concerns about increasing numbers of the workforce suffering from work-related stress and thinking about leaving the NHS (Waters, 2022). This further highlights the complexity of experiences of work-related trauma in the NHS, which is related to both direct clinical work and the systems in which health professionals work.

However, evidence is growing that stress and burn-out may be reduced when healthcare workers feel well prepared for their role through specialist training or when they feel confident in their own knowledge and skills (Lai et al., 2020; Brooks et al., 2019). The importance of organisations displaying compassion and sensitivity towards the workforce and building in support mechanisms to daily work routines; essentially Trauma-Informed Care; can result in significant improvements in staff wellbeing (Bailey & West, 2020; Shanafelt et al., 2020).
**Current Study**

The review of the literature points towards work-related trauma being present among healthcare workers across services. The prevalence of complex trauma presentations within healthcare settings has also been evidenced. Yet, the subsequent shift towards providing trauma-informed services has limited evidence currently. The available evidence directs to the usefulness of the approach and how it can protect patients, stopping re-traumatisation. Trauma-Informed Care further supports staff members in gaining the knowledge and skills for treating patients but also protects staff from the vicarious effects of working with complex trauma.

However, gaps remain within the literature. Little research has looked at work-related trauma and Trauma-Informed Care within Community Mental Health Team (CMHT) members and those working in Adult Mental Health (AMH) services. Indeed, Edwards et al., (2020) have reported that CMHT members experience considerable stress and burn-out due to increasing workloads and a lack of resources. Given this and the cited research above, a similar trend may be observed within the CMHT concerning the impact of work-related trauma. However, this is not an addressed topic of research to date.

Further, with the recent introduction of the National Trauma Training Programme in Scotland, little is known about the qualitative impact of this training. It is a novel field, and it is hoped that the training can support not only people who come into contact with services but also the wider Scottish workforce.

Finally, there is little available qualitative evidence on the field of Trauma-Informed Care and the impact of working in adult mental health settings where contact with distress and trauma is likely. Qualitative evidence can provide a rich understanding of the impact of this work and Trauma-Informed Care. Further, qualitative research may unearth concepts and a deeper understanding of working in mental health and of trauma-informed care which may complement the current quantitative understanding that has been gained so far. This will allow for a breadth of research to start developing. The objectives of this study were therefore twofold:
1. Explore the impact of working in adult mental health settings and community mental health teams where distress and trauma presentations are common.

2. Explore the impact of the National Trauma Training Programme and trauma-informed care on mental health workers working within adult mental health settings.

As such, the following research questions were posed for this study:

1. What are the experiences of mental health workers working in adult mental health settings?

2. Has trauma-informed care been accepted and implemented in adult mental health settings?
Method

Design

The present research adopts a constructivist approach; not seeking to identify a single truth but seeking to elucidate the variety and complexity of conceptualisations phenomena. A qualitative research design was used for the current study. Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2022), is a credible method of analysing qualitative data which is committed to examining how people make sense of their major life experiences (Smith et al., 2022). As such, this epistemological stance outlaid was appropriate for the research. There are three key philosophies within IPA: Phenomenology (the study of experience), Hermeneutics (making sense and meaning from experiences) and Idiography (the specifics and context of individual experiences). The concept of being 'double hermeneutic' is key within IPA, whereby it is assumed that any conclusions drawn are a reflection of the researcher's interpretation of the participant's understanding and retelling of their experience (Smith et al., 2022). As such, IPA assumes phenomena cannot be understood as a 'single truth'; rather, there are multiple interpretations of the meaning of a phenomenon depending on individual, social, cultural, economic, and political context (Willig, 2013).

Participants were interviewed using semi-structured interview questions and interviews were recorded, transcribed, and analysed using IPA. IPA has been successfully employed within NHS research settings to capture staff members' experiences of various working practices unique to the NHS (e.g. Biggerstaff, 2019; Gerskowitch & Tribe, 2021; Olabi et al., 2022). The study protocol can be seen in Appendix E.

Participants

Participants were staff, working both directly and indirectly with patients (i.e. both clinicians and administrative staff) in an Adult Mental Health setting. Participants were permanent employees of a local NHS Health Board and had been in their role for at least six months at the time of interview. Participants in the study had all attended the National Trauma Training Levels 1 and 2.
Sampling was facilitated in two stages. Firstly, convenience sampling was employed, whereby all staff members who attended the training were given a participant information sheet and invited to sign up to hear more about the research. From here, a more purposeful sampling occurred, whereby participants who had consented to be contacted about the research were emailed and invited to discuss the research and what it would entail. Participants who digitally or verbally consented to be involved were invited to an interview, whereby a consent form was given to them. The use of convenience sampling was favourable for this research, considering that the study is exploring a particular phenomenon in line with a particular training that only some staff members would have attended. Therefore, it was not appropriate to use another method of sampling and Stratton (2021) notes that convenience sampling is a useful method of recruitment for qualitative research.

A total of 11 participants were recruited for the current study, which is appropriate for IPA studies, with recommendations between 4-10 participants but not going above 20 (Smith et al., 2022; Ellis, 2016). IPA sampling is purposeful and selects participants to illuminate the research questions and examine convergence and divergence within this. Therefore, recruitment was stopped upon completion of the 11 interviews as the researcher noted the analysis was sufficiently complete in order to develop a full and interesting interpretation of the data, whilst remaining committed to the contextualisation of the sample.

**Ethical Approval**

As the study recruited staff members within the NHS, ethical approval was required via the Integrated Research Application System (IRAS). This is the single system for applying for permission and approval for health and social care research within the United Kingdom. On favourable approval, the project was accepted by the local Health Board's Research and Development Team, and management approval for the research was granted. Finally, Level 1 ethical approval was granted by the School of Health in Social Science Ethics Committee - University of Edinburgh, who were satisfied the project met all ethical requirements. The University of Edinburgh and the local health board jointly sponsored the project. Please see Appendix F-H for ethical approval documents.

**Procedure**
The clinical team within the local health board were pivotal in this study. Two clinicians within the team facilitated the National Trauma Training Level 1 & 2, as detailed in the introduction. The training was advertised via email and posters (Appendix I) to all adult mental health team members, and staff were invited to sign up for the training. Management support was crucial to the implementation of the training in releasing staff from their day-to-day duties to attend. The training was offered on two different occasions to allow staff working shift patterns to have flexibility in attending whilst ensuring the safety of patients.

Whilst the lead researcher attended both training days, they did not facilitate the training so as not to bias the research. The training provided and the research was not mutually exclusive – i.e. staff members could attend the training without being part of the current study. However, the lead researcher was able to promote this study and its aims and begin recruitment on each training day.

On attending the training, staff members were told about the study and participant information sheets were provided (Appendix J). A sign-up sheet was also placed on exit, whereby participants could add their contact details if they consented to be contacted about the research. Within four weeks of attending, the lead researcher emailed all those who had signed up to provide more information on the study and asked whether they would be willing to participate in the research interview. Here, 11 participants responded, and interview dates were booked in within 8-12 weeks of attending training. At this point, consent forms (Appendix K) were provided to participants and, on completion, were securely stored by the research team in accordance with the ethical approval agreement.

**Semi-structured Interviews**

Semi-structured interviews are verbal interchanges whereby the interviewer attempts to elicit information from the participant through questions (Longhurst, 2003). Whilst there are set questions within semi-structured interviews, a bottom-up, participant-led format was used (Willig, 2008). DeJonckheere and Vaughn (2019) report that semi-structured interviews are the most frequent data source within health service research and indeed, their practical guidance for conducting interviews was followed in this study. IPA requires ‘rich’ data, meaning that participants have been granted the opportunity to tell their story, speak freely and reflectively and to develop their ideas and express their concerns at length (Smith et al.,
Semi-structured interviews are suited to in-depth and personal discussion which fits closely with the epistemological stance outlined above and the alignment to IPA and its constructs for this research study.

Interviews took place in person or over MS Teams. An interview schedule of 11 questions was developed by the researcher during supervision and through searching previous literature on similar topics and can be seen in Appendix L. During the development of the questions, careful consideration was given to ensure that each one linked to the study’s research objectives. Additionally, prompts were developed for each question to encourage participants to expand upon their original answers if needed. Participants' job titles and number of years in their role/since qualification were also collected.

a. Pilot Interview

Two pilot interviews were conducted before any data was collected to trial the effectiveness of the interview schedule. Guihen (2020) strongly recommends that a pilot interview be conducted when using IPA, given that it is the only method of data collection being used. The pilot interviews were conducted with trainee clinical psychologists who had attended the training in different settings and the data was not included in the final analysis. Following the pilot interviews, one change was made to the interview schedule and additional prompts were added to some questions to ensure clarity for the participants.

b. Interviews

All 11 participants were interviewed utilising the interview schedule. Establishing rapport is an imperative part of the interview process in IPA and time was spent by the researcher conversing with participants before the official interview was conducted. This ensured that participants felt comfortable and rich data could be elicited (Smith et al., 2009). Additionally, participants were encouraged to answer openly and honestly, being reminded that there were no correct or incorrect answers to give and that their responses would remain anonymous. As mentioned, prompts were also developed and used to keep participants concentrated on the topic. The researcher listened attentively and probed spontaneously throughout the interviews to elicit as much data as possible.
Interviews lasted between 39-59 minutes, with a mean time of 45 minutes. The lead researcher conducted 8 hours and 28 minutes of interviewing in this study.

Given that there were approximately 8-12 weeks between initial contact and the interview taking place, further verbal consent was gained at the start of each interview and participants were reminded of their right to withdraw at any point without consequence. Interviews were recorded on an encrypted device to enable transcription and subsequent analysis.

Following the completion of the interview, participants were fully verbally debriefed about the study and also given a debrief form that they could take away to read and can be seen in Appendix M. Given the nature of the topic being discussed, the researcher was keen to provide a space after the interview should the participant need to talk through anything discussed. Additionally, further wellbeing support numbers were provided to participants on the debrief form.

**Data Transcription**

All interviews were transcribed by the interviewer within one week of completion of the interview, to ensure confidentiality and minimal risk to data breaches. In line with the ethical approval, all identifiable information was removed from each transcript. Once transcribed, the researcher listened back to each recording whilst reading the transcription to ensure it was accurate. On completion of transcribing, each interview was deleted from the encrypted device.

**Analysis**

Given the theoretical underpinnings of IPA, it was deemed an appropriate methodology for this study and is underpinned by several important circumstances, including: i) the unique work setting that the NHS provides, ii) the gravity and consequences of developing work-related trauma through working in mental health settings and iii) the inclusion of clinicians’ perspectives, as well as their own interpretation of their experiences. The use of IPA allows for a wider exploration of the effect of working within AMH settings and the further impact of the NTTP to answer the research questions.
Analytic Process

To ensure commitment and rigour in line with IPA guidelines, the analysis of interview data followed the Smith et al., (2022) guidance. Analysis began with several readings of transcripts, and from here, initial notes and descriptive comments were made to provide a brief account of what was said, as well as any trending content that emerged. Following this, grouping of initial comments commenced to allow Personal Experiential Themes to emerge, providing an initial psychological framing of the phenomena. Connections across these personal experiential statements were then noted down and formed Group Experiential Themes. This process can be seen schematically in Figure 1. During these later steps, the researcher referenced back to the transcripts and quotations to ensure the analysis remained grounded in the initial accounts given by participants. This constant movement between the data-grounded and psychologically-grounded interpretations enabled all aspects of the ‘hermeneutic cycle’ of interpretation to be completed (Smith et al., 2022). An example transcript analysis can be seen in Appendix N and emerging themes alongside an example of the IPA analytic process can be seen in Appendix O.

Reflexivity and Transparency

Given the reflective and interpretive nature of IPA, reflexivity is of importance to the analysis. Reflexivity places the researcher within the context of the study, to ensure transparency as to whether the researcher has been influenced by their own personal context in the collection, analysis, and interpretation of the data.

The present study was completed in partial fulfilment of the researcher’s doctoral training in clinical psychology. In this sense, it is important to acknowledge the pragmatic underpinning of this research as something that was required. However, the researcher constructed the research idea due to an interest in staff wellbeing and Trauma-Informed Care and has held a position of openness and curiosity for the topic.

Additionally, the researcher has knowledge of potential work-related trauma through working in settings that give rise to this and has seen colleagues challenged with burn-out and secondary stress within the NHS. It is possible that this may have impacted upon the interview schedule or the interview itself. Indeed, there is a chance that the researcher may
have assumed there were already some levels of vicarious impact in participants given the nature of the work they do and particularly combined with the added recent challenge of the COVID-19 pandemic on health care professionals (Liberati et al., 2021). Consequently, the researcher made active efforts to be reflexive in nature through the interview process and subsequent analysis. Ongoing regular reflective supervision and keeping a reflexive journal after each interview proved beneficial in maintaining curiosity and openness.
Figure 1
Qualitative mapping of themes

Role Identity

- Passion & Pride in work
- Expectations of the Role

Team Collaboration

- Developing a Collective Mindset
- Barriers to implementing trauma-informed care

Implementation of Trauma Informed Care

- Cultural Shift in attitudes towards trauma
- Theory into Practice

Service Pressures

- Burn-Out
- Enduring & Persevering

- Disconnect from the wider organisation
- Staff Shortages / Staff Turnover

The Lasting Impact of Covid-19

Experiences of working in Adult Mental Health settings

Acceptance and Implementation of trauma-informed care

“Well, we’ve just got to keep going, I suppose”
Findings

A range of professions were interviewed including: mental health nurses, management, administrative, occupational therapists and mental health support workers, with experience ranging between one year and twenty-plus years of service in the NHS. Individual data concerning participant's job occupation and years in service has been removed from this analysis due to the small sample size and risk of confidentiality being broken. Pseudonyms have also been used to protect the anonymity of participants.

Data analysis produced four Group Experiential themes:

1. Role Identity
2. “Well, we’ve just got to keep going, I suppose”
3. Service Pressures
4. The Implementation of Trauma-Informed Care

Each group experiential theme contained two to four subthemes. Evidence of group experiential themes was seen across all transcripts and subthemes appeared in the majority of transcripts. Smith (2011) recommends that for IPA studies with a sample of eight or more, there should be extracts from at least three participants for each theme and a display of theme prevalence across the dataset. Table 1 displays the group experiential themes and subthemes and which transcripts they were present in. Themes 1-3 are pertinent to the first research question posed in this study which concerns the experiences of mental health workers. Theme 4 explores participant’s perspectives on the implementation and acceptance of trauma-informed care, in relation to the second research question.

However, there is a synergistic affiliation between both research questions and indeed, there is an inter-play between trauma-informed care and subsequent experiences of working in healthcare as identified in the literature. There is an association between subthemes in relation to both questions as a result, which is highlighted in Figure 1. This connectedness between themes has been explored further within Clinical Implications using deliberate, controlled reflection – an ‘advanced’ interpretation of IPA.
Table 1  
*Group Experiential Themes and Subthemes*

<table>
<thead>
<tr>
<th>Group Experiential Themes</th>
<th>Subthemes</th>
<th>Prevalence</th>
<th>Transcript number supporting theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role Identity</td>
<td>1. Passion and Pride in work</td>
<td>1. 6/11</td>
<td>3, 4, 5, 6, 10, 11</td>
</tr>
<tr>
<td></td>
<td>2. Team Collaboration</td>
<td>2. 11/11</td>
<td>1-11</td>
</tr>
<tr>
<td></td>
<td>3. Expectations of the role</td>
<td>3. 8/11</td>
<td>1, 2, 3, 5, 6, 7, 9, 11</td>
</tr>
<tr>
<td>“Well, we’ve just got to keep going, I suppose”</td>
<td>1. Enduring &amp; Persevering</td>
<td>1. 6/11</td>
<td>2, 3, 5, 6, 9, 11</td>
</tr>
<tr>
<td></td>
<td>2. Burn-out</td>
<td>2. 7/11</td>
<td>2, 3, 5, 6, 7, 10, 11</td>
</tr>
<tr>
<td>Service Pressures</td>
<td>1. Staff Shortages / Staff Turnover</td>
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<td>2. The lasting impact of Covid-19</td>
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<td>3. Fear and Anger in the System</td>
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<td>4. Disconnect from the wider organisation</td>
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<td>The Implementation of Trauma-Informed Care</td>
<td>1. Cultural shift in attitudes towards trauma</td>
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<td>2. Theory into Practice</td>
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<td>3. Developing a collective mind-set</td>
<td>3. 8/11</td>
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<td>4. Barriers to implementing Trauma-Informed Care</td>
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**Group Experiential Theme 1: Role Identity**

A protective and reciprocal relationship was identified between participants' professional identity and their individual practice, which extended across professions and linked to their experiences of working in adult mental health settings. A sense of meaning from work was gained, alongside the expectation of being confronted with trauma work. A minimisation of the impact of working with trauma developed as a result of this expectation.

**Pride and Passion in Work**

A passion for work was made apparent through participants’ interviews. Participants spoke of the privilege experienced in working with patients and the development of unique and safe relationships being built. The opportunity to be alongside patients was considered a rewarding aspect of the participant’s experience of working in adult mental health.

I always find it quite a privilege when you hear someone's life story and hear all the things they’ve been through or experienced in their life and you get to be a part of change with them and to work with them and to try and develop these positive relationships that they've not had with somebody, and you can see these measurable changes.

Ashleigh

Ashleigh expression of 'measurable changes' speaks to witnessing and sharing in the patient's treatment journey and this being a fulfilling aspect of the job. She continues to express how being challenged through work furthers her passion.

I guess I enjoy it because it always feels varied and quite different. It challenges you very much on your clinical abilities and I think I enjoy that because it can feel very rewarding and it’s a real privilege to be a part of that. The relationship that I have with people feels really meaningful.

Ashleigh

The mention of meaningful relationships between Ashleigh and her patients felt very powerful. Indeed, the therapeutic relationships built between staff and their patients appeared
to be a sustaining element of the job for many participants and allowed for joy to be experienced at work. Participants became enthusiastic when talking about their work with patients; these relationships appeared to be helpful in overcoming the difficulties faced in work.

I do enjoy working with this patient group certainly…you’re doing something that works for people who have almost been maligned a bit…so it’s trying to help them come to terms with it (their trauma) and make their lives a bit more cope-able, you know, and them realising that it’s not their fault. So, to help normalise their trauma responses.

Steph

I really enjoy being with patients, I really really enjoy that side of that because it’s putting my experiences and the possibility of recovery forward…building relationships is really satisfying for me and I hope for patients as well.

Hannah

Both Steph and Hannah speak the sense of value that they get in their roles working alongside patients and how this contributes to their experience.

Nathalie’s following account of one recent patient interaction really highlights the passion within her role, the importance of the therapeutic relationship and then further speaks to the collaboration found in trauma-informed work between staff and patients.

I had a client the other day who chronically self-harms…and they handed over the last of their sharps so that was…a breakthrough for them to say “well I’m moving on from using this as my coping mechanism and I’m going to try all these other things”…and it means you’ve built trust and rapport with a person to a level where they’re going to fight against [their] instinct and go down a new pathway rather than the old pathway…and there’s no feeling like that and that’s fantastic because it feels like they’ve made a difference in themselves and it’s their work that they’ve done, but they couldn’t have done it alone so it’s nice to feel you’ve played a part in somebody’s journey.

Nathalie
Team Collaboration

Participants reflected on a sense of connection to their fellow team members and a sense of belonging that came with this when considering their experiences in working in adult mental health settings. Using team members for advice and guidance on work was also evident throughout the interviews. This element of teamwork was apparent within participant’s immediate multi-disciplinary teams (MDT). Indeed, participants highlighted the use of the MDT for advice and guidance around patient work.

I think that is one of the nice things to think is ‘yes there are a lot of staff pressures but there are still a couple of people that you have around in your team for that support and advice’…I would find the wider team fairly accessible within the CMHT so you know I’m often in communication with medical staff, CPN’s (community psychiatric nurse’s), I’ve got a positive relationship with them and we all work quite closely and tend to muck in.

Ashleigh

Ashleigh’s use of ‘muck in’ speaks to an alliance amongst the team and a sharing of responsibility between all team members. This is further echoed by Nathalie who recognises that whilst there may be limits within her own professional role, the MDT provides numerous advantages in delivering patient-centred care within teams. By fostering a collaborative approach professionals can work in tandem together for the patient, ensuring that the most suitable care is provided.

It does feel helpful to have different professions because you can see, or sometimes you see a client and you know that my role won’t be sufficient to fulfil their needs so you kind of have to have inter disciplinary work to get the best fit for them.

Nathalie

However, a fear of the MDT disintegrating due to staff turnover was further reflected within this team. This fear of losing the team due to poor retention not only highlights how important the team feels to participants, but further how central the team feels for the safety and protection of each other within adult mental health settings.
We’re really lucky to have relationships with certain people that you work with, and we know how important that is. I think, we (the team) have spoken before about that anxiety of ‘what if one of us leaves, what would happen to the other one?’.

Ashleigh

Ashleigh’s anxieties here seem to reflect a wider sense of unease around service pressure, which is further reflected in the third Group Experiential Theme (Service Pressures).

Expectations of the role

A subtheme that ran through interviews was the expectation of being confronted with trauma work but also there is a risk to self at work. There was a minimisation and a normalisation of this impact on participants and a sense that these experiences were to be expected.

The following accounts from Lucy and Ashleigh show the risk they have faced personally within their roles, but interestingly, there are two different perspectives here.

You put yourself in a bit of a risk, risky situations, where your own safety is compromised but I’ve talked to my colleagues about this. I think we laugh about it as a way of coping. You know, we’re remembering...the feelings we had and how frightened we were so we tend to just laugh about it more, rather than go “oh god I could have been killed there” because it was a bit like that at times. I do whatever I can to help someone but maybe some days at the expense of myself, I know that, I know I do.

Lucy

I guess sometimes it can also be a risk to yourself and that some people can be quite agitated or aggressive and that can also feel quite frightening as well and there’s certain patients where you’re trying your best to do Risk Assessments before you go…I guess it is balancing the risk to you as a professional and your clinical judgement but also giving the person the best opportunity of the service. I like to see that as a fluid process that can change…so there’s certainly occasions where I take things home and it can be quite distressing.

Ashleigh
Lucy’s use of humour as a way of coping with dangerous situations appears to be protective, in that it minimises the risk that was faced. However, Ashleigh has identified the balance of risk and clinical judgement with giving access to services for patients. Indeed, both participants here have continued to provide services to patients despite being at risk and have noted the consequences of this on themselves and the distress that they feel.

Further participants have identified increasing work pressures specifically related to the holding of more complex caseloads and again, the expectation to manage this.

    You know, we’re dealing with people on the waiting list for specific trauma work, so we’re trying to, I suppose - support them and give them some coping strategies to stay afloat, to use us as a point of contact, rather than waiting on services.
    Lucy

    As caseloads get bigger and more complex it adds more and more pressure to people.
    Nigel

Participants seem to be accommodating to the mounting pressure at work as it appears to be becoming a normalised aspect of their job.

    Yeah, well that’s my job, I just have to do it, speak to patients, make sure they’re okay and sort whatever is needing sorting. So, I don’t know if I would ever look at it as if I’m being hard done by but maybe that’s my issue. When I think about it, it’s ‘that’s your job, get it done.’
    Keryn

Despite the toll that the work can take, job responsibilities and expectations seem to be reflective of a broader sense of duty and even a ‘calling’ among participants – that in spite of the risk and pressures faced, there is an undeterred commitment to patients – emphasising the vocational nature of jobs within the NHS.
**Group Experiential Theme 2: “Well, we’ve just got to keep going, I suppose”**.

The quote has captured a theme surrounding the enduring pressure and subsequent persevering nature of participants: “Well, we've just got to keep going, I suppose” in participant’s experiences of working in adult mental health with distress and trauma. Participants spoke of the stress they have faced within their role leading to physical and emotional symptoms of burn-out. These experiences echoed throughout participant accounts in relation to working within adult mental health.

**Enduring & Persevering**

A sense of persevering in challenging circumstances at work and having to endure at the expense of the participant’s own wellbeing was clear. Participants spoke of the need to “show up” for their patients.

> I think it’s just a part of the job of working in mental health that we are just exposed to these things and have to get on with it…I think I just usually still end up working with the patient even if it does affect my mental health, I just continue, I just try and deal with my own things separately. It just feels like I’ve got a job to do and just carry on. Sometimes you just need to show up. Well, we’ve just got to keep going, I suppose.  
> Amy

Similarly to the subtheme *Expectations of the Role*, there appears to be a minimisation of the impact of working with distress and trauma and an expectation to “keep going”, despite the significant repercussions.

> I guess it can be quite emotional, and you can take on peoples feeling, it can probably result in burn-out in staff, yeah it can be quite a challenge. It can be distressing to hear distress in sessions. Yeah it’s not always easy.  
> Ellie
Participants reported on experiencing distress when hearing their patient’s distress and the physical consequences, including poor sleep because of their occupation.

I probably sometimes [have trouble sleeping] yeah…sometimes if someone presents with suicidal ideation…that’s quite anxiety provoking so sometimes you would be thinking about it and it stops you sleeping.

Steph

The progressive and profound secondary impacts on participants were evident in ways that paralleled symptoms of secondary traumatic stress and vicarious trauma. Participants spoke of being unable to separate work and home life and having nightmares related to their work.

You’re always thinking of them [the patients] when you go home and you’re always worried about them. It can really impact on your sleep because you don’t sleep because you’re worried, or you start dreaming about them because they’re the last ones you thought about before going off to bed…I’ve had dreams about patients and the situations they’ve been in. Yeah they can go into nightmares, I’ll dream patients have become really unwell and started fighting and then I’ll be trying to get them in the hospital because when I’ve seen that people are becoming unwell, my brain then links it to the worst it can get and me being attacked. Yeah trouble sleeping happens regularly, if I’m stressed I don’t normally sleep very well and I’ll only sleep a bit but yeah it happens quite a lot.

Amy

This is coupled by accounts of strong memories, flashbacks and vicarious trauma symptoms within work. Katie here has clearly expressed the trauma she experienced by completing trauma work within her own home during the pandemic.

I haven’t been able to escape other people’s experiences. It was vicarious trauma that I was experiencing during this time and having these dual roles, there was no separation from home and work.

Katie
Katie’s use of dual roles refers to her professional identity and home-life identity that, in her experience, collided when working from home due to Covid-19 restrictions. Katie's account speaks to a blurring of boundaries between home and work which made the undertaking of trauma work even more difficult, as Katie felt she could not 'escape' from the work.

Amy has also recounted the lasting impact of experiencing violence within the workplace. Here, she accounts how certain associated places may trigger flashbacks but also the ‘random’ timing of these flashbacks, suggesting an intractable impact of the violent attack.

We used to go to [a place] with them (the patient) and every time I pass there, I’m like ‘oh they might be there’ and that gives me flashbacks and thoughts about it. It kind of comes back randomly…and it’s the association of what happened and what could happen again.

Amy

Amy further discusses a shifting world view and a state of anxiety still present from the attack. There is a secondary impact on daily work functioning as a result.

Everything is a bit more present in this job right now…Sometimes I get anxious when I’m going to see a patient if I know they are unwell and then I’m scared that they can see that in my body and then they’ll know I’m scared and it might you know, impact the work we’re doing and them picking it up that I’m scared. Sometimes I think or some patients would do something to me if I was scared.

Amy

Far-reaching consequences have been identified by participants who have continued on in their roles, despite the impact on their own wellbeing.

*Burn-out*

Many participants depicted a sense of burn-out that they experienced within their roles, describing experiences of energy depletion and exhaustion from work and facing increasing challenges at work, despite the expectation to “keep going”. There is an implication of moral injury beginning to develop within participants.
Burn-out, yeah, it’s come close… it was quite a difficult thing because at the same time you want to support people and you don’t want to leave your job because of stress.

Amy

Yeah I have taken work home with me, if you’re spending all day with someone…you’re not getting a break, because you can’t walk away from them, and I was exhausted actually. Physically and mentally exhausted.

Poppy

A sense has also developed that things are increasingly more challenging recently, compared to previous working conditions.

I think both myself and my colleagues are feeling very much closer to breaking point than we have ever been at. I think I’ve seen more burn-out in staff in the last year than ever.

Nigel

Participants also expressed that they were carrying a large responsibility for other people that they could not share due to the confidential nature of their work. This contributed to a developing sense of isolation amongst participants.

I think one of the difficulties is you can’t really talk about it because everything is confidential…I mean I might go home and say it’s been a really difficult day, but you can’t reveal, any in-depth information. It feels like you’re carrying a huge responsibility of people’s stories.

Hannah

I would do my best to not talk about my work with friends or anything like that, or family, because I don’t really have family members that are in mental health as a profession so it can feel quite unusual.

Ashleigh
As a result of not being able to share information, participants appear to have internalised their working experiences, with little opportunity to express and attend to their own needs, contributing to the risk of burn-out.

**Group Experiential Theme 3: Service Pressures**

The impact of working within NHS systems, the lasting impact of Covid-19 and the current social context were apparent during the interviews and part of participants working experiences. These wider factors profoundly impacted participants’ direct patient contact and their relationship with their employing NHS Health Board.

**Staff Shortages**

Systemic difficulties that transposed professional groups were evident in participant’s accounts about their working experiences, with high staff shortages and rapid staff turnover noted by participants. There was a sense that participants felt like a "cog in the wheel" within the organisation and that they were not valued within their roles. The impact of staff shortages was also apparent on participants' wellbeing and contributed to the increasing work pressure.

> Workload wise, staff wise, [we] can’t get any staff…but still I think there’s just a sense that you’re a bit of a cog in the wheel.

*Steph*

> We’ve had a high staff turnover…so I guess in those situations I have been working longer, later and not taking time for myself as well.

*Ashleigh*

Hannah goes on to identify that services pressures increase her anxieties in comparison to working with distressed and traumatised patients, implying a systemic impact on her own wellbeing.

> With service pressures and high turnovers of staff, I think a lot of the things that make me anxious or build upon pressures are not necessarily to do with patient contact.
Hannah

Again, Ellie’s account below indicates that the staffing difficulties faced are contributing to a more challenging job role, one that perhaps wasn’t apparent when staffing levels were adequate.

It’s also the pressure of the environment, so the staffing levels. I think if we had enough staff it would be so much easier to manage and be able to do your job much easier.

Ellie

_The lasting impact of Covid-19_

Accounts from participants have emphasised the lasting impact of the Covid-19 pandemic on both staff wellbeing and direct patient work.

This has included vague boundaries between home life and work, with participants often taking work home. These blurred boundaries were first evidenced in subtheme _Enduring & Persevering_, which noted the secondary impact of completing trauma-work within the home. However, Nigel goes on to talk about the lasting impact of the switch to working from home, with staff members' work-life balance becoming skewed during the pandemic and having little separation still.

There was less work-life separation for sure…people are struggling to leave their work at work, giving them phones and laptops and things is great from an ability to do your job point of view, but it also makes your job much more mobile and gives access when you shouldn’t be doing it.

Nigel

Whilst services are still recovering from the enforced Covid-19 restrictions, there appears to be long-standing implications on healthcare staff as a result.

I think everybody seems to be taking notes home, doing notes at night, working at home. Covid has had an impact on that. Now that you’ve got your laptops at
home…its harder to switch off and you might just crack on with it at home rather than waiting to the next day…that instant access to work through laptops keeps us going when we shouldn’t be. Suddenly it’s a couple of hours later if you’re at home working and then you’re responding to emails that come in and it’s the next thing, the next thing comes, and you keep working.

Ellie

The impact of the pandemic on direct clinical work has also been experienced by participants:

I think, from having to wear masks all the time, not being able to see people’s expressions, the physical distant is hard for everybody when you’re trying to do [your] work, it makes your task very difficult in trying to be sanitised and making someone feel comfortable in going out and about…so that was difficult, but we managed.

Nathalie

This has been furthered by an increasing number of people needing support services when their social networks were cut off through Covid-19 measures and law introduced by the Government.

I’m not sure if it’s a mixture of the pandemic that’s made people, I suppose its triggered them even more, you know in feeling less connected and it’s bought them to us a wee bit more. I suppose in years gone by…people used their families and social networks and communities to support each other a bit more than now, it’s a very isolated in the way we treat people.

Keryn

Seemingly, the mental health system here is facing challenges due to a surge in demand for services, coupled with persistently high staff turnover. This has resulted in mounting pressure being felt by participants.

_Fear and Anger in the System_
Throughout interviews, participants expressed a fear of the NHS system coming under even more pressure and anger at the evolving crisis within the NHS, which felt preventable to many. This was then compounded with a sense of moral distress about these institutional and resource constraints, which created a sense of unease about the quality of patient care and a fear of letting patients down. These experiences noted by participants were directly related to the service they were working within.

Amy’s account below shows the level of pressure that is currently affecting her and her patients by proxy and the emotions that are attached to this. Amy also highlights the increasing risk she is facing in her job and the lack of support for this.

More recently it’s been really bad because we’ve had hardly any staff…so support workers have had more pressure on them and are taking more responsibility than they should have. So, I think more recently it’s been worse because you know, you’re not that level of trained to be taking the risks but you’ve had to take risks for patients…it’s just expected [to take risks] every time I tried to raise it, I just got a “you need to just deal with it”. It made me really upset and angry, more because I feel like the patient isn’t getting the right care either.

Amy

Ashleigh further reflected on the service pressures impacting her case work and her ability to take time off due to prioritising her work and the service.

Naturally as people who care about people on our caseloads it does (service pressures) have an impact on you and like I say at the moment its quite difficult with staffing [levels]…I think sometimes when it comes to taking time off or annual leave I have to have quite a significant, like quite a lot of notice, and I wish that could be more flexible but I guess at the moment it can’t really be because of service demands.

Ashleigh

The dichotomy between the pride to work in the NHS coupled with the increasing worry of the system collapsing was also evident in accounts, again leading to moral distress in participants who reflected that whilst they want to help, they feel they cannot.
I’m proud to wear my uniform, I think the NHS is one of the best things we have in the UK, and I hope it doesn’t get dismantled anytime soon so I feel connected in that sense, I’m proud to work for the NHS but I am worried about it.
Nathalie

I think the struggle is…you know it’s a limited service with a capacity, and it’s not that staff don’t want to help it’s that they can’t.
Keryn

Nigel’s account below further reflects the symbiotic relationship between service pressures and its subsequent impact on patients. Patients have reflected a sense of being let down, with Nigel empathising and understanding, however also belonging to, and holding a position within that system where it is increasingly more challenging to meet patient needs.

I think the pressures that the NHS are under is more difficult to manage when the patient group are not as able to take into account the pressure that we are under. I think there are some patients that just struggle to deal with any kind of distress and if we are under a lot of pressure and our timings aren’t ideal and we have waiting lists and so on it makes it even harder to explain that to people...I can understand them not being sympathetic to us when they see we are not getting to them fast enough and not doing enough to help. The real systemic pressure that we are under. It feels increasing more difficult.
Nigel

**Disconnect from the wider organisation**

All participants noted a disconnect from the wider organisation, expressing a divide between their roles within their teams and the NHS health board at large. This has indicated a lack of a culture of care within the organisation which is directly opposed to working in a trauma-informed way.

Accounts note that the there is a divide between senior leadership – those who make policy decisions – and front-line staff who have to implement them.
I think, the higher up you go within the organisation, the more disconnected you feel. We just don’t see these people, it becomes a policy that someone has written, a dictation of ‘do not do this’, well I don’t know who these people are. Its fed down from the top.

Hannah

This is further echoed below, where a sense of frustration is building from the expectation to implement decisions that front-line staff have had no say in. Staff members appear to feel they are being denied a voice in decision-making.

It feels decisions can be made and they filter down to us and we implement it, but they don’t have a clue as to what and how we work. I try not to think too much about the higher up, just a couple of layers above and then that’s me…I don’t feel any care from the higher up people.

Poppy

Again, the sense of dismissal by the wider organisation is apparent in participant’s accounts of their experiences and being forgotten about within the system.

I don’t know, I think over time just a sense that you’re not listened to, that platitudes are mouthed a bit, without a dedication to change things. I think that’s partly the nature of the organisation via the NHS, you know a massive organisation and it has massive pressures on it.

Steph

Other accounts have spoken about the lack of recognition from the wider organisation about the work that is being done within their teams.

I don’t think the wider organisation recognise what we do and what we’re exposed too and the intensity of the work isn’t recognised…There’s perhaps a disconnect between what we do and the bigger organisation around it…something is going wrong somewhere that I feel that often our service isn’t recognised or valued.

Katie
Feeling disconnected from the wider organisation alongside the increasing service pressures experienced by participants has reflected a sense of being unappreciated and under-valued in the organisation.

**Group Experiential Theme 4: The Implementation of Trauma-Informed Care**

The second research question in this study sought to explore whether trauma-informed care had been accepted as an approach by participants working in adult mental health settings and implemented into their service following the National Trauma Training that they attended. This theme in particular has provided participant’s perspectives on trauma-informed care. Participants described the cultural shift in attitudes towards Trauma-Informed Care that they had witnessed through their years working in the NHS. Participants spoke of the impact of the training they attended on their work practice whilst highlighting barriers to implementing Trauma-Informed Care across collective systems and settings.

**Cultural Shift in attitudes towards trauma**

A change in attitudes towards trauma presentations and Trauma-Informed Care was noted by many participants, who highlighted that they felt a cultural shift in attitudes towards trauma in comparison to when they first began working in the NHS. There was an indication that trauma-informed approaches were generally accepted by participants.

I mean its night and day. You know, I’ve always said that how we treated people, how we spoke to people [wasn’t good], obviously it was a long time ago but you never asked people about what happened to you and about your childhood as well, I think is an automatic thing now, we ask about people’s early experiences and I don’t think people did…You know, there is a shift…I think it has certainly moved on a hell of a lot.

Lucy

Lucy’s account of the changes she has noticed in Trauma-Informed Care across the NHS reflects a more formulation model of working with patients, which again is mirrored by Nigel.
We have gradually got better at understanding why people are presenting in distress and looking more at the reasons for that rather than just looking to treat the distress. And I guess more and more treatment options have come online in terms of therapy and access to these things rather than just medication.

Nigel

The recognition of trauma in public domains has also been highlighted by Hannah, who spoke about the perception of trauma within the community, how this has changed and that there is more acceptance about trauma now, with it being less stigmatised.

I think now that we are talking about trauma a lot more… I think that whole notion of trauma is out there within the public, in the public eye now, so I think people are much happier talking about it...I think at the beginning of my career, people didn’t really realise this particular thing that they experienced might have been something that has affected them more than they think. It is something that’s part and parcel within the team, we do talk about it, we do recognise it. I wouldn’t say it’s a hot topic, but it is there.

Hannah

Hannah has highlighted both the public perception and this shift within the organisation too, reflecting that the two are mirrored. However, interestingly, Hannah’s use of “hot topic” indicates that Trauma-Informed Care may not be the priority within the service, which links into a barrier of implementing Trauma-Informed Care. So whilst there may be an acceptance of the approach, it is more difficult to then implement this.

Theory into Practice

The majority of participants reported how they had used resources and information presented in the training session, in their subsequent work with their patients.

The window of tolerance, I mean that is something that I hadn’t really come across in that way before and I use that all the time now. I guess a lot of the folks we support, they feel a lot of things, but they can’t identify what emotion they are having so to
have the Window of Tolerance to say “oh it’s the green zone, or the red zone or the blue zone” - it’s really easy tool for me to use.

Nathalie

The use of practical resources for Nathalie has been beneficial in helping her patients to further understand and begin to identify their emotions. Indeed, the use of the Window of Tolerance and having some training around how to implement this into patient work appears valuable. Additionally, this was echoed by Ellie and Poppy.

I think it's worthwhile, so having that training and then pointing you in the direction of resources that you can look at further is quite good…I guess that some of the diagrams that we got at that training are quite good to use in practice to try and explain how people may be feeling. The window of tolerance was quite a nice one to show and the trauma tree. I really liked that and how it shows what other areas of your life can be affected.

Ellie

The bit about the early years really, you know, took my interest. That was like “cor” I didn’t realise, I knew there would be links but I didn’t realise it would be so clear as to how young trauma can start. I think that’s what I really learnt. Trauma being across the lifespan, yeah, that was something that took me by surprise. In my role now I have more of an awareness that there could be things that go right back.

Poppy

The use of new terminology also proved useful for Amy in the training, who commented on how she had acquired new language around trauma and how helpful this was.

Before I just thought trauma was just trauma and a big, massive thing, but learning about the small ones, ‘little t’ and the bigger one, ‘big T’ has been really helpful.

Amy

Amy's account here suggests the helpfulness in the nuances of trauma work and differentiating between types of traumas. Indeed, integrating theory into practice through the
trauma training attended allows for further skills and competencies to develop, which Amy highlights.

It felt really beneficial to working in a CMHT as we have a lot of patients who have been through trauma. I think the nurses have more of an idea of what to do with traumatised patients and that’s to do with their training…but we don’t really get that or know what to do with trauma, so it was really good to hear.

Amy

Amy’s reflection here suggests a lack of certainty in her skill set initially and a difference from other members of the team who may have more knowledge. Indeed, the identification of having no previous training but being expected to work with patients who have experienced trauma indicates a disparity within the team before the training.

Developing a Collective mind-set.

There was consensus amongst participants that by involving all staff groups in the training, i.e. clinical and non-clinical staff, everyone was able to have at least some knowledge of trauma and it was accepted amongst all professions. As a result, there is now more equilibrium amongst the team and a collective understanding of Trauma-Informed Care.

There was quite a mixture of people there and I think it's good for everybody to have that awareness, from admin staff who are taking a lot of phone calls to support workers and so forth. A lot of what I took from that was about your approach and in terms of how it is everybody's responsibility. Regardless of our title, or our role, it's about giving people choice and being open and honest.

Ashleigh

Ashleigh's identification of trauma awareness as “everybody's responsibility” echoes the Scottish Government's position that trauma is ‘everybody's business’ (NES, 2019), regardless of role or seniority and this is helpful in the implementation of the approach. Indeed, there is a recognition and identification of potential trauma symptomology that Ellie has identified.
I guess from everybody who answers the phones, to working directly with people, [the training] gives people an understanding about some of the behaviours that you might see.
Ellie

This recognition helps to support patients in an effective and timely manner, whilst remaining sensitive to patient’s trauma needs. There is also a shared sense of understanding that has developed between team members.

It’s nice everybody is doing the same training and then everybody knows what each other’s done and what each other knows…getting onto the same page as each other’s is a useful thing to do.
Nigel

Nigel’s identification of an alignment of thought within teams is integral to the integration of Trauma-Informed Care within an organisation.

**Barriers to implementing Trauma-Informed Care**

Barriers to implementing Trauma-Informed Care were identified within the interviews, indicating difficulties in implementing the approach. The time gap between training and interviews initially highlighted that the training principles may be difficult to sustain when not overtly considered.

The training seems a bit of a while ago in lots of ways as well.
Lucy

So, I feel like the training was a wee while ago so apologies if I haven’t been able to reflect on what was covered in the training...I’m struggling to remember the details.
Ellie

Ah ha, I’m trying to remember but it seems like such a long time ago now.
Steph
Given these comments, there is an indication that the nature of a one-off training is not enough to implement trauma-informed approaches and that Trauma-Informed Care may not be embedded within the organisation as a result. Whole system challenges to Trauma-Informed Care have been further identified by Ashleigh, who notes challenges with automated systems, which are designed to keep services running efficiently but are likely to be at odds with Trauma-Informed Care.

So, with our appointment letters, we don’t have much control over how they are perceived. You hope someone is not offended but it’s very difficult for us to then change or chase because there’s massive waiting lists and it’s not within policy so it makes you think a little about restrictions that they have. This can feel like a barrier to implementing Trauma-Informed Care. I guess the one I can think of, is the DNA (did not attend policy), so if someone doesn’t attend their first appointment, we automatically send an opt-in and I guess we are kind of making the decision of where the appointment takes place, so I guess that’s us taking a wee bit more control.

Ashleigh

This subtheme of Barriers to implementing Trauma-Informed Care seems to highlight that whilst clinicians as individuals may be trauma-informed and are able to recognise the need for Trauma-Informed Care, there are whole systems difficulties which lead to challenges in implementing and embedding the model effectively. The barriers to Trauma-Informed Care are also subtly reflected across Group Experiential Theme 3 (Service Pressures), whereby increasing systemic pressures and its subsequent impact is antithetical to the principles of Trauma-Informed Care. This can be seen in Figure 2.

This is despite the ability of Trauma-Informed Care to protect against the impact of systemic pressures and create a resilient workforce as can be seen in Figure 3. Both of these figures will be considered further within the ‘Clinical Implications’ of the Discussion using ‘deliberate controlled reflection’ (Smith et al., 2022).
Figure 2

An illustration representing the link between themes, the development of moral distress and the barrier to implementing Trauma-Informed Care.

Figure 3

An illustration of the ‘exits’ from the development of burn-out and moral distress using Trauma-Informed Care principles.
Discussion

The aims of this current study were twofold: to explore the impact of working in adult mental health settings where trauma and distress is present and to explore the impact of the national trauma training programme on these staff members. As such, two questions were posed: what are the experiences of mental health workers working in adult mental health setting? and, has trauma-informed care been accepted and implemented in adult mental health settings? This study highlights the demanding and rewarding nature of the working in adult mental health settings and the intricacies of implementing Trauma-Informed Care into organisations. By drawing upon the principles of IPA, four group experiential themes were identified in the data: 1. ‘Role Identity’, 2. “Well we’ve just got to keep going, I suppose”, 3. ‘Service Pressures’ and 4. ‘The Implementation of Trauma-Informed Care’, all of which contained a number of subthemes. The first three group experiential themes presented within the findings contribute participant’s perspectives on working within adult mental health settings in relation to the first research question. Subsequently, participant’s views presented in group experiential theme four relate to the second question as to whether trauma-informed care has been accepted and implemented into adult mental health settings.

The author was actively engaged within the study through having a dual role of both researcher and health professional, sharing a space of enquiry with the participant experience. Whilst holding this reflexive position, the interpretation is guided by the participants experiences of working in adult mental health and the acceptance and implementation of trauma-informed care within these settings and is therefore data driven. Thus, the following discussion considering the interpretations of the themes is based on engaging in the double hermeneutic cycle whilst being aware of the contextual milieu of the researcher.

The findings suggest that there is a passion and a commitment amongst NHS staff members to working within adult mental health and that there are benefits to trauma-informed approaches within these settings. However, whilst the increasing attention given to trauma is encouraging for staff, this is currently overshadowed by service demands and systemic pressures. Indeed, these demands and pressures threaten staff wellbeing and passion. This is at odds with Trauma-Informed Care, making the approach difficult to embed within services.
Evaluation of findings

Considering Group Experiential Theme 1 (Role Identity), in relation to participants experiences of working in adult mental health settings, participants in the study displayed a harmonious passion (Vallerand et al., 2003) which is derived from the internalisation of work in one's identity. Work appears to occupy a significant but not excessive space in participants' life (Subtheme: Pride and Passion). However, this is a difficult space to occupy for participants due to the increasing systemic pressure they are under. Whilst participants expressed that a passion for the role was sustaining, Schabram and Maitlis (2017) have reported that people in job roles which involve a 'calling', i.e. a role that fits with personal values, are more likely to end up burnt-out and leaving the role. The authors identified that when personal values and expectations clash with the realities of the work settings, an apathy for work develops, leading to higher rates of burn-out. Whilst Schabram and Maitlis' findings were from a different setting, 'calling' professions are found in abundance within healthcare settings. However, Yoder (2010) notes that pleasure in one's work may prevent compassion fatigue and burn-out amongst health care professionals. Indeed, the current study demonstrated a collective vocation to provide care and a common sense of purpose that cut across professions and hierarchies. This has also been demonstrated in other healthcare research that noted a sense of shared professional commitment in NHS workers to patients (Montgomery et al., 2021; Baldwin & George, 2021).

A sense of comradery became evident in the present study (Subtheme: Team Collaboration). Participants spoke of the importance of teamwork and the presence of a professional bond, highlighting their experiences of working within adult mental health settings. This professional bond echoes studies exploring the connection in healthcare staff throughout the Covid-19 pandemic as similar to that of members of the military, where resilience amongst troops and a shared sense of togetherness is developed (Baldwin & George, 2021). This is particularly interesting as participants further highlighted feelings of isolation in their personal lives. They could not share information about their work with their friends and family due to confidentiality processes. Here, the sense of teamwork felt containing to participants and health professionals working together across professional boundaries is a welcomed move.
Despite evidence of the positive benefits of participants' roles, participants highlighted a sense of being expected to be confronted with risk at work as part of their experience (Subtheme: Expectations of the Role). Sadly, this reflects the wider NHS structure, with 14.3% of NHS workers experiencing at least one act of physical violence in 2021, equating to 200 violent attacks a day (NHS Staff Survey, 2021). Risk at work no longer appears to be an exception and is part of participants experiences of working in adult mental health settings. Edward et al., (2016) report that mental health workers are three times more likely to be assaulted by a patient than other healthcare professional groups, increasing the risk of developing work-related trauma. This may also be an underestimate of the actual number due to an acceptance that violent incidents are an inevitable part of the job (Anderson & West, 2011). Interestingly, the current study highlighted the balance between risk to oneself and providing patients with an opportunity to benefit from services on offer. This conflict highlights the nuances of working within adult mental health and a sense of duty of care versus risk to self.

Given this sense of offering services despite the increasing risk faced, a direct quote captured the enduring and persevering sense that NHS staff members experience in their roles. Indeed, the quote “Well, we've just got to keep going, I suppose” chosen for the second theme speaks to the determination of staff in the NHS but reflects the growing risk of burn-out on staff. In a narrative review, Johnson et al., (2015) reported that whilst rising levels of burn-out and poor wellbeing in healthcare staff are an international concern, staff in mental healthcare report poorer wellbeing than in other healthcare sectors. This is associated with higher absenteeism and turnover, which in turn affects poorer quality of patient care. There is an ‘emotional labour’ attached to mental health services due to the nature of the work and, in part, the underfunding of services, which creates additional pressures (Seago et al., 2001). The current findings support the concept of 'emotional labour' with participants expressing the need to endure through working challenges and the physical toll of this, including impacts on sleep (Subtheme: Enduring and Persevering). Poor sleep is associated with burn-out and work-related trauma (Wang et al., 2020; Vancamfort & Mugisha, 2022; Salloum et al., 2021). Enduring and persevering through work appears to be linked to burn-out development. Feelings of burn-out can lead to turnover within the workforce and a negative feedback loop, intensifying burn-out feelings among remaining employees due to the increasing service pressures resulting from understaffing (Menschner & Maul, 2016).
The study's findings further reflected the contemporary social context, as evidenced by the third theme of ‘Service Pressures’, evidencing participant’s organisational experiences of working in adult mental health care. The Care Quality Commission (2021) reported on unprecedented pressures on CMHTs due to the pandemic, leading to staff shortages and teams still being in the ‘recovery’ stages. Indeed, the impact of covid-19 and staff shortages was noted in the findings (Subtheme: The lasting impacting of Covid-19). However, a wider sense of the pressures outwith covid-19 has also been evidenced, including a developing fear and anger in the system, and feeling disconnected from the wider organisation, which were both subthemes in group experiential theme 3. NHS staff routinely face morally challenging situations, but our findings suggest that participants continually go above and beyond their job roles and qualifications to provide services to patients. A developing sense of letting patients down and anger towards the system they belong to then appears to follow for participants. The clash of personal and organisational values is inferred, leading to the potential development of moral distress among participants, as also reported in research by Hegarty et al., (2022). NHS workers feel betrayed by the government and NHS leaders and cannot provide the duty of care to patients due to organisational pressures, leading to adverse impacts on staff members’ mental health (Hegarty et al., 2022). Whilst our study did not find themes relating to betrayal, the interconnectedness of other themes, such as burn-out, enduring and persevering, and expectations of the role, are not surprising. Reconciling these incompatible value systems appears to come at a high personal cost, and the findings contribute to the emerging evidence on moral distress and burn-out (Liberati et al., 2021; Hegarty et al., 2022).

Raven (2023) observes that the NHS can no longer rely on the self-sacrifice of its staff, a sentiment echoed in the current findings where participants expressed complex relationships with their employing health board (Subtheme: Disconnect from the wider organisation). The tension between healthcare staff and their employing organisations has been highlighted in previous research (Vera San Juan et al., 2021) and our study indicates that participants feel undervalued and overlooked by the wider organisation although their roles are integral to patient care and again, this highlights a moral conflict being experienced by participants. The findings point towards a lack of a culture of care within the organisation, which directly opposes Trauma-Informed Care principles which NHS Education for Scotland and the Scottish Government are implementing. Indeed, a wealth of evidence shows that organisational performance critically depends on the health and wellbeing of the staff
employed across industry (e.g. van de Vordee et al., 2011; Krekel et al., 2019; Huettermann & Bruch, 2019; Yadav et al., 2022). Enthusiasm for trauma-informed approaches has grown significantly (Purtle, 2020) and considering the second research question in this study, the findings from Group Experiential Theme 4 (The Implementation of Trauma-Informed Care), indicates that trauma-informed approaches are generally accepted by participants, however more difficult to implement into systems.

The study evidenced that there is a cultural shift in attitudes towards trauma within the NHS, which is encouraging for the future implementation of Trauma-Informed Care (Subtheme: Cultural Shift in Attitudes Towards Trauma) and suggests the approach is accepted. This shift is noticeably progressive and aimed at creating environments that foster recovery and prevent the traumatisation of patients. Findings suggest that participants generally view the concept of Trauma-Informed Care positively, emphasising the benefits of using formulation-based approaches to treatment and understanding distress rather than solely treating the resulting symptoms.

Training in Trauma-Informed Care is the only unanimous recommendation for its implementation in organisations (Branson et al., 2017). The training offered here was well received by participants (Subtheme: Theory into Practice), who noted the practical usefulness, suggesting the approach is feasible for participants. Similar results were reported by Palfrey et al., (2019), who found that their workshop increased mental health staff’s confidence, awareness, and attitudes towards treating children exposed to trauma in child and adolescent services. Training non-clinical staff is just as critical for implementing trauma-informed practices, given the high rates of work-related stress and harassment experienced by this group in the NHS (NHS Staff Survey Results, 2019), suggesting they are not immune to systemic pressures or the effects of burn-out. The inclusion of this group in our study has provided a novel take (Subtheme: Developing a Collective Mindset). Their inclusion in our study is in line with the Scottish Government's "trauma is everybody's business" agenda (NES, 2021), as non-clinical staff play a crucial role in patient engagement. Menschner and Maul (2016) noted that non-clinical staff often interact with patients more frequently than clinical staff and, therefore, can contribute significantly to Trauma-Informed Care. Our study highlights the benefits of developing a collective mind-set about trauma and fostering collaboration among different professions, another step towards implementing Trauma-Informed Care.
Although the training was viewed favourably, it is clear that a one-off session is not enough to fully integrate Trauma-Informed Care into the organisation (Subtheme: Barriers to Implementing Trauma-Informed Care) and therefore its implementation remains a challenge. The time lag between the training and the interviews highlights the challenge of implementing the approach, as participants struggled to remember the information. This forgetting curve (Ebbinghaus, 1985; Murre & Dros, 2015) suggests that without continuous reinforcement, Trauma-Informed Care may not be applied across different levels and therefore not implemented into the adult mental health setting. Additionally, the intense workload and pressure of working in the NHS may create resistance towards Trauma-Informed Care, with policies prioritising decreasing waiting times over patient choice (Carey, 2009). Indeed, participants expressed frustration about these policies, recognising that they have roles to fulfil but feeling disempowered within the system.

According to Bayerle et al., (2022), there appears to be a shift in healthcare systems towards a task-focused approach to care rather than prioritising patient choice due to the public health crisis caused by the pandemic. However, adopting a Trauma-Informed Care approach could create safe and supportive environments for both patients and healthcare staff. Nevertheless, this would require a significant change in the way care is delivered and staff are supported, which our study suggests is not currently happening. To successfully implement Trauma-Informed Care in the NHS, the challenges identified within this study and the wider literature must be addressed through a concerted effort. As such, there are clinical implications to the present findings.

Clinical Implications

Given that IPA focuses on personal accounts, caution must be taken in over-generalising the results. However, Polit and Beck (2010) state that for those well acquainted with the topic, there is potential for results to be transferred into appropriate settings. Indeed, the researcher’s reflexive position and interest in trauma-informed care within the NHS and how it is implemented to both protect staff members and patients has informed the following interpretations. Smith et al., (2022) outline, there is an 'advanced' interpretation that goes beyond the participant's sense-making and conceptualisations and connects with an array of theoretical positions. As such, there are clinical implications when considering the above
findings using this advanced interpretation, known as 'deliberate controlled reflection' (Smith et al., 2022).

Upon analysing the interviews, it was apparent that the barriers to implementing Trauma-Informed Care were also subtly present across the other Group Experiential Themes. Participants reflected upon the difficulties they encountered while working in a stressful and pressurised adult mental health system that conflicts with Trauma-Informed Care. The increasing systemic pressures and the need to persevere in spite of these pressures are antithetical to Trauma-Informed Care. It appeared that participants took such pride in their role, which led to them being more willing to endure and persevere through the work challenges; however, as these challenges continued to increase, this resulted in burn-out. Alongside this, there is an implication of moral distress beginning to develop in participants due to the clash between their pride and passion – their personal values that led them to the role – and the increasing service pressures faced. Figure 2 illustrates this cycle. Dean et al., (2020) report that moral injury and distress in healthcare staff is the 'invisible endemic' and that acknowledgement and validation from leadership within organisations can help to prevent its development.

It is, therefore, crucial to acknowledge, recognise and amplify the pride and passion NHS staff members feel in their work to help buffer against the development of burn-out and potential moral distress in their roles.

The capacity for Trauma-Informed Care is bound within the environment from which it is provided, and as such, the culture of the organisation is incredibly important. Considering the hypothesised development of burn-out and moral distress illustrated in Figure 2 based on the themes identified in this study, when trauma-informed principles are embedded within the organisation, they may act as a buffer.

Figure 3 illustrates the potential ways to 'exit' the cycle of burn-out and moral distress, which have been explained as follows. It has been noted that community mental health workers can experience burn-out whilst simultaneously having high job satisfaction (Lasalvia et al., 2009; Onyett, 2011). By amplifying participants' pride and passion about their roles, they may feel more valued and connected to the organisation. This may lead to an increase in their harmonious pride and the sustainability of their passion (Landay et al., 2022) - where work
does not occupy unhealthy space in participants' life, and they can recognise its impact and disconnect appropriately when needed (Benitez et al., 2023) - serving as an ‘exit’ from the development of burn-out.

However, clinicians cannot sustain their wellbeing through individual, internalised changes alone, and broader system changes are necessary (Killian, 2008). By embedding and integrating knowledge about trauma into policies, procedures, language, culture and practice (SAMSHA, 2014), the sense of enduring and persevering through work pressures may decrease, creating another ‘exit’ from the cycle as organisations are better equipped to respond to pressures and prioritise their staff. Trauma-Informed Care principles can be used at an organisational level to better respond to systemic pressures, such as reducing work overload, recognising staff efforts with genuine praise and involving management with front-line staff (Nelson, 2004). This is associated with increased job satisfaction and staff retention (Scanlan et al., 2013), thereby reducing the sense of enduring and lessening the risk of burn-out.

Moreover, Trauma-Informed Care highlights the importance of value-congruence between staff and their organisations, which is positively associated with staff wellbeing and lower burn-out (Sagiv & Schwartz, 2000), providing yet another ‘exit’ from the cycle. Additionally, according to Evans (2014), "organisational survival anxiety" can create resentment towards the organisation among employees, which can clash with their personal values and lead to the development of moral distress, as implied within the findings of this study. Thus, another ‘exit’ is represented if moral distress develops by using Trauma-Informed Care principles to better support staff with their social and emotional wellbeing by providing further training and increasing resources.

Indeed, embedding a Trauma-Informed Care framework across an organisation can protect the wellbeing of staff by increasing the overall resilience of the workforce. Implementing trauma-informed systems has been found to improve staff wellness and lessen burn-out in other settings (Salloum et al., 2019; Hales et al., 2017). However, research on the benefits of the implementation of Trauma-Informed Care for workers remains limited. Whilst IPA does not typically result in the use of models, considering the literature and the current findings, the illustrated figures are not intended to be generalised beyond the current participant group or provide new theories. However, they are intended to demonstrate the development of burn-out and moral distress in participants and how embedding Trauma-Informed Care into NHS
settings may prevent this and provide 'exits' at each stage by connecting with other relevant research findings. Consequently, further research should focus on the mediating role of Trauma-Informed Care in burn-out and moral distress of healthcare workers to add to this current understanding.

This study has further evidenced that mental health services are not immune to the evolving NHS crisis that is being reported upon. In addition to the documented patient implications (e.g. Cooksley et al., 2022; Boyle, 2023), the strain on healthcare services is greatly impacting the wellbeing of staff members. The current situation highlights the increased support needed for NHS staff. Chronic NHS workforce shortages and the subsequent impact have been evidenced in this study. Creating a sustainable working environment, upon which more people are trained to provide better care and who are looked after, is key to retention. Addressing these shortages will require sustained investment in the NHS and a focus on improving workforce capacity and providing greater resources to manage workloads. This will not only improve staff wellbeing but also ensure the delivery of quality of care to patients. Therefore, continuing with the National Trauma Training Programme of all staff must remain a priority at both a local and national level. The collective mind-set around Trauma-Informed Care is an important finding when considering the training needs of other staff groups in different services to allow for the culture to embed across all levels of the organisation and then be sustained.

**Limitations and future research**

Firstly, participants in this study were self-selecting, and all worked within one geographical location. Therefore, the extent of the experiences of working within AMH settings and the implementation of Trauma-Informed Care may not have been adequately captured. Additionally, descriptive data was not presented for this study due to the small sample size and the risk of confidentiality being broken. Thus, it is difficult to characterise the data or cross-compare between experiences based on any characteristic data. It is difficult to generalise these findings beyond the local context.

Despite the benefits of providing in-depth insights into the lived experience of participants, IPA is subjective in nature. This can make it a challenge to generalise these findings and further corroborate the research in different settings. Additionally, there is a risk of researcher
bias throughout the data, as highlighted in subsection *Reflexivity and Transparency*. The findings are just one possible interpretation of data represented in a specific context that could further limit generalisability (Hutchinson, 1993). Respondent validation would have enhanced this study (Elliott & Lazenbatt, 2005), and whilst using a reflective journal and supervision was to protect against any bias, it must be noted as a possibility.

A sample size of 11 may be considered ‘large’ for an IPA study, meaning there may be limitations to the idiographic approach and that analysis for each case may not be as detailed (Smith et al., 2009). However, this study recruited across two training days and wanted to accurately capture the experiences of adult mental health workers whilst retaining ‘idiographic focus’ (Smith et al., 2009). Ellis (2016) notes that a sample size under 20 is appropriate for IPA and the sample size here appeared reasonable to answer the research questions posed.

Despite these limitations, this research has provided valuable insight into the experiences of staff members working within adult mental health settings with distressed and traumatised patients and the impact of the national trauma training programme. However, future research concerning the experiences of other mental health professionals across different services and within different geographic locations would be welcome, especially given the national drivers promoting trauma-informed practice and training at all levels of the healthcare workforce (NES, 2017). Future recruitment could include healthcare professionals beyond adult mental health settings. Additionally, quantitative research concerning the impact of work-related trauma and the national trauma training programme would be a welcome addition. Indeed, exploring the mediating role of Trauma-Informed Care on burn-out and moral distress would supplement the current findings with inferential statistics which would add additional rigour to the findings.
Conclusion

The study provides a preliminary understanding of the experiences of NHS staff members working within adult mental health with distressed and traumatised patients and the acceptance and implementation of Trauma-Informed Care using the National Trauma Training Programme. The findings suggest that there is a passion and a commitment amongst NHS staff members to working within adult mental health and that there are benefits to trauma-informed approaches within these settings. However, whilst the increasing attention given to trauma is encouraging for staff, this is currently overshadowed by service demands and systemic pressures. Indeed, these demands and pressures threaten staff wellbeing and passion. This is at odds with Trauma-Informed Care, making the approach difficult to embed within services. Additionally, it explores the impact of the National Trauma Training Programme on staff in adult mental health settings. The study identified four Group Experiential Themes. ‘Role Identity’ was the first theme that identified participants' pride and passion in their roles, the importance of teamwork and their job expectations. Secondly, a sense that participants had to endure and persevere through work and experiences of burn-out was captured by the following quote "Well, we've just got to keep going, I suppose", which the second theme was named. Thirdly, ‘Service Pressures’ highlighted the impact of the current social context and the lasting impact of Covid-19; and finally, ‘The Implementation of Trauma-Informed Care’ considered both the positive and more challenging aspects of embedding the approach. The study provides insight into an underrepresented group within a research context and complements the current social context of the NHS and Trauma-Informed Care. The findings may provide the foundations for more consistent research to be carried out, particularly concerning the mediating role of Trauma-Informed Care on burn-out and moral distress. Additionally, with an emphasis on the National Trauma Training Programme in Scotland, this study has further laid the foundations for using staff experiences to enhance the training and provision so that it is better maintained and implemented across all levels of healthcare in Scotland.
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Appendix

Appendix A: Journal of Traumatic Stress Author Guidelines

Author Guidelines
Submission and Peer Review Process

Before you submit, you will need:

Your manuscript: this should be an editable file including text, figures, and tables, or separate files—whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. Figures should be uploaded in the highest resolution possible. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. Supporting information should be submitted in separate files. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers, and the editorial office will send it back to you for revision.

An ORCID ID, freely available at https://orcid.org. (Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)

The title page of the manuscript, including:

Your co-author details, including affiliation and email address. (Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)

Statements relating to our ethics and integrity policies, which may include any of the following (Why are these important? We need to uphold rigorous ethical standards for the research we consider for publication):
- data availability statement
- funding statement
- conflict of interest disclosure
- ethical standards statement
- patient consent statement
- permission to reproduce material from other sources
- clinical trial registration

Important: the journal operates a double-blind peer review policy. Please anonymize your manuscript and supply a separate title page file.

Title Page
- The title page should contain:
- A brief informative title containing the major key words. The title should not contain abbreviations (see Wiley’s best practice SEO tips);
- A short running title of less than 40 characters;
• The full names of the authors;
• The author’s institutional affiliations where the work was conducted, with a footnote for the author’s present address if different from where the work was conducted;
• Acknowledgments.

Important: the journal operates a double-blind peer review policy. Please anonymize your manuscript and prepare a separate title page containing author details.

Main Text File
Please ensure that all identifying information such as author names and affiliations, acknowledgements or explicit mentions of author institution in the text are on a separate page.
The main text file should be in Word format and include:
• A short informative title containing the major key words (the title should not contain abbreviations).
• Abstract
• Up to seven keywords
• Main body, formatted as:
  • Method
  • Participants
  • Procedure
  • Measures
  • Data Analysis
  • Results
  • References
• Tables (each table complete with title and footnotes)
• Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below).

Reference Style
Journal of Traumatic Stress uses APA reference style. However, because JTS offers Free Format submission, you do not need to format the references in your article until the revision stage when your article is more likely to be accepted.

Figures and Supporting Information
Figures, supporting information, and appendices should be supplied as separate files, preferably in Word. You should review the basic figure requirements for manuscripts for peer review, as well as the more detailed post-acceptance figure requirements. View Wiley’s FAQs on supporting information.

Peer Review
This journal operates under a double-blind peer review model. Papers will only be sent to review if the Editor-in-Chief determines that the paper meets the appropriate quality and relevance requirements.

In-house submissions, i.e. papers authored by Editors or Editorial Board members of the title, will be sent to Editors unaffiliated with the author or institution and monitored carefully to ensure there is no peer review bias.
Wiley’s policy on the confidentiality of the review process is available here.

Guidelines on Publishing and Research Ethics in Journal Articles
The journal requires that you include in the manuscript details IRB approvals, ethical treatment of human and animal research participants, and gathering of informed consent, as appropriate. You will be expected to declare all conflicts of interest, or none, on submission. Please review Wiley’s policies surrounding human studies, clinical trial registration, and research reporting guidelines.

Article Types

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<td>Research Article</td>
<td>Report of new research findings or conceptual analyses that make a significant contribution to knowledge</td>
<td>7,500 words, including abstract, references, tables, and figures</td>
<td>Yes</td>
<td>Data Availability Statement, IRB Statement</td>
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<tr>
<td>Review Article</td>
<td>Overview of developments in the field or current lines of thought; synthesizes multiple sources of information and has long list of references</td>
<td>7,500 words, including abstract, references, tables, and figures</td>
<td>Yes</td>
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Appendix B: PROSPERO Registered Protocol

A systematic review of psychological interventions for the treatment of 'work-related' trauma in helping professions

Citation


Review question

To identify existing psychological evidence-based interventions in the treatment of vicarious trauma, compassion fatigue and secondary traumatic stress.

To determine the effectiveness of interventions identified.

Searches

Databases searched will be: PsycINFO, PsycARTICLES, EMBASE and MEDLINE. Given there were no previous reviews in the topic found, a decision was made to not apply a time limit to relevant papers, to ensure that all research in the area could be considered.

Three primary search terms were considered for this review (psychological intervention, vicarious trauma, helping profession), each of which were supplemented by a relevant range of terms to be completed between February 2022 and May 2023.

Exclusions include:

- Studies which are qualitative in nature.
- Studies which only investigate the prevalence of vicarious trauma amongst clinicians.
- Studies that are not published in English or have been translated into English.
- Studies that solely use pharmacological based interventions for the treatment of vicarious trauma.

Types of study to be included

To meet inclusion criteria, each article will have to: i) include adult participants aged 18 or over who worked with in helping professions, ii) involve evidence-based psychological interventions, iii) involve a definition work-based distress and/or trauma i.e. vicarious trauma, secondary traumatic stress and/or compassion fatigue, iv) include at least one outcome measure of vicarious trauma, compassion fatigue, secondary traumatic stress, traumatic stress, work-based or psychological distress, v) have a quantitative element (if within mixed-methods studies).

Articles will be excluded if they are: i) solely qualitative in nature, ii) only investigated the prevalence of vicarious trauma, compassion fatigue or secondary traumatic stress in professions, iii) only investigated the prevention of vicarious trauma, compassion fatigue or secondary traumatic stress in professions, iv) solely used pharmacological based interventions, v) studies that have not been published in English, vi) book chapters, vii) bulletins or opinion pieces, viii) individual case studies.
Condition or domain being studied

Work-related trauma which includes vicarious trauma, compassion fatigue and secondary traumatic stress may present within helping professions due to the nature of their roles in being confronted with traumatic events and empathetically engaging with others. This review will consider evidence-based psychological interventions in the treatment of work-based trauma.

Participants/population

Helping professions including: mental health workers, front-line medical workers, disaster and aid workers, emergency service personnel.

Intervention(s), exposure(s)

Evidence-based psychological / therapeutic interventions which may include behaviourial and cognitive therapies, Eye Movement Desensitisation and Reprocessing, mindfulness-based interventions, psycho-education, group therapy

Comparator(s)/control

Not applicable.

Context

Studies focusing within the helping professions and work-related trauma.

Main outcome(s) [1 change]

Changes in work-related trauma scores from pre-intervention to post-intervention (and last available follow-up), alongside the type of intervention that was utilised will be the main outcome for this studies. Studies will most likely be utilising different outcome measures and interventions to cover the wide range of work-related trauma. No cross-comparison will be available due to the lack of heterogeneity in the research (noted through scoping searches) and the review will instead narratively address the outcomes of each study.

The review will aim to aid clinicians in addressing work-related trauma in helping professions and note whether treatment interventions should be different from post-traumatic stress disorder and/or complex post-traumatic stress disorder due to the unique nature of work-related trauma in helping professions.

Measures of effect

The review will utilise the effect sizes reported within studies collated, most likely cohen's d or hedges g. Due to the lack of heterogeneity that is expected within this study, no cross comparison of effect sizes will be completed.

Additional outcome(s)

Further outcomes include the practical application of interventions: the number of sessions of those interventions offered and duration to gain an overview of evidenced treatments in the psychological treatment of vicarious trauma.

Identifying the outcome measures used in each study will also be a secondary outcome of the study to further understand how well outcome measures may capture progress (or lack thereof) of interventions.

Data extraction (selection and coding)

All studies will be screened using Covidence systematic review software. The remaining studies will then be screened via the eligibility requirements based on their titles. The abstracts of the remaining studies will then be read individually by
the lead researcher and screened against the eligibility criteria. A second independent reviewer will also complete the steps outlined above. Any discrepancies between reviewers will be discussed and resolved using a collaborative process i.e. reviewing individual notes and comparing findings. Cohen's Kappa Coefficient (k) will be calculated as a measure of inter-rater reliability.

The selection process will be outlined using the PRISMA flow diagram, as recommended within PRISMA-P Explanation and Elaboration (2020) guide.

Data extraction will include study characteristics: author, design, cohort, country, area of focus, sample size, mean age, intervention used, outcome measures, time-points of data collection and intervention duration.

Trauma related outcomes and secondary outcomes of the study will also be included within results alongside effect sizes.

Risk of bias (quality) assessment

The Effective Public Health Practice Project (EPHPP) Quality Assessment Tool (National Institute for Health and Clinical Excellence, 2006) will be used. The EPHPP has been designed to assess the quality of studies across various quantitative designs. The tool uses six items of methodological standards to provide an overall rating of strong, moderate, and weak quality evidence as follows:

1. Selection bias
2. Study design
3. Confounders
4. Blinding
5. Data collection method

Strategy for data synthesis

Given the likely heterogeneity of interventions and potential low sample size number, it is not anticipated that a meta-analysis will be appropriate. A narrative overview of results and features of design will be provided. Specifically, this will include summary tables of extracted data and descriptive narrative findings as above. Effect sizes of each study will be reported if they are available. When reviewing, the strength of the evidence presented in the review and the impact of bias will be considered.

Analysis of subgroups or subsets

None planned.

Contact details for further information

Jessica Woeginger
s2137960@ed.ac.uk

Organisational affiliation of the review

University of Edinburgh

Review team members and their organisational affiliations
Miss Jessica Woeginger, University of Edinburgh
Dr Rachel Happet, University of Edinburgh
Dr Alison Wells, NHS Lothian

Type and method of review
Intervention, Narrative synthesis, Systematic review

Anticipated or actual start date
20 February 2023

Anticipated completion date
01 May 2023

Funding sources/sponsors
Not applicable

Conflicts of interest

Language
English

Country
Scotland

Stage of review
Review Ongoing

Subject index terms status
Subject indexing assigned by CRD

Subject index terms
Burnout, Professional; Compassion Fatigue; Humans; Psychosocial Intervention

Date of registration in PROSPERO
22 February 2023

Date of first submission
18 February 2023
Stage of review at time of this submission

The review has not started

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</table>

The record owner confirms that the information they have supplied for this submission is accurate and complete and they understand that deliberate provision of inaccurate information or omission of data may be construed as scientific misconduct.

The record owner confirms that they will update the status of the review when it is completed and will add publication details in due course.

Versions

22 February 2023
Appendix C: Effective Public Health Practice Project (EPHPP) Tool

QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES

COMPONENT RATINGS

A) SELECTION BIAS

(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?
1. Very likely
2. Somewhat likely
3. Not likely
4. Can’t tell

(Q2) What percentage of selected individuals agreed to participate?
1. 90 - 100% agreement
2. 60 - 79% agreement
3. Less than 60% agreement
4. Not applicable
5. Can’t tell

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<tbody>
<tr>
<td>See dictionary</td>
<td>1</td>
<td>2</td>
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</table>

B) STUDY DESIGN

Indicate the study design
1. Randomized controlled trial
2. Controlled clinical trial
3. Cohort analytic (two group pre + post)
4. Case-control
5. Cohort (one group pre + post before and after)
6. Interrupted time series
7. Other specify
8. Can’t tell

Was the study described as randomized? If NO, go to Component C.

No   Yes

If Yes, was the method of randomization described? (See dictionary)

No   Yes

If Yes, was the method appropriate? (See dictionary)

No   Yes

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<tr>
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</tbody>
</table>
C) CONFounders

(Q1) Were there important differences between groups prior to the intervention?
   1 Yes
   2 No
   3 Can’t tell

The following are examples of confounders:
   1 Race
   2 Sex
   3 Marital status/family
   4 Age
   5 SES (income or class)
   6 Education
   7 Health status
   8 Pre-intervention score on outcome measure

(Q2) If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?
   1 80 – 100% (most)
   2 60 – 79% (moderate)
   3 Less than 60% (few or none)
   4 Can’t Tell

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<tr>
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</tbody>
</table>

D) BLINDING

(Q1) Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?
   1 Yes
   2 No
   3 Can’t tell

(Q2) Were the study participants aware of the research question?
   1 Yes
   2 No
   3 Can’t tell

<table>
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<tr>
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</tbody>
</table>

E) DATA COLLECTION METHODS

(Q1) Were data collection tools shown to be valid?
   1 Yes
   2 No
   3 Can’t tell

(Q2) Were data collection tools shown to be reliable?
   1 Yes
   2 No
   3 Can’t tell

<table>
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<tbody>
<tr>
<td>See dictionary</td>
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</tbody>
</table>
F) WITHDRAWALS AND DROP-OUTS

(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?
1 Yes
2 No
3 Can't tell
4 Not Applicable (i.e. one time surveys or interviews)

(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).
1 80-100%
2 60-79%
3 Less than 60%
4 Can't tell
5 Not Applicable (i.e. Retrospective case-control)

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<tr>
<td></td>
<td></td>
<td></td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

G) INTERVENTION INTEGRITY

(Q1) What percentage of participants received the allocated intervention or exposure of interest?
1 80-100%
2 60-79%
3 Less than 60%
4 Can't tell

(Q2) Was the consistency of the intervention measured?
1 Yes
2 No
3 Can't tell

(Q3) Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?
4 Yes
5 No
6 Can't tell

H) ANALYSES

(Q1) Indicate the unit of allocation (circle one)
- Community
- Organization/Institution
- Practice/Office
- Individual

(Q2) Indicate the unit of analysis (circle one)
- Community
- Organization/Institution
- Practice/Office
- Individual

(Q3) Are the statistical methods appropriate for the study design?
1 Yes
2 No
3 Can't tell

(Q4) Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?
1 Yes
2 No
3 Can't tell
GLOBAL RATING

COMPONENT RATINGS
Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

<table>
<thead>
<tr>
<th></th>
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<td>B</td>
<td>STUDY DESIGN</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>C</td>
<td>CONFOUNDERS</td>
<td>1</td>
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<td>3</td>
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<tr>
<td>D</td>
<td>BLINDING</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>E</td>
<td>DATA COLLECTION METHOD</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>F</td>
<td>WITHDRAWALS AND DROPOUTS</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

GLOBAL RATING FOR THIS PAPER (circle one):

1  STRONG  (no WEAK ratings)
2  MODERATE (one WEAK rating)
3  WEAK  (two or more WEAK ratings)

With both reviewers discussing the ratings:

Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings?

No  Yes

If yes, indicate the reason for the discrepancy

1  Oversight
2  Differences in interpretation of criteria
3  Differences in interpretation of study

Final decision of both reviewers (circle one):

1  STRONG
2  MODERATE
3  WEAK
Quality Assessment Tool for Quantitative Studies Dictionary

The purpose of this dictionary is to describe items in the tool thereby assisting raters to score study quality. Due to under-reporting or lack of clarity in the primary study, raters will need to make judgements about the extent that bias may be present. When making judgements about each component, raters should form their opinion based upon information contained in the study rather than making inferences about what the authors intended. Mixed methods studies can be quality assessed using this tool with the quantitative component of the study.

A) SELECTION BIAS

(Q1) Participants are more likely to be representative of the target population if they are randomly selected from a comprehensive list of individuals in the target population (score very likely). They may not be representative if they are referred from a source (e.g. clinic) in a systematic manner (score somewhat likely) or self-referred (score not likely).

(Q2) Refers to the % of subjects in the control and intervention groups that agreed to participate in the study before they were assigned to intervention or control groups.

B) STUDY DESIGN

In this section, raters assess the likelihood of bias due to the allocation process in an experimental study. For observational studies, raters assess the extent that assessments of exposure and outcome are likely to be independent. Generally, the type of design is a good indicator of the extent of bias. In stronger designs, an equivalent control group is present and the allocation process is such that the investigators are unable to predict the sequence.

Randomized Controlled Trial (RCT)

An experimental design where investigators randomly allocate eligible people to an intervention or control group. A rater should describe a study as an RCT if the randomization sequence allows each study participant to have the same chance of receiving each intervention and the investigators could not predict which intervention was next. If the investigators do not describe the allocation process and only use the words ‘random’ or ‘randomly’, the study is described as a controlled clinical trial.

See below for more details.

Was the study described as randomized?
Score YES, if the authors used words such as random allocation, randomly assigned, and random assignment.
Score NO, if no mention of randomization is made.

Was the method of randomization described?
Score YES, if the authors describe any method used to generate a random allocation sequence.
Score NO, if the authors do not describe the allocation method or describe methods of allocation such as alternation, case record numbers, dates of birth, day of the week, and any allocation procedure that is entirely transparent before assignment, such as an open list of random numbers of assignments.
If NO is scored, then the study is a controlled clinical trial.
Was the method appropriate?

Score YES, if the randomization sequence allowed each study participant to have the same chance of receiving each intervention and the investigators could not predict which intervention was next. Examples of appropriate approaches include assignment of subjects by a central office unaware of subject characteristics, or sequentially numbered, sealed, opaque envelopes.

Score NO, if the randomization sequence is open to the individuals responsible for recruiting and allocating participants or providing the intervention, since those individuals can influence the allocation process, either knowingly or unknowingly.

If NO is scored, then the study is a controlled clinical trial.

Controlled Clinical Trial (CCT)
An experimental study design where the method of allocating study subjects to intervention or control groups is open to individuals responsible for recruiting subjects or providing the intervention. The method of allocation is transparent before assignment, e.g. an open list of random numbers or allocation by date of birth, etc.

Cohort analytic (two group pre and post)
An observational study design where groups are assembled according to whether or not exposure to the intervention has occurred. Exposure to the intervention is not under the control of the investigators. Study groups might be non-equivalent or not comparable on some feature that affects outcome.

Case control study
A retrospective study design where the investigators gather ‘cases’ of people who already have the outcome of interest and ‘controls’ who do not. Both groups are then questioned or their records examined about whether they received the intervention exposure of interest.

Cohort (one group pre + post (before and after)
The same group is pretested, given an intervention, and tested immediately after the intervention. The intervention group, by means of the pretest, act as their own control group.

Interrupted time series
A time series consists of multiple observations over time. Observations can be on the same units (e.g. individuals over time) or on different but similar units (e.g. student achievement scores for particular grade and school). Interrupted time series analysis requires knowing the specific point in the series when an intervention occurred.

Other:
One time surveys or interviews

C) CONFOUNDERS

By definition, a confounder is a variable that is associated with the intervention or exposure and causally related to the outcome of interest. Even in a robust study design, groups may not be balanced with respect to important variables prior to the intervention. The authors should indicate if confounders were controlled in the design (by stratification or matching) or in the analysis. If the allocation to intervention and control groups is randomized, the authors must report that the groups were balanced at baseline with respect to confounders (either in the text or a table).

D) BLINDING

(01) Assessors should be described as blinded to which participants were in the control and intervention groups. The purpose of blinding the outcome assessors (who might also be the care providers) is to protect against detection bias.

(02) Study participants should not be aware of (i.e. blinded to) the research question. The purpose of blinding the participants is to protect against reporting bias.
E) DATA COLLECTION METHODS

Tools for primary outcome measures must be described as reliable and valid. If ‘face’ validity or ‘content’ validity has been demonstrated, this is acceptable. Some sources from which data may be collected are described below:

Self reported data includes data that is collected from participants in the study (e.g. completing a questionnaire, survey, answering questions during an interview, etc.).

Assessment/Screening includes objective data that is retrieved by the researchers. (e.g. observations by investigators).

Medical Records/Vital Statistics refers to the types of formal records used for the extraction of the data.

Reliability and validity can be reported in the study or in a separate study. For example, some standard assessment tools have known reliability and validity.

F) WITHDRAWSALS AND DROP-OUTS

Score YES if the authors describe BOTH the numbers and reasons for withdrawals and drop-outs.

Score NO if either the numbers or reasons for withdrawals and drop-outs are not reported.

Score NOT APPLICABLE if the study was a one-time interview or survey where there was not follow-up data reported.

The percentage of participants completing the study refers to the % of subjects remaining in the study at the final data collection period in all groups (i.e. control and intervention groups).

G) INTERVENTION INTEGRITY

The number of participants receiving the intended intervention should be noted (consider both frequency and intensity). For example, the authors may have reported that at least 80 percent of the participants received the complete intervention. The authors should describe a method of measuring if the intervention was provided to all participants the same way. As well, the authors should indicate if subjects received an unintended intervention that may have influenced the outcomes. For example, co-intervention occurs when the study group receives an additional intervention (other than that intended). In this case, it is possible that the effect of the intervention may be over-estimated. Contamination refers to situations where the control group accidentally receives the study intervention. This could result in an under-estimation of the impact of the intervention.

H) ANALYSIS APPROPRIATE TO QUESTION

Was the quantitative analysis appropriate to the research question being asked?

An intention-to-treat analysis is one in which all the participants in a trial are analyzed according to the intervention to which they were allocated, whether they received it or not. Intention-to-treat analyses are favoured in assessments of effectiveness as they mirror the noncompliance and treatment changes that are likely to occur when the intervention is used in practice, and because of the risk of attrition bias when participants are excluded from the analysis.
Component Ratings of Study:
For each of the six components A – F, use the following descriptions as a roadmap.

A) SELECTION BIAS
Strong: The selected individuals are very likely to be representative of the target population (Q1 is 1) and there is greater than 80% participation (Q2 is 1).
Moderate: The selected individuals are at least somewhat likely to be representative of the target population (Q1 is 1 or 2) and there is 60 - 79% participation (Q2 is 2). ‘Moderate’ may also be assigned if Q1 is 1 or 2 and Q2 is 5 (can’t tell).
Weak: The selected individuals are not likely to be representative of the target population (Q1 is 3); or there is less than 60% participation (Q2 is 3) or selection is not described (Q1 is 4); and the level of participation is not described (Q2 is 5).

B) DESIGN
Strong: will be assigned to those articles that described RCTs and CCTs.
Moderate: will be assigned to those that described a cohort analytic study, a case control study, a cohort design, or an interrupted time series.
Weak: will be assigned to those that used any other method or did not state the method used.

C) CONFOUNDERS
Strong: will be assigned to those articles that controlled for at least 80% of relevant confounders (Q1 is 2); or (Q2 is 1).
Moderate: will be given to those studies that controlled for 60 – 79% of relevant confounders (Q1 is 1) and (Q2 is 2).
Weak: will be assigned when less than 60% of relevant confounders were controlled (Q1 is 1) and (Q2 is 3) or control of confounders was not described (Q1 is 3) and (Q2 is 4).

D) BLINDING
Strong: The outcome assessor is not aware of the intervention status of participants (Q1 is 2); and the study participants are not aware of the research question (Q2 is 2).
Moderate: The outcome assessor is not aware of the intervention status of participants (Q1 is 2); or the study participants are not aware of the research question (Q2 is 2).
Weak: The outcome assessor is aware of the intervention status of participants (Q1 is 1); and the study participants are aware of the research question (Q2 is 1); or blinding is not described (Q1 is 3 and Q2 is 3).

E) DATA COLLECTION METHODS
Strong: The data collection tools have been shown to be valid (Q1 is 1); and the data collection tools have been shown to be reliable (Q2 is 1).
Moderate: The data collection tools have been shown to be valid (Q1 is 1); and the data collection tools have not been shown to be reliable (Q2 is 2) or reliability is not described (Q2 is 3).
Weak: The data collection tools have not been shown to be valid (Q1 is 2) or both reliability and validity are not described (Q1 is 3 and Q2 is 3).

F) WITHDRAWALS AND DROP-OUTS - a rating of:
Strong: will be assigned when the follow-up rate is 80% or greater (Q1 is 1 and Q2 is 1).
Moderate: will be assigned when the follow-up rate is 60 – 79% (Q2 is 2) OR Q1 is 4 or Q2 is 5.
Weak: will be assigned when a follow-up rate is less than 60% (Q2 is 3) or if the withdrawals and drop-outs were not described (Q1 is No or Q2 is 4).
Not Applicable: if Q1 is 4 or Q2 is 5.
Appendix D: Kappa Workings (SPSS)

### Symmetric Measures

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<th>Approximate Significance</th>
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<td>N of Valid Cases</td>
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a. Not assuming the null hypothesis.
b. Using the asymptotic standard error assuming the null hypothesis.

CROSSTABS
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/CELLS=COUNT COLUMN
/CELLS ROUND CELL.

### Crosstabs

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#### Rater1 * Rater2 Crosstabulation

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Appendix E: Empirical Study Protocol

Non-CTIMP Study Protocol

An exploration of the experience of trauma training in Community Mental Health Team members working with traumatised and distressed patients.

The University of Edinburgh and/or Lothian Health Board ACCORD
The Queen’s Medical Research Institute
47 Little France Crescent
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INTRODUCTION 1.1 BACKGROUND

Transforming Psychological Trauma

The Scottish Government has committed to preventing Adverse Childhood Experiences (ACEs) and supporting the resilience and recovery of all children and adults affected by psychological trauma. Part of this commitment involved the introduction of the National Trauma Training Programme, led by NHS Education for Scotland (NES) to support a trauma-informed and trauma-responsive workforce and services across the country. This programme is currently funded until March 2023 and also forms a part of the Scottish Government’s Coronavirus Mental Health Transition and Recovery Plan.

Trauma and Complex Trauma

Exposure to psychological trauma in general is very prevalent (Benjet et al., 2016; Roberts, Gilman, Breslau, Breslau & Koenen, 2011), and many people will experience trauma in various forms during their lifetime. Complex Psychological Trauma (CPT) occurs as a result of repetitive, prolonged trauma involving harm or abandonment by interpersonal relationships with an uneven power dynamic (Stein, Wilmot & Solomon, 2016). It is often associated with physical, sexual, emotional abuse or neglect in childhood, intimate partner violence, kidnapping, modern slavery, and bullying (Coleman, Chouliara & Currie, 2021). CPT is therefore relational in nature with a long-lasting impact (Courtois & Ford, 2009). Currently, the prevalence of CPT is more difficult to establish, because of the wide range of trauma that it encapsulates. However, Coleman et al (2018), suggest that the prevalence of CPT is likely higher than any reported figures, due to underreporting by survivors of trauma and the stigmatising nature of such traumas.

CPT tends to have significant physical and psychological impacts on survivors and their use of services (World Health Organisation, 2013). Specifically, childhood sexual abuse alone is a major
cause of poor mental health, functional disability, high use of health services and has been linked to physical difficulties, including gynaecological and gastrointestinal symptoms, asthma, functional impairment, and poor subjective health both in childhood and adulthood (Cohen et al., 2008; Leserman, 2005; Spataro, Mullen, Burgess, Wells & Moss, 2004). There are also psychological impacts associated with CPT, including mood difficulties, anxiety and use of substances (Molnar et al., 2001). Marriage and family problems have also been associated with CPT (Dube et al., 2005) and it can be a cause of serious psychiatric problems both in childhood and adulthood (Teicher & Parigger, 2015). As a result, CPT has a large impact on health resources too, and annual health care costs worldwide were found to be significantly higher for those who suffered complex traumas (WHO, 2013). Given that CPT has profound mental and physical health consequences and is associated with long-term economic costs across the life-span there has been a call for an increase in support for both survivors of trauma and to also prevent exposure to trauma. Additionally, The United Kingdom Psychological Trauma Society (UKPTS) note that the prevalence of CPT is likely to increase in coming years, identifying exposure to war, extreme weather conditions (e.g. flooding), Covid-19 and other extreme circumstances as possible contributing factors. Indeed, UKPTS hypothesise that interpersonal functioning and emotion regulation will be significantly impaired in those experiencing CPT.

Vicarious Trauma

With the increased prevalence and consequent growing needs to support those who have experienced trauma, it is likely that more healthcare clinicians will be holding caseloads and working directly with patients affected by trauma, even if this is not the reason for referral. It therefore seems likely that clinicians will be exposed to the demands of providing trauma- specific support and services. Working clinically with CPT is known to be personally and relationally demanding (Staub and Vollhardt, 2008) and the risk of vicarious traumatisation, burn-out and compassion fatigue is higher in those working with CPT (Chouliara et al., 2009) than those who are not exposed to this client group. Studies point to the elevated rate of trauma amongst counsellors and therapists working with traumatised individuals (Boeber & Reger, 2006), with reported symptoms such as intrusive imagery, nightmares, increased fear of safety for self and loved ones, irritability, and emotional numbing. Additionally, longer- term reactions have also been reported including a sense of hopelessness and a changed world view in which others are viewed with scepticism (Iliffe & Steed, 2000; Ortlepp & Friedman, 2002). Indeed, the number of trauma cases on a therapist’s caseload has been found to influence symptom level in clinicians alongside the availability of social support and whether there was a personal history of trauma (Brady et al., 1999; Ortlepp & Friedman, 2002). Interestingly, Ortlepp and Friedman (2002) further report that for therapists who perceived that they had adequate training to effectively work with CPT this helped to reduce the sense of hopelessness that may accompany working with traumatised patients.

1.2 RATIONALE FOR STUDY

Gaps in the Research

Whilst the above literature shows the prevalence of trauma and subsequent vicarious trauma on healthcare populations, there has been little evidence of the impact of this directly on Community Mental Health Team (CMHT) members. Trends further suggest that CMHT members will also be working with an increasing population of patients who have experienced trauma. Indeed, Edwards et al., (2020) have reported that CMHT members experience considerable stress and burnout as a result of increasing workloads and a lack of resources. Given this and the cited research above, it is postulated that a similar trend would be observed within the CMHT concerning the impact of vicarious trauma, however this is not an overly addressed topic of research to date.
Further, with the recent introduction of the National Trauma Training Programme, little is known about the qualitative impact of this training. It is a new and novel field, and the aims of training are as follows:

- Is informed by people with lived experience
- It recognises the importance of wellbeing in the workforce
- It recognises where people are affected by trauma and adversity
- People are able to respond in ways that prevent further harm
- It supports recovery
- It can address inequalities and improve life chances

Therefore, it is hoped that the training can not only support people who come into contact with services, but also the wider workforce (as seen in the second aim), in recognising the impact that working with CPT may have.

This research will therefore look to address these gaps in the research and explore the impact of the National Trauma Training Programme on CMHT members. It will further attempt to explore the role of vicarious trauma on CMHT members and whether the training can help to mitigate against vicarious trauma.

The purpose of this Interpretive Phenomenological study is to explore the impact of trauma training on Community Mental Health Team members working with traumatised and distressed patients.

**STUDY OBJECTIVES**

**OBJECTIVES**

**Primary Objective**

- To explore and understand what Community Mental Health Team members experiences of Vicarious Trauma are.

- To explore whether Community Mental Health Team members feel that trauma training may help to mitigate against the impact of Vicarious Trauma.

**3 STUDY DESIGN**

*Design*

This is an exploratory study, using a mixed methods design to identify emerging themes and patterns of experiences amongst the participants. At baseline, participants will be asked to provide informed consent, give demographic details and, in line with the training programme, complete pre-training questionnaires, including the Vicarious Trauma Scale. Participants will then attend the National Trauma Training Programme (Level 1&2). Data collection post training will be done through post-training evaluations and semi-structured interviews with members of the CMHT. An interview agenda will be developed by the researcher, with a bottom-up, participant-led format (Willig, 2008). The interview agenda will be flexible, allowing for new and emerging themes to be explored. Post-training evaluations will also be administered.

*Post-Intervention Semi-Structured Interviews*
- Interviews with participants focusing on the impact of training, vicarious trauma and practice working with traumatised and distressed patients.

Ethical Approval

Full ethical approval will be sought from the University of Edinburgh and NHS Management approval from R&D via IRAS.

Ethical Considerations

Prior to the commencement of data collection, the researcher will ensure that participants recruited are fully informed about the research content and procedure. Information sheets outlining the purpose of the study and what will be involved will be given to all participants prior to any commencement of research. Participants will be informed that their contribution is voluntary, and they are able to withdraw from the study at any point, including after data collection. Participants will be further informed of confidentiality within the research, including limits of this i.e. if any safeguarding concerns are raised.

Following data collection, participants will be fully debriefed on the research and provided with appropriate support helplines should they need it.

Data will be kept in a secure and confidential online space, provided through the University of Edinburgh/NHS Lothian software platforms.

Participants/Recruitment

Participants in this study will be derived from an already established CMHT in East Lothian Adult Mental Health Services. The CMHT is made up of Community Mental Health Nurses, Occupational Therapists, Support Workers, Psychiatrists and Art Therapists. All members of the team will be invited to participate in the research and attend the training (the two of which are not mutually exclusive – i.e. participants can attend training without being part of the research project). Participants will hold their own case load of patients who are all experiencing some level of mental health care and treatment. Recruitment will take place over one month to identify suitable participants. Eight-ten participants will be recruited from the CMHT, following an inclusion/exclusion criterion.

Intervention

Levels 1&2 of the National Trauma Training Programme will be the intervention provided in this study. Level 1&2 focus on an introduction to trauma, its impact and then subsequent safety and stabilisation when working with those with trauma, resulting in ‘trauma-skilled’ practitioners. The training can either be provided face-to-face or in an online setting (Covid-19 dependent and flexible) and is likely to be delivered in one full day or two half-day blocks depending on team availability. The training has been developed by NHS Education for Scotland and is a structured programme, covering the same modules and content. Therefore, all participants who complete the training across Scotland will receive a standardised and consistent approach (i.e. length of time of the training, module content, examples used), lending to a robustness of the intervention being delivered and potential generalisability of the subsequent results.

Procedure
Following ethical and management approval, gaining fully informed consent and successful recruitment, participants will be invited to attend the Trauma Training Programme which will be delivered by members of the Psychological Therapies Team. Covid dependent, this training will be delivered in either a face-to-face setting or over an online platform – both of which are viable options. Before training begins, participants will be instructed to complete the pre-training measures which includes the demographic data and pre-training questionnaires. The training will then be delivered to the CMHT, with time given at the end of training for participants to complete the training evaluation questionnaires.

Following the training, participants will be invited to take part in a semi-structured interview, within twelve weeks of completing the training. Some set questions will be present during the interview, and follow-up unstructured questions will also be present. This will allow for a more spontaneous exploration of some topics. Interviews will last for approximately 45minutes-60minutes and will be recorded on an encrypted device. The interviews will then be transcribed in line with ethical approval and using encrypted software. On completion of the interview, participants will be thanked for their participation in the research and provided with relevant debrief sheets about the research and contact details should they wish to withdraw their data.

Analysis

Analysis will take place using Interpretive Phenomenological Analysis (IPA) to explore any themes that are present and draw conclusions from the research. The demographic data and training evaluations will also be presented.

4 STUDY POPULATION
4.1 NUMBER OF PARTICIPANTS

Participants in this study will be derived from an already established CMHT in East Lothian Adult Mental Health Services. The CMHT is made up on Community Mental Health Nurses, Occupational Therapists, Support Workers, Psychiatrists and Art Therapists. All members of the team will be invited to participate in the research and attend the training (the two of which are not mutually exclusive – i.e. participants can attend training without being part of the research project). Participants will hold their own case load of patients who are all experiencing some level of mental health care and treatment. Recruitment will take place over one month to identify suitable participants. Eight-ten participants will be recruited from the CMHT, following an inclusion/exclusion criterion.

4.2 INCLUSION CRITERIA

Inclusion criteria:

Core profession within the Community Mental Health Team
Holding an active caseload (working predominantly with adults aged 18-65) Permanent job role
Worked in the team for 6+ months
English speaking

EXCLUSION CRITERIA

Bank/agency staff
Worked in the team for <6 months Non-English speakers
Non-completers of the training intervention
PARTICIPANT SELECTION AND ENROLMENT IDENTIFYING PARTICIPANTS

Potential participants will be identified through attendance at the Trauma Training. Here, the project will be presented to all those who are taking part in the training and they will be given the opportunity to ask questions about the research and to indicate if they would be interested in participating. If they meet the inclusion criteria, potential participants will then be contacted to arrange the interview, which will include the information sheet and consent sheet being given.

5.2 CONSENTING PARTICIPANTS

After participants express an interest, they will be given at least 24 hours to digest the information before being contacted again to see if they would like to take part. If participants agree, the consent form will be provided (in person or by email) and an interview date will be arranged. Prior to the interview commencement, verbal consent will again be sought to ensure participants are happy to proceed.

5.2.1 Withdrawal of Study Participants

Participants are free to withdraw from the study at any point and request that all of their data collected to that point not be included in the study.

6 STUDY ASSESSMENTS 6.1 STUDY ASSESSMENTS

7 DATA COLLECTION

The training will be conducted between November 2021-January 2022 and will likely involve two training slots to cover the whole team shift patterns. It is planned that interviews will then be conducted between March-April 2022 with analysis, interpretation and write-up planned between May 2022-May 2023. Jessica Woeginger, chief investigator will collect the data.

7.1 Source Data Documentation

8 DATA MANAGEMENT

8.1.1 Personal Data

Consent forms and information forms will be stored in locked cabinets at the East Lothian Community Hospital (ELCH). These will be in the upstairs office which is populated by Adult Mental Health Staff. Signed consent forms will be stored separately from other participant data. Audio recordings will be recorded on NHS encrypted devices, and transferred to a password protected NHS Lothian computer at the ELCH as soon as possible, with the recordings then being deleted from the device. Recordings will be deleted from computers as soon as possible following transcription, which will anonymise the data. Data transcripts from the recordings will be anonymised and also stored securely on NHS Lothian computers, as above. Anonymised data will be stored separately to identifiable data. Only anonymised transcripts will be transferred to the University of Edinburgh for analysis. Quotations from these transcripts may be used in publications, but will not contain identifiable information.

8.1.2 Data Information Flow
Identifiable information will be provided on the consent form and demographic details, which will be stored initially in locked cabinets at the ELCH. The demographic information will be anonymised within four weeks of collection. As above, audio recordings will be transcribed as soon as possible and then deleted off of the device they were recorded on.

8.1.3 Transfer of Data

Anonymised data will only be transferred between NHS Lothian and the University of Edinburgh.

8.1.4 Data Controller

The University of Edinburgh and NHS Lothian are joint data controllers.

8.1.5 Data Breaches

Any data breaches will be reported to the University of Edinburgh and NHS Lothian Data Protection Officers who will onward report to the relevant authority according to the appropriate timelines if required.

9 STATISTICS AND DATA ANALYSIS

9.1 SAMPLE SIZE CALCULATION

Recommendations from Smith et al., (2009) for doctorate level projects relating to the number of interviews, rather than participants, suggests between four and ten interviews. Indeed, it is suggested that for data analysis to be successful, a large amount of data may be unsuitable for the time limits and reflections required when conducting qualitative studies. Additionally, Turpin et al., (1997) recommend that for the Doctorate in Clinical Psychology, six to eight participants is appropriate for an IPA study as this sample size gives an opportunity to examine similarities and differences between individuals. The study will aim to collect between 8-10 interviews to ensure that enough rich data for analysis is collected.

9.2 PROPOSED ANALYSES

Analysis will be conducted according to IPA methodology (Smith & Osborn, 2003). The primary goal of IPA researchers is to investigate how individuals make sense of their experiences and thus this method has been chosen to explore and evaluate the study objectives. IPA usually requires a fairly homogenous sample, for analysis within a group and within this study, this would be suitable, given that all participants will come from the same team. Whilst there may be within-group variation in the participant group, IPA highlights the need of shared experiences which this participant group will have.

Analysis of the interviews will follow Pietkiewicz & Smith’s (2012) practical guide for IPA. This involves a number of steps to ensure the authenticity of the research. The analysis will initially begin with multiple readings of transcripts and making notes. Notes are then transformed into emergent themes which are then transformed into relationships and clusters of themes.

Whilst quantitative data is being collected, there are insufficient participant numbers to power quantitative statistics for this exploratory study. Therefore, conclusions will not be drawn from this quantitative data. However, it may provide a useful adjunct to the qualitative findings for this sample group, who are expected to be at higher risk of vicarious traumatisation due to their role, rather than being representative of a population or the norms for the measures. Therefore, a deep-dive into the sample will then be taken, using IPA on the interviews, as outlined above.
RISKS

1. Given the past eighteen months, the biggest risk to the project currently is the ongoing global pandemic and a resurgence of Covid-19 with further restrictions/lockdowns implemented across the United Kingdom. This significantly impacted previous and current research projects. Steps have been considered to mitigate against this impact, including being able to provide the intervention (trauma training) through an online format and also being able to conduct the interviews over MS Teams, a platform used extensively by both NHS Lothian and the University of Edinburgh. The participant group for this study have continued to work throughout the pandemic, albeit in different formats, and the study can be adapted to accommodate this i.e. collection of data through an online platform.
   Risk Level: Low-Medium

2. Insufficient recruitment would be a further risk to this project. Whilst steps have been taken to establish links with the participant group, ultimately recruitment must be considered. To mitigate against insufficient recruitment links have been established with other staff teams and with consideration, these could be approached to partake in the research study.
   Risk Level: Low

3. The focus on vicarious trauma may be potentially distressing and trigger adverse reactions in some participants. Prior to the interviews, participants will be provided with an information sheet, outlining the purpose of the study and the topics that will be discussed during the interviews. To ensure the research is safe, the interview agenda will consist of open-ended questions and participants will be encouraged to only share what they are comfortable with. As with the nature of semi-structured interviews, the interviews will be collaborative in nature and guided by the information provided. Following the research and the interviews, participants will be given the opportunity to debrief where they will be able to discuss any distress they may have felt. Participants will also be given a debrief sheet and reminded that they can withdraw from the study at any point. There is also a staff-specific helpline and therapy service within NHS Lothian which is available to all staff and provides a confidential and safe place for staff to receive support. Staff members will be given all of the information for this service should they require access to it.
   Risk Level: Low-Medium

4. Given the qualitative nature of the study and small sample size, there is a risk of a breach of confidentiality and participants being identified through direct quotes. Participants will be fully informed that there is this risk in the information and informed consent sheet, and this will be further reiterated at the commencement of the interview. For data transcription and write-up, participants will be given a pseudonym and any identifiable information will be extracted. Great care will be taken in this process by the researcher and data will be coded at the earliest possible and stored on a secure platform. Participants will also be reminded of their right to fully withdraw their data from the study at any point, including after they have taken part in their interview. Additionally, given that the Clinical Supervisor within this research is indirectly connected to the CMHT, steps will be taken to ensure that the clinical supervisor does not have access to the raw data and is not involved in coding of data to ensure that there is no breach of confidentiality in this respect.
   Risk Level: Low

5. There is a risk that the quality of data may be poor due to the quality of recordings or recording equipment. To manage this, all equipment will be tested prior to use. Risk Level: Low
6. Qualitative research can be a time-consuming endeavour and there is a risk that the project may not be completed on time, due to the volume of transcribing involved and the restricted time-limit imposed. The study may need revision if parts of the project take significantly longer than expected. Ongoing reviews of the research process and timeframe will be discussed with both supervisors on the project to address and prevent any potential obstacles.

Risk Level: Low

11 OVERSIGHT ARRANGEMENTS 11.1 INSPECTION OF RECORDS

Investigators and institutions involved in the study will permit trial related monitoring and audits on behalf of the sponsor, REC review, and regulatory inspection(s). In the event of audit or monitoring, the Investigator agrees to allow the representatives of the sponsor direct access to all study records and source documentation. In the event of regulatory inspection, the Investigator agrees to allow inspectors direct access to all study records and source documentation.

11.2 STUDY MONITORING AND AUDIT

The ACCORD Sponsor Representative will assess the study to determine if an independent risk assessment is required. If required, the independent risk assessment will be carried out by the ACCORD Quality Assurance Group to determine if an audit should be performed before/during/after the study and, if so, at what frequency.

Risk assessment, if required, will determine if audit by the ACCORD QA group is required. Should audit be required, details will be captured in an audit plan. Audit of Investigator sites, study management activities and study collaborative units, facilities and 3rd parties may be performed.

12 GOOD CLINICAL PRACTICE 12.1 ETHICAL CONDUCT

The study will be conducted in accordance with the principles of the International Conference on Harmonisation Tripartite Guideline for Good Clinical Practice (ICH GCP).

Before the study can commence, all required approvals will be obtained and any conditions of approvals will be met.

12.2 INVESTIGATOR RESPONSIBILITIES

The Investigator is responsible for the overall conduct of the study at the site and compliance with the protocol and any protocol amendments. In accordance with the principles of ICH GCP, the following areas listed in this section are also the responsibility of the Investigator. Responsibilities may be delegated to an appropriate member of study site staff.

12.2.1 Informed Consent

The Investigator is responsible for ensuring informed consent is obtained before any protocol specific procedures are carried out. The decision of a participant to participate in clinical research is voluntary and should be based on a clear understanding of what is involved.

Participants must receive adequate oral and written information – appropriate Participant Information and Informed Consent Forms will be provided. The oral explanation to the participant will be performed by the Investigator or qualified delegated person, and must cover all the elements specified in the Participant Information Sheet and Consent Form.
The participant must be given every opportunity to clarify any points they do not understand and, if necessary, ask for more information. The participant must be given sufficient time to consider the information provided. It should be emphasised that the participant may withdraw their consent to participate at any time without loss of benefits to which they otherwise would be entitled.

The participant will be informed and agree to their medical records being inspected by regulatory authorities and representatives of the sponsor(s).

The Investigator or delegated member of the trial team and the participant will sign and date the Informed Consent Form(s) to confirm that consent has been obtained. The participant will receive a copy of this document and a copy filed in the Investigator Site File (ISF) and participant’s medical notes (if applicable).

12.2.2 Study Site Staff

The Investigator must be familiar with the protocol and the study requirements. It is the Investigator’s responsibility to ensure that all staff assisting with the study are adequately informed about the protocol and their trial related duties.

12.2.3 Data Recording

The Principal Investigator is responsible for the quality of the data recorded in the CRF at each Investigator Site.

12.2.4 Investigator Documentation

• The Principal Investigator will ensure that the required documentation is available in local Investigator Site files ISFs.

12.2.5 GCP Training

For non-CTIMP (i.e. non-drug) studies all researchers are encouraged to undertake GCP training in order to understand the principles of GCP. However, this is not a mandatory requirement unless deemed so by the sponsor. GCP training status for all investigators should be indicated in their respective CVs.

12.2.6 Confidentiality

All evaluation forms, reports, and other records must be identified in a manner designed to maintain participant confidentiality. All records must be kept in a secure storage area with limited access. Clinical information will not be released without the written permission of the participant. The Investigator and study site staff involved with this study may not disclose or use for any purpose other than performance of the study, any data, record, or other unpublished information, which is confidential or identifiable, and has been disclosed to those individuals for the purpose of the study. Prior written agreement from the sponsor or its designee must be obtained for the disclosure of any said confidential information to other parties.

12.2.7 Data Protection

All Investigators and study site staff involved with this study must comply with the requirements of the appropriate data protection legislation (including the General Data Protection Regulation and Data Protection Act) with regard to the collection, storage, processing and disclosure of personal information.

Computers used to collate the data will have limited access measures via user names and passwords.

Published results will not contain any personal data and be of a form where individuals are not identified and re-identification is not likely to take place.

STUDY CONDUCT RESPONSIBILITIES 12.3 PROTOCOL AMENDMENTS
Any changes in research activity, except those necessary to remove an apparent, immediate hazard to the participant in the case of an urgent safety measure, must be reviewed and approved by the Chief Investigator.

Amendments will be submitted to a sponsor representative for review and authorisation before being submitted in writing to the appropriate REC, and local R&D for approval prior to participants being enrolled into an amended protocol.

12.4 MANAGEMENT OF PROTOCOL NON COMPLIANCE

Prospective protocol deviations, i.e. protocol waivers, will not be approved by the sponsors and therefore will not be implemented, except where necessary to eliminate an immediate hazard to study participants. If this necessitates a subsequent protocol amendment, this should be submitted to the REC, and local R&D for review and approval if appropriate.

Protocol deviations will be recorded in a protocol deviation log and logs will be submitted to the sponsors every 3 months. Each protocol violation will be reported to the sponsor within 3 days of becoming aware of the violation. All protocol deviation logs and violation forms should be emailed to QA@accord.scot

Deviations and violations are non-compliance events discovered after the event has occurred. Deviation logs will be maintained for each site in multi-centre studies. An alternative frequency of deviation log submission to the sponsors may be agreed in writing with the sponsors.

12.5 SERIOUS BREACH REQUIREMENTS

A serious breach is a breach which is likely to effect to a significant degree: (a) the safety or physical or mental integrity of the participants of the trial; or (b) the scientific value of the trial.

If a potential serious breach is identified by the Chief investigator, Principal Investigator or delegates, the co-sponsors (seriousbreach@accord.scot) must be notified within 24 hours. It is the responsibility of the co-sponsors to assess the impact of the breach on the scientific value of the trial, to determine whether the incident constitutes a serious breach and report to research ethics committees as necessary.

12.6 STUDY RECORD RETENTION

All study documentation will be kept for a minimum of 3 years from the protocol defined end of study point. When the minimum retention period has elapsed, study documentation will not be destroyed without permission from the sponsor.

12.7 END OF STUDY

The end of study is defined as the last participant’s last visit. The Investigators or the co-sponsor(s) have the right at any time to terminate the study for clinical or administrative reasons.

The end of the study will be reported to the REC, and R+D Office(s) and co-sponsors within 90 days, or 15 days if the study is terminated prematurely. The Investigators will inform participants of the premature study closure and ensure that the appropriate follow up is arranged for all participants involved. End of study notification will be reported to the co-sponsors via email to resgov@accord.scot

A summary report of the study will be provided to the REC within 1 year of the end of the study.

12.8 CONTINUATION OF TREATMENT FOLLOWING THE END OF STUDY

Detail if intervention will be continued to be provided following the end of the study. If not provide justification

12.9 INSURANCE AND INDEMNITY
The co-sponsors are responsible for ensuring proper provision has been made for insurance or indemnity to cover their liability and the liability of the Chief Investigator and staff.

The following arrangements are in place to fulfil the co-sponsors’ responsibilities:

- The Protocol has been designed by the Chief Investigator and researchers employed by the University and collaborators. The University has insurance in place (which includes no-fault compensation) for negligent harm caused by poor protocol design by the Chief Investigator and researchers employed by the University.

- Sites participating in the study will be liable for clinical negligence and other negligent harm to individuals taking part in the study and covered by the duty of care owed to them by the sites concerned. The co-sponsors require individual sites participating in the study to arrange for their own insurance or indemnity in respect of these liabilities.

- Sites which are part of the United Kingdom's National Health Service will have the benefit of NHS Indemnity.

- Sites out with the United Kingdom will be responsible for arranging their own indemnity or insurance for their participation in the study, as well as for compliance with local law applicable to their participation in the study.

13 REPORTING, PUBLICATIONS AND NOTIFICATION OF RESULTS

13.1 AUTHORSHIP POLICY

Ownership of the data arising from this study resides with the study team.
Appendix F: Ethical Approval (NHS Lothian)

Lothian NHS Board

Queen’s Medical Research Institute
47 Little France Crescent, Edinburgh, EH16 4TJ

FM/JM/approval 10th December 2021

Jessica Woeginger
Trainee Clinical Psychologist Royal Edinburgh Hospital EH10 5HL

Dear Ms Woeginger

Lothian R&D Project No: 2021/0225
Title of Research: An exploration of the experience of trauma training in Community Mental Health Team members working with traumatised and distressed patients.

Participant Information Sheet: Consent Form:

Participant Information Sheet Version 2, dated 27 November 2021
Consent Form Version 2, dated 27 November 2021

Protocol: Version 1, dated 02 October 2021
Approved Location(s) within NHS Lothian: NHS Lothian

I am pleased to inform you this letter provides Site Specific approval for NHS Lothian for the above study and you may proceed with your research, subject to the conditions below.

Please be aware that ACCORD has issued COVID-19 Clinical Research Plan and Guidance that includes instructions for restarting/commencing non-COVID-19 clinical research, and also advice on what to do if there is a requirement to halt recruitment of new participants to an active study, what to do if the study design needs to be amended or if there is a resource issue within the study team in light of the ongoing COVID-19 pandemic.

The ACCORD guidance is available on the ACCORD website;

http://www.accord.scot/about-accord/accord-news/covid19-planning-and-guidance-research-0

The guidance detailed here applies to research projects Sponsored by NHS Lothian and/or the University of Edinburgh and to NHS Lothian hosted studies until further notice.

Please note that the NHS Lothian R&D Office must be informed of any changes to the study such as amendments to the protocol, funding, recruitment, personnel or resource input required of NHS Lothian.
Substantial amendments to the protocol will require approval from the ethics committee which approved your study and the MHRA where applicable.

Lothian NHS Board

Data controllers and processors have a legal obligation to hold a register of all its information assets (e.g. personal information (data) and/or special categories of personal data held in paper or electronic format for the purpose of clinical research). This R&D management approval is given on the understanding that you, as a potential information asset owner, will register any information assets associated with this research project with your employing organisation (where the data is held) in accordance the Data Protection Act 2018.

Please keep this office informed of the following study information, which is a condition of NHS Lothian R&D Management Approval:

1. Date you are ready to begin recruitment, date of the recruitment of the first participant and the monthly recruitment figures thereafter.
2. Date the final participant is recruited and the final recruitment figures.
3. Date your study / trial is completed within NHS Lothian.

I wish you every success with your study.

Yours sincerely

Fiona McArdle

Ms Fiona McArdle Deputy R&D Director

Cc: Dr Alison Wells, Consultant Clinical Psychologist, ELCH

Lothian NHS Board

Insert 1 - Contracts

1a We note that this project includes a researcher(s) who will require a Letter of Access from NHS Lothian. The individual(s) concerned <insert names> should contact our offices with a view to applying for the necessary documentation. Please note all final paperwork will have to be signed and returned to our R&D offices before the researcher(s) can commence work on the project.

1b We note that this project includes a researcher(s) who will require an Honorary Research Contract from NHS Lothian. The individual(s) concerned <insert names> should contact our offices with a view to applying for the necessary documentation. Please note all final paperwork will have to be signed and returned to our R&D offices before the researcher(s) can commence work on the project.
Insert 2 – GCP Training

Please note that ACCORD policy for GCP & SOP Training requires you to have undertaken documented GCP training within the previous 24 months, before commencing activities with respect to the Project listed above. ACCORD policy also states that the Principal Investigator is responsible for ensuring that local research site staff members have undertaken GCP training before beginning Project specific activities.

Insert 3 – Externally Sponsored Clinical Trial of an Investigational Medicinal Product (CTIMP) or Clinical Investigation of a Medical Device (CIMD) or a clinical trial of an Advanced Therapy Investigational Medicinal Product (ATIMP) (delete as appropriate)

Please note that it is your responsibility as Principal Investigator for this externally sponsored Clinical Trial of an Investigational Medicinal Product (CTIMP) or Clinical Investigation of a Medical Device (CIMD) or a clinical trial of an Advanced Therapy Investigational Medicinal Product (ATIMP) (delete as appropriate) to maintain a record of all Serious Adverse Events (SAEs) occurring in participants you recruit to the study. You are also responsible for reviewing trial safety data sent to you by the Sponsor and it is recommended that you alert the ACCORD office if you have any concerns regarding the safety data or conduct of the trial.

Insert 4 – Participant Identification Centre Studies

We note that NHS Lothian is participating in this trial as a Participant Identification Centre (PIC).

Insert 5 – EudraCT

Insert 6 – Patient Identifiable Information & Information Governance

We note that this study has obtained Caldicott approval or approval from the Public Benefit and Privacy Panel (PBPP) and/or approval from NHS Lothian Information Governance/IT Security for those aspects of the study that involve collection and/or transfer of identifiable information (delete as appropriate). You are responsible for informing the NHS Lothian R&D Office if there are any changes to the study that impact the terms of this approval or these approvals (delete as appropriate).

Results of Clinical Trials of Investigational Medical Products (CTIMPs) must be uploaded to the European Clinical Trials Database (EudraCT) within 12 months of the ‘end of trial’ or within 6 months of the ‘end of trial’ for paediatric studies. This task is delegated to Chief Investigators of CTIMPs co-sponsored by the University of Edinburgh and NHS Lothian. Further instruction can be found at www.accord.scot or by contacting the ACCORD Office at enquiries@accord.scot.

Approval - LOT (2021.0225), 10.12.21

Final Audit Report 2021-12-10

Created: By: Status: Transaction ID:

2021-12-10
Jill McFarlane (v1mcfar@exseed.ed.ac.uk)
Signed GBJCHBCAABAGsyxkCJAlfLkWgHdJH_Gbcj_iJR

"Approval - LOT (2021.0225), 10.12.21" History

Document created by Jill McFarlane ( ) 2021-12-10 - 10:53:58 AM GMT
Document emailed to Fiona McArdle ( ) for signature 2021-12-10 - 10:54:19 AM GMT

Email viewed by Fiona McArdle ( ) 2021-12-10 - 11:25:29 AM GMT

Document e-signed by Fiona McArdle ( ) Signature Date: 2021-12-10 - 11:25:46 AM GMT - 11:25:46 AM GMT - Time Source: server

Agreement completed. 2021-12-10 - 11:25:46 AM GMT

Adobe Sign
Dear Jessica

Thank you for your email and for providing us with all the relevant documents. We have now checked that your project adheres to any University governance concerns and your application has been logged. As your project has been reviewed and received a favourable opinion by IRAS it does not require further review by the Clinical Psychology Ethics Committee database.

If you need to make any changes to the protocol these would go through the REC, but I would appreciate if you could also copy University ethics into any correspondence.

Wishing you all the best with your project.

Best wishes,

Ingrid

Ingrid Obsuth, PhD
Lecturer in Clinical Psychology
Ethics & Integrity Lead
**Appendix H: University of Edinburgh Level 1 Ethics Form**

School of Health in Social Science Research Ethics Application

The supervisor or primary investigator must complete and sign this form after checking that all relevant sections are completed, and relevant documents are attached. For all undergraduate (UG) and MSc student projects, it is the supervisor’s responsibility to submit this form and all attachments. Please note that failure to do this will result in the application being returned (and not processed) causing your research to be delayed.

<table>
<thead>
<tr>
<th>Supervisor (name and UUN)</th>
<th>Dr Rachel Happer,</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Investigator (name and UUN)</td>
<td>Jessica Woeginger,</td>
</tr>
<tr>
<td>List of all collaborators (with affiliated institutions in brackets)</td>
<td>Dr Alison Wells (NHS Lothian)</td>
</tr>
<tr>
<td>Student’s programme of study (if applicable)</td>
<td>Doctorate of Clinical Psychology</td>
</tr>
<tr>
<td>Project Title</td>
<td>An exploration of the experience of trauma training in Community Mental Health Team members working with traumatised and distressed patients.</td>
</tr>
<tr>
<td>Case Number (if known – assigned by Administrator at time of 1st submission)</td>
<td></td>
</tr>
<tr>
<td>Proposed Project Start Date</td>
<td>November 2021</td>
</tr>
<tr>
<td>Proposed Project End Date</td>
<td>September 2023</td>
</tr>
</tbody>
</table>

Please indicate whether the primary investigator on this project is staff or student and select your subject area:

- [ ] Staff
- [ ] UG or MSc Student
- [x] DClin Student
- [ ] PhD
- [ ] CPASS Studies
- [x] Clinical Psychology
- [ ] Nursing

This is a:

- [x] New application for ethical review – first submission
- [ ] Resubmission following reviewer comments
- [ ] Resubmission with requested amendments

Has been reviewed by an external ethical board, such as NHS IRAS or a UK HEI (multi-site studies only) with a favourable opinion? Level 1 *

- [x] IRAS (NHS research ethics)  
- [ ] Other: __NHS Lothian Research and Development

Please tick one option that best describes your application:

- [ ] Collecting or generating new data involving other people: Level 2
- [ ] Extracting, re-coding and analysing existing data that contains sensitive information (i.e. identifiable information): Level 2
- [ ] Analysing secondary (archival) data that is routinely collected or is an existing anonymised dataset: Level 1
Collecting new data BUT an external ethical review board (such as NHS IRAS; UK HEI – for multi-site studies; etc) has fully reviewed this project and generated a favourable opinion. Level 1

This application is complete with the following attachments (tick all that apply):

<table>
<thead>
<tr>
<th>Advert/flyer □</th>
<th>Caldicott application stating what data was requested □</th>
<th>Caldicott signed approval □</th>
<th>Consent form/s □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data collection tools (e.g. interview guides) ☒</td>
<td>Debrief with signposting ☒</td>
<td>IRAS application ☒</td>
<td>NGO or local authority letters □</td>
</tr>
<tr>
<td>Participant Information Sheet/s ☒</td>
<td>Participant Information Sheet (young person version) □</td>
<td>R&amp;D application □</td>
<td>Researcher Checklist (C-19) □</td>
</tr>
<tr>
<td>Risk assessment □</td>
<td>Standardised recruitment email □</td>
<td>Sponsorship Letter OR Email to confirm no sponsorship needed / statement explaining why sponsorship is not needed. □</td>
<td></td>
</tr>
</tbody>
</table>

Other attachments (please specify):
- Letter from East Lothian Adult Mental Health Services in support of the research

---

**To be completed by primary investigator or project supervisor**

By signing this front sheet, I confirm that I have prepared and/or reviewed this ethics application and related documents in accordance with ethical guidelines. I also confirm I have checked that all relevant sections of the application form are completed and relevant documents are attached.

Supervisor or/PI Signature:

Student signature: Jessica Woeginger

Date: 7/01/2022

---

On completion, this Word document along with the relevant attachments should be submitted to ethics.hiss@ed.ac.uk.

Note: Please note all undergraduate and MSc applications MUST been signed and submitted by the project supervisor.
<table>
<thead>
<tr>
<th>ISSUES ARISING FROM THE PROPOSAL – to be completed by Ethics Reviewer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thank you for your application. The review process has generated the following queries regarding your application. Please address the following items, and provide a note underneath each comment letting us know how you have addressed them. OR</td>
</tr>
<tr>
<td>Thank you for your application. We have completed the review process and can provide a favourable opinion.</td>
</tr>
</tbody>
</table>

| Signature: |
| Position: |
| Date: |

<table>
<thead>
<tr>
<th>APPLICANT’S SIGNATURE FOLLOWING REVISIONS – to be completed by applicant</th>
</tr>
</thead>
<tbody>
<tr>
<td>I confirm that I have addressed all of the queries generated during the ethical review process of my application. I have outlined in the box above underneath each comment how each request was addressed and/or provided further clarification.</td>
</tr>
</tbody>
</table>

| Supervisor/PI Signature: |
| Student signature: |
| Date: |

<table>
<thead>
<tr>
<th>CONCLUSION TO ETHICAL REVIEW – to be completed by Ethics Lead</th>
</tr>
</thead>
</table>
The applicant’s response to our request for further clarification or changes has now satisfied the requirements for ethical practice and the application has therefore been given a favourable opinion.

OR

Thank you for providing responses to our comments. Some outstanding questions remain:

Signature:
Position:
Date:

that a favourable opinion has been provided for this project (for example as an attachment to MSc dissertations).

NOTE: Once reviewed please include the page on which this box appears as a formal document demonstrating that favourable opinion has been provided for this project (for example as an attachment to MSc dissertations).
If you are applying for amendments to a previously reviewed and processed project, please use the below form to detail the amendments you wish to make:

<table>
<thead>
<tr>
<th>This section is to be completed for amendments only</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMENDMENT/S: REQUEST FOR APPROVAL – to be completed by applicant</td>
</tr>
</tbody>
</table>

I would like to apply for the following amendments to this previously processed project which had generated a favourable opinion:

Supervisor/PI Signature:

Student signature:

Date:

<table>
<thead>
<tr>
<th>CONCLUSION TO ETHICAL REVIEW OF AMENDMENT – to be completed by Ethics Lead</th>
</tr>
</thead>
</table>

The requested amendment satisfies the requirements for ethical practice and it has therefore received a favourable opinion.

OR

Additional information is required related to:

Signature:

Position:

Date:
NOTE: Once reviewed please include the page on which this box appears as a formal document demonstrating that favourable opinion has been provided for this project (for example as an attachment to MSc dissertations).
LEVEL 1 and 2 – Confidentiality and Handling of Data

Section 1: Introduction

External Research Ethics Approval:

Does your research project require the approval of any other institution and/or ethics committee, nationally or internationally?

Note: It is each researcher’s responsibility to check whether their project requires Sponsorship, Caldicott Approval, R&D approval, and/or IRAS (see https://www.ed.ac.uk/health/research/ethics/sponsorship-and-governance). The principal investigator is responsible for ensuring compliance with any additional ethical requirements that might apply, and/or for compliance with any additional requirements for review by external bodies.

☐ This research project does not require external ethics approval. 
OR

If you require external approval, please state the name of the review body:
☒ IRAS (NHS research ethics) ☐ Local Authority ☐ Other: ____________________________

NB: If you require external approval from IRAS/NHS/Caldicott, you must have external approval before submitting your application for School of Health in Social Science Research Ethics approval. You can only submit your application to us once external approval has been obtained, and you must include all documentation including your application to and approval of external approval as an attachment.

If you require approval from a local authority, you must first receive ethics approval from the School of Health in Social Science Research Ethics Committee, before submitting your application to the local authority.

Q1. Project summary

Please provide a brief summary of your proposed study. Do not exceed 1500 words. Our interest is in areas of your methodology where ethical issues may arise so please focus your detail on areas such as recruitment, consent, describing your participants and the nature of their involvement, and data handling.
The National Trauma Training Programme was developed by NHS Education for Scotland following an investment by the Scottish Government. There is a growing recognition of the impact of traumatic events on people and the vision of NES and the Scottish Government is to develop a trauma informed and responsive nation and workforce. One aspect of the training recognizes the importance of wellbeing within the workforce. Community Mental Health Team (CMHT) members often work with patients who may be distressed and have experienced high levels of trauma, however due to the increasing demands in their roles, little attention may be paid to CMHT members own wellbeing. Additionally, as the training programme is still fairly new, little is currently known about the impact of the training on those who partake in it.

Given the above, this study will explore the impact of the trauma training programme on CMHT members and further examine vicarious trauma in a CMHT. This study will recruit members of a CMHT working in East Lothian Adult Mental Health to participate in the research. 8-10 participants will complete Level 1 and 2 of the National Trauma Training Programme which will be delivered by expert facilitators in the training. Participants will complete a range of standard pre- and post-training evaluations. They will then be invited to semi-structured interviews, to ascertain their views on the training programme and vicarious trauma. Interviews will last approximately one hour.

Using Interpretive Phenomenological Analysis (IPA), a qualitative method of analysis which explores themes and patterns in people’s experiences, the data collected from the interviews will be analysed to gain a better understanding and explore the following:

- The impact of the trauma training on a CMHT
- The impact of vicarious trauma on a CMHT
- Whether trauma training can mitigate against the effects of vicarious trauma

Methodology:
This is an exploratory study, using a qualitative design to identify emerging themes and patterns of experiences amongst the participants. Participants will be invited to participate in the training, and here the study will be introduced. Potential participants will be able to express an interest in partaking in the study and all will be given the participant information sheet. Here, participants will complete pre-training questionnaires, demographic details and then attend National Trauma Training Programme (Level 1&2), followed by post-training evaluations. Participants who are interested in the study will be contacted to answer any questions they may have and gain informed consent to participate. Data collection will be done through semi-structured interviews with members of the CMHT. An interview agenda has been developed by the researcher, with a bottom-up, participant-led format (Willig, 2008). The interview agenda will be flexible, allowing for new and emerging themes to be explored. Post-training evaluations will also be administered.

Ethical Considerations
Prior to the commencement of data collection, the researcher will ensure that participants recruited are fully informed about the research content and procedure. Information sheets outlining the purpose of the study and what will be involved will be given to all participants prior to any commencement of research. Participants will be informed that their contribution is voluntary, and they are able to withdraw from the study at any point, including after data collection. Participants will be further informed of confidentiality within the research, including limits of this i.e. if any safeguarding concerns are raised.
Following data collection, participants will be fully debriefed on the research and provided with appropriate support helplines should they need it.

Data will be kept in a secure and confidential online space, provided through the University of Edinburgh/NHS Lothian software platforms.

Participants/Recruitment
Participants in this study will be derived from an already established CMHT in East Lothian Adult Mental Health Services. The CMHT is made up on Community Mental Health Nurses, Occupational Therapists, Support Workers, Psychiatrists and Art Therapists. All members of the team will be invited to participate in the research and attend the training (the two of which are not mutually exclusive – i.e. participants can attend training without being part of the research project). Participants will hold their own case load of patients who are all experiencing some level of mental health care and treatment. Recruitment will take place over one month to identify suitable participants. Eight-ten participants will be recruited from the CMHT.

Intervention
Levels 1&2 of the National Trauma Training Programme will be the intervention provided in this study. Level 1&2 focus on an introduction to trauma, its impact and then subsequent safety and stabilisation when working with those with trauma, resulting in ‘trauma-skilled’ practitioners. The training can either be provided face-to-face or in an online setting (Covid-19 dependent and flexible) and is likely to be delivered in one full day or two half-day blocks depending on team availability.

Procedure
Following ethical approval, participants will be invited to attend the Trauma Training Programme which will be delivered by members of the Psychological Therapies Team. Covid dependent, this training will be delivered in either a face-to-face setting or over an online platform – both of which are viable options. Before training begins, participants will be instructed to complete the battery of measures which includes the demographic data and pre-training questionnaires. The training will then be delivered to the CMHT, with time given at the end of training for participants to complete the training evaluation questionnaires. This is routine data. Potential participants will be given the participant information sheet and will be able to express an interest in participating in the research. They will then be contacted after at least 24 hours to answer any questions they may have about the research and gain consent to participate.

Following gaining fully informed consent, participants will be invited to take part in a semi-structured interview, within twelve weeks of completing the training. Some set questions will be present during the interview, and follow-up unstructured questions will also be present. This will allow for a more spontaneous exploration of some topics. Interviews will last for approximately 45minutes-60minutes and will be recorded on an encrypted device. The interviews will then be transcribed in line with ethical approval and using encrypted software. On completion of the interview, participants will be thanked for their participation in the research and provided with relevant debrief sheets about the research and contact details should they wish to withdraw their data.

Analysis
Analysis will take place using Interpretive Phenomenological Analysis (IPA) to explore any themes that are present and draw conclusions from the research. The demographic data and training questionnaires will also be presented.
Q2. Will you collect or use NHS data?
☒ Yes ☐ No
If “yes” – what NHS data will you collect or use?
The study will focus on NHS staff members and collect their experiences of the trauma training and vicarious trauma resulting from their work.

Q3. What information about participants/data subjects will you collect and/or use?

Routine descriptive data will be collected:
- Age
- Job role
- Years in profession
- Gender
- Ethnicity

Semi-structured Interviews
The interviews will be conducted conversationally, with one respondent at a time, employing a blend of closed- and open-ended questions. Follow up ‘why’ or ‘how’ questions will also accompany the set interview questions. Interviews will last for approximately one hour to minimise fatigue for both interviewer and respondent (Adams, 2015). The interviews will be used to assess the impact of the training and further understand the role of vicarious trauma in this. 10 questions will be asked and are attached within the Interview agenda.

The semi-structured interview guide for primary care (DeJonkheere & Vaughn, 2018) will be followed, emphasising the importance of open-ended questions, collaborative discussion following set questions and active listening to respond to replies.
Q4. What training will staff who have access to the data receive on their responsibilities for its safe handling? Have all staff and students who have access completed the mandatory data protection training on the self-enrolment page of Learn?

The two supervisors of this study are both competent and experienced researchers governed by the University of Edinburgh and NHS Lothian.

Mandatory data protection training has been completed by all those involved in the project.

Q5. Will the information include special categories of personal data (health data, data relating to race or ethnicity, to political opinions or religious beliefs, trade union membership, criminal convictions, sexual orientations, genetic data and biometric data)?

☐ Yes ☒ No

If “yes” – Explain what safeguards e.g. technical or organisational you have in place; including any detailed protocols if this requires special and/or external processing, storage, and analysis.

Q6. Please indicate how your research is in the public interest:

☒ Your research is proportionate
☐ Your research is subject to a governance framework
☐ Research Ethics Committee (REC) review (does not have to be a European REC)
☐ Peer review from a funder
☐ Confidentiality Advisory Group (CAG) recommendation for support in England and Wales or support by the Public Benefit and Privacy Panel (PBPP) for Health and Social Care in Scotland
☐ Other
Q7. It is essential that you identify, and list all risks to the privacy of research participants. You will then need to consider the likelihood of the risks actually manifesting and the severity of harm if the risks actually manifest.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Likelihood of risk manifesting</th>
<th>Severity of harm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Remote</td>
<td>Possible</td>
</tr>
<tr>
<td>Identifiable due to data linkage</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Identifiable due to low participant numbers</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Identifiable due to geographical location</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Identifiable due to transfer of data</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Identifiable due to access of data</td>
<td>☒</td>
<td>☐</td>
</tr>
</tbody>
</table>

Please use this text box to record any other risks and the likelihood of them occurring, along with the severity of harm. Please also use this when dealing with secondary data.

1. The focus on vicarious trauma may be potentially distressing and trigger adverse reactions in some participants. Prior to the interviews, participants will be provided with an information sheet, outlining the purpose of the study and the topics that will be discussed during the interviews. To ensure the research is safe, the interview agenda will consist of open-ended questions and participants will be encouraged to only share what they are comfortable with. As with the nature of semi-structured interviews, the interviews will be collaborative in nature and guided by the information provided. Following the research and the interviews, participants will be given the opportunity to debrief where they will be able to discuss any distress they may have felt. Participants will also be given a debrief sheet and reminded that they can withdraw from the study at any point. There is also a staff-specific helpline and therapy service within NHS Lothian which is available to all staff and provides a confidential and safe place for staff to receive support. Staff members will be given all of the information for this service should they require access to it.
   Risk Level: Low

2. Given the qualitative nature of the study and small sample size, there is a risk of a breach of confidentiality and participants being identified through direct quotes. Participants will be fully informed that there is this risk in the information and informed consent sheet, and this will be further reiterated at the commencement of the interview. For data transcription and write-up, participants will be given a pseudonym and any identifiable information will be extracted. Great care will be taken in this process by the researcher and data will be coded at the earliest possible and stored on a secure platform. Participants will also be reminded of their right to fully withdraw their data from the study at any point, including after they have taken part in their interview. Additionally, given that the Clinical Supervisor within this research is indirectly connected to the CMHT, steps will be taken to ensure that the clinical supervisor does not have access to the raw data and is not involved in coding of data to ensure that there is no breach of confidentiality in this respect.
   Risk Level: Low
3. There is a risk that the quality of data may be poor due to the quality of recordings or recording equipment. To manage this, all equipment will be tested prior to use.
   Risk Level: Low

4. Qualitative research can be a time-consuming endeavour and there is a risk that the project may not be completed on time, due to the volume of transcribing involved and the restricted time-limit imposed. The study may need revision if parts of the project take significantly longer than expected. Ongoing reviews of the research process and timeframe will be discussed with both supervisors on the project to address and prevent any potential obstacles.
   Risk Level: Low

Please identify measures you could take to reduce or eliminate risks identified as possible/significant or probable/severe.

Given the qualitative nature of the study and small sample size, there is a risk of a breach of confidentiality and participants being identified through direct quotes. Participants will be fully informed that there is this risk in the information and informed consent sheet, and this will be further reiterated at the commencement of the interview. For data transcription and write-up, participants will be given a pseudonym and any identifiable information will be extracted. Great care will be taken in this process by the researcher and data will be coded at the earliest possible and stored on a secure platform. Participants will also be reminded of their right to fully withdraw their data from the study at any point, including after they have taken part in their interview. Additionally, given that the Clinical Supervisor within this research is indirectly connected to the CMHT, steps will be taken to ensure that the clinical supervisor does not have access to the raw data and is not involved in coding of data to ensure that there is no breach of confidentiality in this respect.

Q8. Will information containing personal, identifiable data be transferred to, shared with, supported by, or otherwise available to third parties outside the University?

☐ Yes  ☒ No

If “yes” - Please explain why this necessary and how the transfer of the information will be made secure. If the third party is based outside the European Economic Area please obtain guidance from the Data Protection Officer.

Q9. Other than the use by third parties, will the data be used, accessed or stored away from University premises?

☒ Yes  ☐ No

If “yes” - Describe the arrangements you have put in place to safeguard the data from accidental or deliberate access, amendment or deletion when it is not on University premises, including when it is in transit, and (where applicable) it is transferred outside the EEA.
Some data (consent forms, descriptive data) will be stored on NHS Lothian premises in a locked filing cabinet, in a locked office at the East Lothian Community Hospital. The office in the hospital is accessible to those who work in East Lothian Mental Health Services, however, only the researcher and team lead of the East Lothian Psychological Therapies Team will have access to a key to unlock the filing cabinet.

Q10. Will feedback of findings be given to your research project participants or data subjects?

☑ Yes  ☐ No

*If “yes” - How and when will this feedback be provided?*

An easy-read summary of the study will be made available to all participants if they so wish.

*If “no” - Please provide rationale for this.*

---

Q11. How do you intend to use/disseminate the results of your research project?

The study will be written up in the format of a doctoral thesis and will include a systematic review of the relevant literature. Together, these will be submitted in partial fulfilment to the Doctorate in Clinical Psychology course at the University of Edinburgh.

The results of the study will be disseminated across NHS Lothian including within the team who completed the research and to the Trauma Training Champions within the health-board. Additionally, the results will be further disseminated to NHS Education for Scotland who developed the training programme. Dissemination will take place via written papers and presentations.

The systematic review and research project will be prepared for the submission to a relevant academic journal, with an aim to disseminate the research to a wider audience. Both the clinical supervisor and academic supervisor will be involved in the identification of a suitable academic journal.
Section 2: Security-sensitive material

The Terrorism Act (2006) outlaws the dissemination of records, statements and other documents that can be interpreted as promoting or endorsing terrorist acts.

Q12. Does your research involve the storage on a computer of any such records, statements or other documents?
☐ Yes ☒ No (if you answered no to this question please jump to section 3)

If “yes” - Please type 'Yes' to indicate that you agree to store all documents on that file store

Q13. Might your research involve the electronic transmission (for example, as an email attachment) of such records or statements?
☐ Yes ☒ No

If “yes” - Please type ‘Yes’ to indicate that you agree not to transmit electronically to any third party documents stored in the file store

Q14. Will your research involve visits to websites that might be associated with extremist, or terrorist, organisations?
☐ Yes ☒ No

If “no”, please proceed to Question 15.

If “yes” - You are advised that such sites may be subject to surveillance by the police. Accessing those sites from University IP addresses might lead to police enquiries. Please type ‘Yes’ to acknowledge that you understand this risk

By submitting to the ethics process, you accept that your School Research Ethics Officer and the convener of the University’s Compliance Group will have access to a list of titles of documents (but not the contents of documents) in your document store. Please type ‘Yes’ to acknowledge that you accept this.

Please confirm that you have contacted your School Research Ethics Officer to discuss security-sensitive material by ticking ‘Yes’

☐ Yes, I have contacted my School’s Research Ethics Officer
☐ No, I have not contacted my School’s Research Ethics Officer
Q15. Does your project require use of copyrighted material?

☐ Yes  ☒ No

*If “yes” please give further details*
Section 4: Good conduct in collaborative research

Q16. Does your project involve working collaboratively with other academic partners?
☒ Yes ☐ No (if you answered no to this question please jump to section 5)

If “yes” - Is there a formal agreement in place regarding a collaborative relationship with the academic partner(s)?

This research is being conducted in line with the aims and agreements of NHS Lothian.

If “no” - Please explain why there is no formal agreement in place.

Q17. Does your project involve working collaboratively with other non-academic partners?
☐ Yes ☒ No

If “yes” - Is there a formal agreement in place regarding a collaborative relationship with the non-academic partner(s)?

If “no” - Please explain why there is no formal agreement in place.

Q18. Does your project involve employing local field assistants (including guides/translators)?
☐ Yes ☒ No

If “yes” - Is there a formal agreement in place regarding the employment of local field assistants (including guides and translators)?

If “no” - Please explain why there is no formal agreement in place.

Q19. Will care be taken to ensure that all individuals involved in implementing the research adhere to the ethical and research integrity standards set by the University of Edinburgh?
☒ Yes ☐ No

If “no” - Please explain why care will not be taken.
Q20. Have you reached agreement relating to intellectual property?

☒ Yes  ☐ No

*If “no” - Please explain why you have not reached agreement*
Section 5: Good conduct in publication practice

In publication and authorship, as in all other aspects of research, researchers are expected to follow the University’s guidance on integrity. https://www.ed.ac.uk/governance-strategic-planning/content-to-be-removed/research-integrity. By ticking yes, you confirm that full consideration of the items described in this Section will be addressed as applicable.

☒ Yes  ☐ No

If you intend to collect new data, please continue completing the Level 2 application in the next page.

If you are NOT collecting any new data, you have now completed the Level 1 application. Please submit this document alongside all attachments to ethics.hiss@ed.ac.uk.
Appendix I: Training Poster

NES Trauma Training Level 2

Alison Wells, Dot Hansen and Jess Woeginger will be delivering two slots of the Trauma Training.

Date: Thursday 24th February and Thursday 7th April
Time: 11.45am-2.30pm

The training will be delivered from the Community Hall at ELCH with a live Teams link, so you are able to attend in person or remotely.

If you would like to book a place, please email Caitlin Meecham, if you have any questions please contact Dot or Alison.
Appendix J: Participant Information Sheet

An exploration of the experience of trauma training in Community Mental Health Team members working with traumatised and distressed patients.

Participant Information

You are being invited to take part in a research study exploring the experiences of Community Mental Health Team members working with traumatised and distressed patients. Jessica Woeginger, at The University of Edinburgh is leading this research, under the supervision of Dr Rachel Happer and Dr Alison Wells. Before you decide to take part, it is important that you understand why the research is being conducted and what it will involve. Please take the time to read the following information carefully.

What is the purpose of the study?

Working with traumatised and distressed patients is known to be personally and relationally demanding (Staub and Vollhardt, 2008) and the risk of vicarious traumatisation, burn-out and compassion fatigue is higher in those working with complex trauma patients (Chouliara et al., 2009) than those who are not exposed to this client group. This however, has not been studied in Community Mental Health Team’s, who are an under-represented group within research. With the introduction of the national trauma training programme across Scotland, it is hypothesised that the training can help to protect staff against vicarious trauma.

This research will therefore look to address these gaps in the research and explore the impact of the National Trauma Training Programme on CMHT members. It will further attempt to explore the role of vicarious trauma on CMHT members and whether the training can help to mitigate against vicarious trauma.

Why have I been invited to take part?

You have been invited to take part in the research as you are a member of a Community Mental Health Team who has participated in the Trauma Training.

Do I have to take part?

No – it is entirely up to you. If you do decide to take part, you are still free to withdraw at any time and without giving a reason. Please note down your participant number and provide this to the lead researcher if you seek to withdraw from the study at a later date. Deciding not to take part or withdrawing from the study will not affect your employment now or in the future.

Please note, once data has been anonymised (01/2023), it will not be possible to withdraw your data.
What will happen if I decide to take part?

For this piece of research, all participants must have attended the Trauma Training in advance of the interviews being conducted.

Before the interview, the researcher will tell you more about the research procedure and answer any questions you may have. You will be asked to give your consent to participating in the study by reading and signing a consent form provided. Your consent form can be returned via email or in person.

The interview can either take place in a face-to-face setting, or via a video call using MS Teams, at a time that is convenient for you. You can choose to turn off your camera if you would like to and if you are participating via a video call, this should be in a quiet, private area. The interview should take around 30-60 minutes to complete. On the day of the interview, you will be asked to give further verbal consent to participate in the study. The interview will ask about your experience of the trauma training, the impact of this training and any vicarious trauma you have experienced as a result of your work. You can take a break from the interview at any point if needed. With your consent, the interview will be audio recorded.

What are the benefits of taking part?

There are no direct benefits to taking part in the research. However, CMHT’s are an under-represented group within research and by contributing to this study, you will help the University to better understand the impact of working with distressed and traumatised patients and the impact of the trauma training.

Are there any potential risks in taking part?

The risks of this study have been deemed as ‘low’ and there are no significant risks associated with the research. However, some participants may find that discussing their personal experiences of vicarious trauma to be potentially distressing. If, during or following the interview, you feel distressed you will initially be offered support from the main researcher e.g. by taking a break from the interview. In the unlikely event that the distress continues, the interview will be terminated. If needed, you will be encouraged to contact the relevant services e.g. GP, Staff wellbeing helpline for further support following the interview. Please find some contact details below for support organisations.

Following the interview, you will be given a debrief sheet.

NHS National Staff Wellbeing Line: 0800 111 4191
Samaritans: 116 123
Mind: 0300 123 3393

If any information is shared during the contact with the researcher that suggests you, a child or another adult is at significant risk of harm, the researcher has a duty to report this.

What if I want to withdraw from the interview?

You are able to withdraw from the research at any point and agreeing to participate in the study does not oblige you to remain in the study. If at any stage you no longer wish to be part of the study,
then please inform the lead researcher, Jessica Woeginger on __________________________. If you wish to withdraw, you are advised to contact the researcher at the earliest opportunity as your data may be used in the production of formal outputs i.e. in journal articles, thesis etc. On specific requests, we will destroy all your identifiable answers, however we will need to maintain our records of your initial consent to participate.

Will my taking part be kept confidential?

All the information we collect during the course of the research will be kept confidential and there are strict laws which safeguard your privacy at every stage.

How will we use information about you?

We will need to use information from you for this research project.

This information will include: your name, contact details, job role, years in the profession. People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are and will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

If you consent to being audio recorded, all recordings will be destroyed once they have been transcribed. Your data will only be viewed by the research team. All electronic data will be stored on a password-protected computer file and all paper records will be stored in a locked filing cabinet.

Your consent information will be kept separately from your responses in order to minimise risk.

Once we have finished the study, we will keep some of the data so we can check the results. We will write out reports in a way that no-one can work out that you took part in the study.

What are your choices about your how you information is used?

- You can stop being part of the study at any time, without giving a reason and you can withdraw your data at any point.
- We need to manage your records in specific ways for the research to be reliable. This means that we wont be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information at: https://www.ed.ac.uk/records-management/privacy-notice-research, or by asking one of the research team.

The University of Edinburgh and NHS Lothian are the sponsors for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Edinburgh will destroy identifiable information about you within six months of your participation. The anonymised data may be used in future ethically approved research.

What will happen with the results of this study?
This study will be written up in the form of a doctoral thesis and further journal articles and presentations may be published. Quotes and key findings will always be made anonymous and with your consent, information may also be kept for future research. The finding of the study will also likely be shared with relevant organisation e.g. NHS Education for Scotland, NHS Lothian.

A summary of the research project and its findings will be made available in an accessible format to you. Should you wish to receive a copy of this, you will need to provide the researcher with an email address to send this to.

Who is organising and funding the research?

The research is being sponsored by The University of Edinburgh and NHS Lothian and the main organiser of the research is Jessica Woeginger, trainee Clinical Psychologist on the Doctorate of Clinical Psychology.

Who has reviewed the study?

A favourable ethical opinion has been obtained from the Ethics Committee in the School of Health and Social Science from The University of Edinburgh. NHS Management Approval has also been given.

Who can I contact?

If you have further questions about the study please contact the leader research, Jessica Woeginger by email:

The study is being supervised by Dr Rachel Happer at the School of Health in Social Science, The University of Edinburgh. Dr Happer may be contacted on

The study is being clinically supervised by Dr Alison Wells, NHS Lothian who may be contacted on

Should you wish to contact someone independent of this research, about this study, please contact Dr Helen Griffiths, Programme Director on

If you wish to make a complaint about this study, please contact the Research Governance Team on cahss.researchmisconduct@ed.ac.uk and in your communications, please provide the study title and nature of your complaint.
Appendix K: Participant Consent Form

An exploration of the experience of trauma training in Community Mental Health Team members working with traumatised and distressed patients.

Participant consent form

Study title: An exploration of the experience of trauma training in Community Mental Health Team members working with traumatised and distressed patients

1. I confirm that I have read and understood the Participant Information Sheet (Version 2, 27/11/2021) for the above study

2. I have been given the opportunity to consider the information provided, ask questions, and have had these questions answered to my satisfaction.

3. I understand that my participation is voluntary and that I can withdraw at any point without giving a reason and without my employment or legal rights being affected.

4. I consent to my name, professional role, contact details and years in my profession being collected. I understand that this information will be anonymised for the purpose of the research.

5. I agree to my interview being audio recorded for subsequent transcription and understand it will be deleted once transcribed and anonymised.

6. I understand that my anonymised study data and interview transcript will be stored for a minimum of five years and may be used in future ethically approved research studies.

7. I understand that relevant sections of my data collected during the study may be looked at by individuals from the Sponsors (University of Edinburgh and NHS Lothian), where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.

Name (please print) _____________________________

Signature _____________________________ Date _____________
Appendix L: Interview Agenda

An exploration of the experience of trauma training in Community Mental Health Team members working with traumatised and distressed patients.

Hi,

My name is Jessica Woeginger and I’m the lead researcher for the project looking at the impact of the trauma training you took part in and vicarious trauma on staff members wellbeing.

Thanks for completing the consent form, to take part, however I am aware that some time has passed since you filled the form out and this interview today. With that in mind, do you still wish to take part in today's interview?

If yes, continue, if No debrief participant.

I thought it might be useful to recap what the purpose of the research is and the structure of today’s interview.

As the participant information sheet outlined, today’s interview will seek to understand the impact of the trauma training that you attended in XXX (enter month) and also the impact of working with distressed and traumatised patients on your own wellbeing.

There will be a total of 10 questions, and I may ask you some further prompts to allow you to share your answers in greater depth. The interview itself is likely to last around 60 minutes so please ensure you are comfortable. However, you can withdraw from this interview at any point without any consequences. You are also welcome to take breaks during the interview, just let me know if you need one.

At the end of the interview, there is some time I’ve put aside to debrief and discuss anything you may have found distressing.

There are no right or wrong answers for the interview and I am interested in hearing openly and honestly from you. As mentioned in the consent form, the interview will be audio recorded.

Before we start, do you have any questions?

If yes, answer questions and if no, proceed to question 1.
Questions

1. Could you tell me about your experience of the trauma training?
Prompts: What was the training like? Does the training feel beneficial to a CMHT?

2. Have you noticed any changes in your practice since completing the training? If so, what changes have you noticed?
Prompts: why do you think the changes occurred? When did you first notice the changes?

3. Have you noticed any changes within yourself since completing the training? If so, what changes have you noticed?
Prompts: why do you think the changes occurred? When did you first notice the changes?

4. What is your experience of working with distressed and traumatised clients?
Prompts: How do you manage working with this patient group? Is there anything you enjoy? Is there anything that you find difficult?

5. How, if at all, does working with distressed and traumatised patients impact on you?
Prompts: Is this more so than your regular routine work? Do you often think about your patients outside of work? Have you ever felt close to or experienced burn-out?

6. Have you ever felt that your work impacts on your home life?
Prompts: Are you able to tell me how? Do you often take your work home? Are you able to spot the signs if work is impacting heavily on you?

7. Do you have any experience of flashbacks or intrusive memories about your patients?
Prompts: Do reminders of your work with patients upset you? Have you ever had trouble sleeping or experienced night-mares? What has helped in dealing with this?

8. What coping skills do you think that other CMHT members would consider as important that may have helped your own wellbeing?

9. How do you recognise stress?

10. If at all, what kind of self-care do you engage in?
Prompts: Has this changed since completing the training?

11. Do you feel supported by your team and the wider organisation?
Prompts: Do you have access to regular supervision/debriefs? Is there a culture of self-care? If so, can you say more about that? Do you feel you wellbeing is prioritised at work?

Closing question
Is there anything else you would like to discuss that has not already been covered?

Thank you very much for taking part in this interview
Appendix M: Debrief Form

Thank you for your time and participation in this study.

The present study aims to explore the experiences of community mental health team members experiences of trauma training and vicarious trauma they may have experienced through working with distressed and traumatised patients.

During the interview, you were asked some questions relating to the trauma training which you participated in between February 2022-April 2022. You were then asked further questions about the impact of working with distressed and traumatised patients and invited to share your experiences of this. We greatly appreciate your contribution to this study and we appreciate that talking about trauma-related topics may be sensitive and potentially distressing for some participants.

If the interview, or other aspects of the study has made you feel distressed and you would like to talk to someone about this, please contact your GP. You may also contact one of the following agencies for support:

NHS National Staff Wellbeing Line: 0800 111 4191
Samaritans: 116 123
Mind: 0300 123 3393

- **NHS National Wellbeing Phone Line** is a staff support line providing emotional and wellbeing support to NHS staff. You can contact this line on 0800 111 4191

- **Samaritans** is a 24-hour confidential phoneline offering emotions support for anyone struggling to cope. You can contact the Samaritans on 116 123

- **Mind** provides advice and support to empower anyone experiencing a mental health problem. They campaign to improve services, raise awareness and promote understanding. You can contact Mind on 0300 123 3393 or visit their website www.mind.org.uk

- **Breathing Space** is a confidential phoneline for anyone aged 16 or above, who experiences low mood, anxiety, or depression. Tel: 0800 83 85 87
- **Counselling Directory** helps connect people, who need emotional support, with a qualified counsellor or psychotherapist in their local area: [https://www.counselling-directory.org.uk/](https://www.counselling-directory.org.uk/)

- **NHS 24** provides urgent health advice out of hours, when your GP practice is closed: call 111.

Once again, thank you for your participation.

Jessica Woeginger  
Lead Researcher
## Appendix N: Example Transcripts (Personal Experiential Themes)

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1. **Could you tell me about your experience of the trauma training?**
   - Prompts: What was the training like? Does the training feel beneficial to a CMHT?
   - Yeah so, trying to think back but I suppose but yeah I thought it was a good introductory training as well and there was quite a mixture of people there and I think its good for everybody to have that awareness, from admin staff who are taking a lot of our phone calls, to support workers and so forth. A lot of what I took from that was about your approach and in terms of how it is everybody’s responsibility and regardless of our title or our role its about giving people choice and being open and honest. I liked quite a lot of the examples, from what I remember, there was also discussion around different forms of abuse and kinda trauma and a bit of discussion I think about complex PTSD. Umm. And also as professionals that when we are working with people who have these histories and generally people on our caseload have and how we also cope with working in this environment and what support is in place for us in general. So yeah, I found it to be an interesting training and yeah, I guess strikes me in reflectiveness where there can be differences in what you can put in place because I guess a lot of service pressures or staff shortages makes things a lot more difficult unfortunately.

   - **Training to the right level for you:** umm, I think, generally I felt like I had some of the knowledge maybe beforehand, I was with another colleague who came along and he is a brand new graduate, and never had much mental health experience and I think he found it helpful. So I think it was comforting and reassuring to have the training but I wondered if there were some other elements that I should maybe have been aware of or maybe more advanced training but I guess I don’t know.

2. **Changes in how you approach your staff?** I think in general, we have. Yeah, it would be difficult to pin it on the training but I think in general people are much more aware as to what’s going on outside of work and I guess that whole wellbeing agenda ties into it as well. I think Covid in general has made us much more aware of stuff that goes on outside of work, but it certainly adds into that and links it and helps you bare things in mind.

   - Impact of covid

3. **Barriers implementing TiC** Just time and umm, time and staffing problems and I am a little bit concerned about what I’ve heard about it being rolled out elsewhere because I’ve heard that some people have just been sent videos and some people have been sent bits to read you know. I think having people in a room and presenting the training is what is key to making sure that everybody understands and gets on the same page with it. I’m aware that other teams within the council have been, they seem to be turning into a ticky box exercise whereas for me I think its essential that people are turning up and joining in. so it’s putting words into actions, it’s not just remaining as a tick box for teams. It’s a disparity of who gets what and the way it’s been done. But time, space availability all of these things it’s the level of prioritisation. It’s the screaming barriers its how high up the list people are putting it.

   - Staff shortages and service pressures

   - Words into actions and not just doing it because it’s the ‘done thing’

   - How much is it prioritised elsewhere in the partnership?

3. **Have you noticed any changes within yourself since completing the training?** if so, what changes have you noticed?
   - Prompts: why do you think the changes occurred? When did you first notice the changes?

   - More training needed
### Appendix O: Personal Experiential Theme Table and Example IPA Process

| Interview 1 | Time-gap of training – how it is implemented and sustained  
|            | Staff Shortages  
|            | Service Pressures  
|            | Prior Trauma informed practice influencing work - minimising training need?  
|            | Expectation within role to get on with this work and not be affected.  
|            | Role of Covid  
|            | Connection as a protective factor  
|            | Connection with team / mutual understanding of staff support?  
|            | Team supports  
|            | Valued in work as protective factor?  
|            | Vulnerability of work  

| Interview 2 | Questioning of role/self  
|            | Importance of training  
|            | Training matching expectations / job role  
|            | Theory to practice  
|            | Normalising of trauma experiences  
|            | Personal triggers in work  
|            | Constant trauma exposure  
|            | Staff shortages  
|            | Hard work  
|            | Use of MDT  
|            | Impact of this work – physical, emotional, social  
|            | Burn-out  
|            | High stress  
|            | Enduring / Persevering  
|            | Trouble Sleeping  
|            | Expectations of the job  
|            | Cut off / different from other industries  
|            | Anger at the system  
|            | Letting down patients / duty of care / personal responsibility  

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<tr>
<th>Interview 8</th>
<th>Impact of Covid</th>
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<tbody>
<tr>
<td></td>
<td>Current social context of NHS / Service demands and pressures</td>
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<td>Teamwork makes dreamwork</td>
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<td>work-life balance</td>
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<td>Getting ill from stress</td>
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<td>Wellbeing vs pressure of the job – priorities</td>
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<td>Short – staffed</td>
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<td>Trouble sleeping</td>
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<td>Impact of Covid</td>
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<td></td>
<td>Lack of awareness/understanding of role from others (family and friends) ?</td>
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<td>Not taking entitled leave / breaks because of pressures</td>
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<td>Fear of the system coming under more pressure</td>
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<td>- How will it/we cope?</td>
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<td>Good use of MDT</td>
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<td>Interview 9</td>
<td>Impact of covid</td>
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<td>Deeper understanding from training</td>
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<td>New learning from training</td>
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<td>TIC in practice</td>
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<td>Connecting the dots in TIC</td>
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<td>Role identification ‘ I’m just a ..x..’</td>
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<td>Teamwork makes dreamwork</td>
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<td>deskilled in pandemic – shift in working ways</td>
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<td>Risk in job – expected?</td>
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<td>Home-work boundaries important</td>
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<td>Staff turnover and service pressures</td>
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<tr>
<th>Interview 10</th>
<th>Training levels the playing field – everyone has same basic knowledge</th>
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<tbody>
<tr>
<td></td>
<td>Implementation of TIC – hard at times</td>
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<td>Staff shortages</td>
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<td>Service Pressures</td>
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<td>Words into action – actually implementing TIC and culture shift</td>
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<td>Changing attitudes towards trauma</td>
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<td>Service limitations in person centred care</td>
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<td>Passion for work</td>
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<td>NHS Pressures – letting patients down</td>
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<td>Medical vs psychosocial model in TIC</td>
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<td>Interview 11</td>
<td>Useful resources</td>
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<td>Identification of realm of TIC</td>
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<td>Work can be overwhelming</td>
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<td>Teamwork makes dreamwork</td>
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<td>Need for quality supervision</td>
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<td>High work load – expected to keep going?</td>
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<td>MDT vital</td>
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<td>Work-home balance skewed</td>
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<td>Burn-out</td>
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<td>Pride in work – sustaining</td>
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<td>Therapeutic relationship</td>
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<td>Stress impact</td>
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<td>Sleep difficulties</td>
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<td>Disconnect from wider organisation</td>
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<td>NHS Pressures</td>
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<td>Fear of change/things getting worse?</td>
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