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Research Portfolio:

The 'Shadow' Side of Healthcare: An exploration of Workplace Bullying and the Paradox of Trauma-Informed Care using Thematic Synthesis and Interpretative Phenomenological Analysis

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Doctorate in Clinical Psychology

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Submitted in part fulfilment of the degree of Doctorate in Clinical Psychology at the University of Edinburgh, October 2023

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Title of Work: The 'Shadow' Side of Healthcare: An exploration of Workplace Bullying and the Paradox of Trauma-Informed Care using Thematic Synthesis and Interpretative Phenomenological Analysis.

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Glossary of Terms, Acronyms, and Abbreviations

Acronym/Abbreviation	Term
ECHCP*	Early career healthcare professionals
HCP	Healthcare professionals
IPA	Interpretative phenomenological analysis
TS	Thematic Synthesis
TIC	Trauma-Informed Care
TIP	Trauma-Informed Practice
WPB	Workplace bullying

*Please note that the term ‘early career healthcare professional’ (ECHCP) will be used throughout Chapter 1 (Systematic Review) to refer to students, trainees, junior, and newly qualified healthcare professionals. These terms will be used interchangeably throughout the study, depending on which participant/study is being referred to.

Lay Summary

In recent years, there has been growing awareness of the negative effects of complex trauma on victims and survivors. This has led to the development of trauma-informed care (TIC), a framework which aims to promote care practices that are sensitive and responsive to the needs of trauma survivors, and thus a safer and higher standard of care for this population. TIC is underpinned by the principles of safety, collaboration, trust, choice, and empowerment. The National Trauma Training Programme in Scotland (NHS Education for Scotland [NES], 2016) aims to promote a safer, more compassionate healthcare organisation for all stakeholders. This includes the development of a positive workplace culture, with a greater emphasis on staff wellbeing and supportive relationships in work (e.g., supervision, as part of an MDT).

Despite widespread attention given to the implementation of TIC in policy and guidelines, this has not yet been fully translated into clinical practice, or sufficiently explored through research. The researcher also noticed that despite the shift towards TIC and improved staff wellbeing, harmful care practices continue to exist, as well as issues relating to problematic power dynamics and workplace bullying in healthcare, as observed anecdotally and in the academic literature. The overarching objective of this research was therefore to explore the dialectic between these two diametrically opposed cultures and how these have simultaneously transpired. In other words, the researcher was interested in how, at a time when healthcare services are supposed to be more trauma-informed and focused on staff wellbeing, there is a crisis of workplace bullying and harassment, which seem to be at an all-time high. To the researcher's knowledge, there are no known studies that have explored how these two paradoxical cultures, workplace bullying and TIC, have simultaneously come to be and co-habit the healthcare system. The researcher aimed to examine these issues from the perspective of staff working in such a polarised and fragmented workforce, with the first study looking at the experience of victims/survivors of WPB and the second exploring staff views on the implementation of TIC.

Chapter one provides a review of 12 qualitative studies on early career healthcare professionals' (ECHCPs') experiences of workplace bullying in the UK. Participants revealed the extreme severity, extent, and pervasive effects of workplace bullying in healthcare, in particular the detrimental impacts on victims' mental health and patient safety. Bullying was seen to be maintained over time by perpetrators, many of whom were in leadership and supervisory roles, abusing their positions of power and hierarchical status. Victims were reluctant to report bullying for due to the futility of doing so ('no point – nothing will happen'), fear of repercussions (e.g., bullying getting worse, professional 'blacklisting'), and a lack of accessible, anonymous reporting systems. As This resulted in a 'culture of silence', in terms of victims being 'silenced', but also silence on behalf of witnesses, bystanders, and course staff, many of whom chose to 'look the other way' and were complicit in bullying through passivity and lack of support for victims. It was clear from the findings that workplace bullying in healthcare has reached a crisis point and urgently needs to be addressed. There is a need for a complete cultural overhaul at all levels of the system, including greater supports for victims of workplace bullying, and accountability for perpetrators, as well as improved information, awareness, and prevention of workplace bullying. This was discussed in the context of the move towards TIC, as this provides a useful framework to facilitate a systemic and organisational paradigm shift.

Chapter two was an original qualitative study which aimed to explore psychological practitioners' experiences of the implementation of trauma-informed care (TIC). Seven participants working with survivors of complex trauma were recruited from adult mental health and substance use services. The researcher conducted in-depth interviews, giving each participant time and space to reflect on their views and experiences of the roll-out of TIC. The analysis of interviews revealed that that staff are experiencing issues with *how* TIC is being rolled out, rather than TIC itself. Specifically, participants noted that TIC has *not* been delivered in a way that upholds the principles upon which it is based (e.g., choice, safety, empowerment, collaboration, trust, diversity, and inclusion). TIC initiatives were perceived as insensitive and poorly attuned to the needs of staff

teams, who are already overwhelmed and under-resourced. Participants described the challenges of trying to implement TIC principles, while also upholding contradictory internal policies and procedures. Concerns were raised about the internal cultures in healthcare at present, such as professional discord, problematic power dynamics, and inadequate staff support, which are making it difficult for staff to fully embrace the TIC movement and implement these care principles for others. Participants described mixed responses to the TIC implementation among different professional groups, noting the challenges of trying to integrate TIC with the dominant medical model, due to fundamental differences in these ways of working. For TIC to be successfully implemented, staff need to feel safe, supported, and adequately resourced in their current roles before they can take on additional training and demands. Discrepancies between the TIC framework and internal NHS policies and cultures need be reviewed, and, where possible, resolved. At its core, TIC represents an attempt to 're-humanise', or place the focus back onto the 'human relationships' that are at the heart of high quality, person-centred care. The findings highlighted ways to develop a more trauma-informed, inclusive workforce and compassionate organisational culture overall, where staff wellbeing and patient safety are prioritised. Implications for clinical practice and research were considered.

Research Portfolio Thesis Abstract

This thesis portfolio aimed to shed light on the current climate in healthcare, paying particular attention to workplace bullying (WPB), a significant issue with serious implications for all stakeholders. This researcher was interested in exploring how WPB has persisted at a time when healthcare is undergoing a paradigm shift towards trauma-informed care (TIC) and placing greater emphasis on staff wellbeing. This raises questions about how such divergent and ostensibly incompatible cultures as that of WPB and TIC have emerged and been able to co-exist, as well as the possible implications of the polarisation in contemporary healthcare.

The first chapter details a qualitative evidence synthesis (QES), which used thematic synthesis to analyse qualitative research available on early career healthcare professionals' (ECHCPs') experiences of WPB in the UK. Three analytical themes were identified which highlighted that WPB is a significant and pervasive issue, with serious implications for all stakeholders, including staff wellbeing and patient care. The Jungian concept of 'the shadow' was applied to make sense of the findings, as WPB represents a toxic side to the healthcare profession that is less well-known and often is maintained through silence, fear, and oppression. A cultural overhaul is needed to address WPB, including greater accountability for perpetrators, support for victims, and a strong anti-bullying stance and awareness raising campaign across the organisation. There is an appetite for change among ECHCP, and strategies to facilitate the shift towards a more trauma-informed, compassionate workplace for all were discussed.

The findings of this review highlighted a need for more research on the implementation of TIC. The second chapter details an empirical study which explored psychological practitioners' experiences of the roll-out of TIC in adult mental health and substance use services in an NHS Scotland health-board. Seven participants took part in semi-structured interviews, the transcripts from which were analysed using interpretive phenomenological analysis (IPA). The findings revealed the many ways in which the implementation of TIC has felt paradoxical, as well as the mixed responses from different

HCPs across the MDT. Participants felt that the shift towards TIC involves a much-needed re-humanisation of the healthcare system as a whole, both in terms of staff wellbeing and the quality of patient care. There has been increasing deprivation of humanity in healthcare, which can be seen in the prioritisation of target-driven agenda that are leaving staff overwhelmed and burnt out, with less time to form trusting relationships with patients and deliver person-centred care. This can also be seen in the discord among the workforce, with issues such as WPB, problematic power dynamics, and staff generally feeling under-valued at work. Findings are discussed in relation to clinical implications and future research.

Wordcount: 31,283

Chapter 1. Systematic Review

Early Career Healthcare Professionals' Experiences of Workplace Bullying in the UK:

A Qualitative Evidence Synthesis

Grace Kealy^{1,2,3}, Charlene Plunkett¹, Peter Littlewood², Alison Wells²

Author Note

This chapter has been prepared in accordance with author guidelines for the international peer-reviewed journal *The Qualitative Report* (see Appendix A).

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Abstract

Background: Workplace bullying (WPB) is a significant yet under-reported issue in healthcare with serious implications for staff and patients. Previous systemic reviews have focused on this phenomenon internationally and among specific healthcare disciplines. This review aims to examine the qualitative research on early career healthcare professionals' (ECHCPs') views and experiences of WPB in a UK context.

Method: 10 databases were searched for qualitative studies that met the inclusion criteria. The findings were extracted and analysed using thematic synthesis (Thomas & Harden, 2008).

Results: 443 studies were screened using the PRISMA updated protocol (Page et al., 2021) and Covidence, from which 12 studies met criteria for this review. Three analytical themes were developed: (1) The Shadow Side of Healthcare; (2) Power with impunity: how WPB in healthcare has prevailed; and (3) A Call for Change.

Discussion: WPB in healthcare is a significant and pervasive issue, the effects of which can be detrimental to the mental health and welfare of victims, as well as patient safety. Abuse of power, fear, and silence were recurrently identified as factors that have maintained this problem over time. A cultural overhaul is needed to move towards a more trauma-informed healthcare environment that prioritises safety and wellbeing for all. Healthcare organisations need to implement strong anti-bullying policies and procedures, as well as greater supports for victims, and accountability for perpetrators of WPB. Findings are discussed in relation to clinical and research implications.

Keywords: Workplace bullying, trainee, healthcare professional, UK, thematic synthesis.

Conflicts of interest: none.

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Introduction

Workplace bullying (WPB) is a significant and pervasive issue in healthcare, which poses serious risks for the safety and wellbeing of staff and patients, as well as economic and organisational burden to the NHS (Kline, & Lewis, 2019; Zapf et al., 2020). Research has shown that, compared to other employment sectors, healthcare is disproportionately affected by WPB; however, the specific reasons for this are less well established (Zapf et al., 2020). Public inquiries have identified that WPB has played a central role in problematic workplace cultures in UK healthcare services, including poor management and issues related to malpractice. These have included, for example, the Bowles (2012) investigation of NHS Lothian management, and the 2013 Francis Report, which published findings of an inquiry into issues of malpractice at the Mid Staffordshire NHS Foundation Trust. These investigations highlighted that WPB contributed to highly toxic workplace cultures and issues related to malpractice in healthcare, whereby patient safety and quality of care was significantly compromised or lacking. NHS Staff Council (2023) published an infographic which demonstrates the severity, extent, and impact of WPB in healthcare, including greater likelihood of clinical errors, reduced patient safety/quality of care, and issues related to staffing levels and performance, teamwork, morale, and mental health. The World Health Organisation identified WPB as a public health concern (Srabstein, & Leventhal, 2010), which has been described as a 'silent epidemic' in healthcare (Edmonson et al., 2017; Samsudin et al., 2018). Some evidence suggests that WPB in healthcare has increased in recent years, which, given an already overwhelmed and under-resourced NHS, is a significant concern (Rhead et al., 2021). Despite recognition of the seriousness and extensiveness of WPB in healthcare, it remains a relatively poorly understood phenomenon, which has yet to be fully addressed in research or clinical practice (Kline, 2022; Rhead et al., 2021). A critical review of the evidence base will be provided below to give the reader an understanding of some of the research which has been conducted in this area, as well as some of the challenges in researching this topic.

One of the key challenges of studying WPB is that many different definitions exist, and it is a term used to describe a broad spectrum of behaviours (Brown et al., 2021; Halim & Riding, 2018). WPB can be considered a subjective phenomenon, in that one-person's experiences of bullying, or what they perceive as bullying, might differ from others (Nielsen et al., 2020). For the purposes of this research, WPB will be defined in the broadest sense, to include any negative behaviour that is intended to harm and/or undermine another person or group at work (Brown et al., 2021; Lever et al., 2019). This can include but is not limited to insulting and/or offensive language, harsh criticism, verbal abuse, psychological manipulation, intimidating, threatening, or aggressive use of language and/or behaviour, harassment, discrimination, and exclusion in the workplace (Averbuch et al., 2021; Lee et al., 2022; NHS, 2022; Shorey and Wong, 2021).

The lack of an agreed-upon definition and measurement of WPB in healthcare has led to significant variability in estimated prevalence rates and difficulties determining the true scale of this issue. For example, in a systematic review of 18 studies, with a combined sample of 9,597 international junior doctors, Samsudin et al. (2018) reported estimated prevalence rates between 30 – 95%; while Lever et al. (2019), in a review of 45 international studies, reported that WPB ranged from 3.9% to 86.5%, with a pooled mean estimate of 26.3%. According to the NHS Staff Survey (2019), bullying, harassment, and/or abuse from other colleagues was reported by 19% of staff, with 12.3% indicating that these behaviours were carried out by managers. The NHS Staff Council (2019) reported that an alarming 98% of NHS staff described experiencing incivility in the workplace. Due to issues with the definition and measurement of WPB in healthcare, as well as potential barriers to reporting WPB as result of shame, fears of disclosing and/or self-identifying as someone who has been victimised by or experienced WPB, these prevalence rates may be underestimated. (Birks et al., 2017; Chatziioannidis et al., 2017; Samsudin et al., 2018).

The Evidence Base on Workplace Bullying in Healthcare

Healthcare can be an intensely demanding environment to work in, which when coupled with poor working conditions, including staff shortages, resources, and funding, it is perhaps

unsurprising that HCPs are at-risk of staff burnout and compassion fatigue. Working in a stressful environment such as this, with inadequate resources and staff support, can create a fraught atmosphere where problematic team dynamics and tensions are more likely to occur (Zapf, 1999). This may explain why healthcare settings such as these can give rise to issues such as WPB. Although the issue of WPB in healthcare is commonly known by those in the healthcare profession, it is received notably less attention in research, practice, and public discussion.

Issues related to power and hierarchy have been identified as key factors in WPB, as research has shown that early career healthcare professionals (ECHCPs), such as students, trainees, and junior members of staff, are at greater risk of being poorly treated by senior colleagues in positions of power (Hills et al., 2012). In their systematic review, Leisy and Ahmad (2016) found that that fear, silencing, hierarchy, denial, and normalisation of abuse all contributed to a bullying culture towards junior doctors in medical training. 'Teaching by humiliation', a term used to describe a range of harmful behaviours carried out under the guise of pedagogy, such as intimidation, hostility, abusive and undermining behaviour, is a known form of bullying that has been normalised within medical education (Scott et al., 2015; Singh & Singh, 2018). In a study of 146 medical students, Scott et al. (2015) reported that 74% had directly experienced and 83.6% had witnessed 'teaching by humiliation' during their training. A more recent high-profile study in NHS England investigated a culture of sexual misconduct and violence towards women in the surgical workforce (Begeny et al., 2023). The findings revealed that 63.3% of female participants reported experiencing sexual harassment, 29.9% had been sexually assaulted, 10.9% were targets of forced physical contact, and 0.8% reported being raped by male colleagues. This research demonstrates the severity of WPB and harassment in healthcare at present, which at its most extreme can include sexual violence and serious criminal offences that need to be recognised and investigated as such (Fleming & Fisher, 2021). Unfortunately, studies have shown that incidences of WPB and harassment often go unreported due to fears of repercussions (e.g., hindered career progression) (Leisy &

Ahmad, 2016), as well as systemic misogyny and minimisation of sexual misconduct as ‘banter’ (Fleming & Fisher, 2021).

In a narrative synthesis of academic bullying in medicine, Averbuch et al. (2021) reported that male doctors and consultants were the most common perpetrators of bullying, and female doctors the most common victims. Despite experiencing significant psychological distress, most participants in this study did not formally report WPB, and those that did described being disappointed in the outcome. Averbuch et al. (2021) identified several facilitators of WPB, such as reports not being appropriately acted on, normalisation of bullying, problematic power dynamics, and hierarchy in healthcare. The large sample of studies (68 studies; 35 779 participants) in this review, lent to greater breadth, but less depth of analysis. The inclusion of both victim *and* perpetrator responses lessened the homogeneity of the sample and, in turn, the depth of analysis into one group’s perspective of WPB. Additionally, as this study was based on a mostly American sample, findings may not be transferable to a UK population or context.

Lee et al. (2022) conducted a meta-synthesis of WPB across 35 Korean and 28 international studies. Like previous research, early career nurses with less experience were the most common targets of bullying, and perpetrators were typically nurses in positions of power and hierarchical status. Again, factors contributing to WPB here included a lack of repercussions for perpetrators of WPB, normalisation of WPB, poor working conditions, problematic power dynamics and a hostile working environment. When victims tried to report WPB, they were often silenced by way of being ignored, reprimanded, and/or subject to intensified bullying. Victims reportedly experienced significant physical and mental health difficulties in response to WPB, as well as burnout, high staff turnover, and greater risk of clinical errors, all of which had the potential to compromise the quality and safety of patient care. Similarly to the aforementioned research, this study was not conducted among UK participants, and therefore findings may be less transferable to workers in the NHS or a UK-specific context. This study also focused solely on the experiences of nurses, which may not reflect the wider multidisciplinary team (MDT).

In a 2021 meta-synthesis of 27 international studies of nurses' experiences of WPB, Shorey and Wong identified a 'the vicious cycle of bullying', which described the main contributing factors to WPB as reported in the findings of this review. They detailed the different types of bullying reported, ranging from exclusion and intimidating behaviour, to smear campaigns and hindered career progression. They reported on "drivers" of WPB, such as power, control, discrimination, ineffective leadership, and stressful working conditions. WPB affected people in many ways ranging from being silenced, to experiencing mental and physical health difficulties, which in turn impacted clinical practice and quality of care. Different responses to WPB were also reported, such as "denial", "helplessness", and resignation, whilst others coped by simply "adapting" and being "resilient". It was unclear from this review how or even if victims of WPB should have to learn to adapt to or be resilient in the face of injustices and inappropriate behaviour such as this. Studies included in this review were from predominantly American and Australian samples, and therefore, as before, may not be generalisable to a UK sample or context.

These findings provide a useful starting point in terms of describing some factors associated with WPB in healthcare. However, the evidence base is in its infancy and despite longstanding reports of WPB, it remains a significant organisational and systemic issue in healthcare yet to be fully understood or addressed by way of clinical research or practice. Which has yet to be fully understood or resolved in clinical practice or research (Kline, 2022; NHS Staff Council, 2019; Rhead et al., 2021).

Rationale for Current Study

The above review highlights that despite WPB being a significant and persistent issue in healthcare, academic literature and practical solutions in this area are lacking. Several methodological limitations and gaps in the extant research were identified. The lack of agreed-upon definitions and measurement tools to assess WPB pose challenges for quantitative research and reviews at present. Research has pointed to hierarchy and power dynamics as playing a role in the culture of WPB in healthcare, with trainee and junior HCPs identified as the most targeted victims

(Averbuch et al., 2021; Lee et al., 2022). Therefore, this review will include studies exploring early career healthcare professionals' (ECHCPs) experiences of WPB. This study will explore qualitative studies on WPB in a UK-specific context to explore any unique cultural, organisational, and socio-political factors not yet captured by previous reviews, most of which consisted of international samples. As prior reviews in this area have predominantly focused on medically-trained HCPs (i.e., doctors, nurses), this study will include HCPs from across the MDT. Finally, qualitative reviews on WPB in healthcare have been broad in scope, encompassing a large number of studies, which appears to have limited the depth of analysis and presentation of key findings. Thus, the researcher sought to refine the focus and scope of this review, promoting a more homogeneous and manageable sample of studies, and in doing so, maximising the potential for an in-depth analysis of findings.

Research Question and Aims

This study aims to conduct a 'qualitative evidence synthesis (QES)' (Noyes et al., 2023) of the existing qualitative research on early career healthcare professionals' (ECHCPs') experiences of WPB in a UK context. As the evidence base on WPB is still in its infancy, a QES was chosen as an appropriate first step to explore the literature available on this topic, highlight key findings, gaps in the evidence base, and recommendations for future research. This study will use thematic synthesis (TS) to identify, critically analyse, and synthesise the qualitative research available on this topic, and in doing so, answer the research question below:

What are ECHCPs' experiences of WPB in the UK?

To the authors knowledge, this is the first QES to explore WPB in healthcare using the following criteria:

- (i) In a UK-specific context.
- (ii) Among ECHCPs (e.g., students, trainees, junior, and foundation level healthcare professionals).
- (iii) Inclusive of all multidisciplinary perspectives.

Method

Search Strategy

The systematic search was conducted across the following databases: Ovid (PsychINFO, EMBASE, MEDLINE), EBSCOHOST (CINAHL Plus, Education Source), and ProQuest (Education Collection, International Bibliography of the Social Sciences [IBSS], Library & Information Science Collection, Social Science Database, Sociology Collection). The search terms were developed by reviewing the literature and in consultation with the university librarian. They were as follows: 'workplace bullying OR harassment', 'trainee' OR 'student' OR 'junior' OR 'graduate', 'healthcare professional', 'UK' OR 'NHS', and 'qualitative' OR 'experiences' OR 'views'. A systematic search was conducted using BOOLEAN search terms and protocols (See Appendix B). This was done several times since December 2022, but the final search for this study was run in March 2023. Reference lists and google scholar were also searched in the interest of completeness.

Inclusion and Exclusion Criteria

To address gaps in previous research, define the scope and focus of this review, and ensure the most high-quality, peer-reviewed, relevant, and up-to-date studies were included in this review, the following inclusion/exclusion criteria were determined (see table 1 below).

Table 1.
Inclusion and Exclusion Criteria

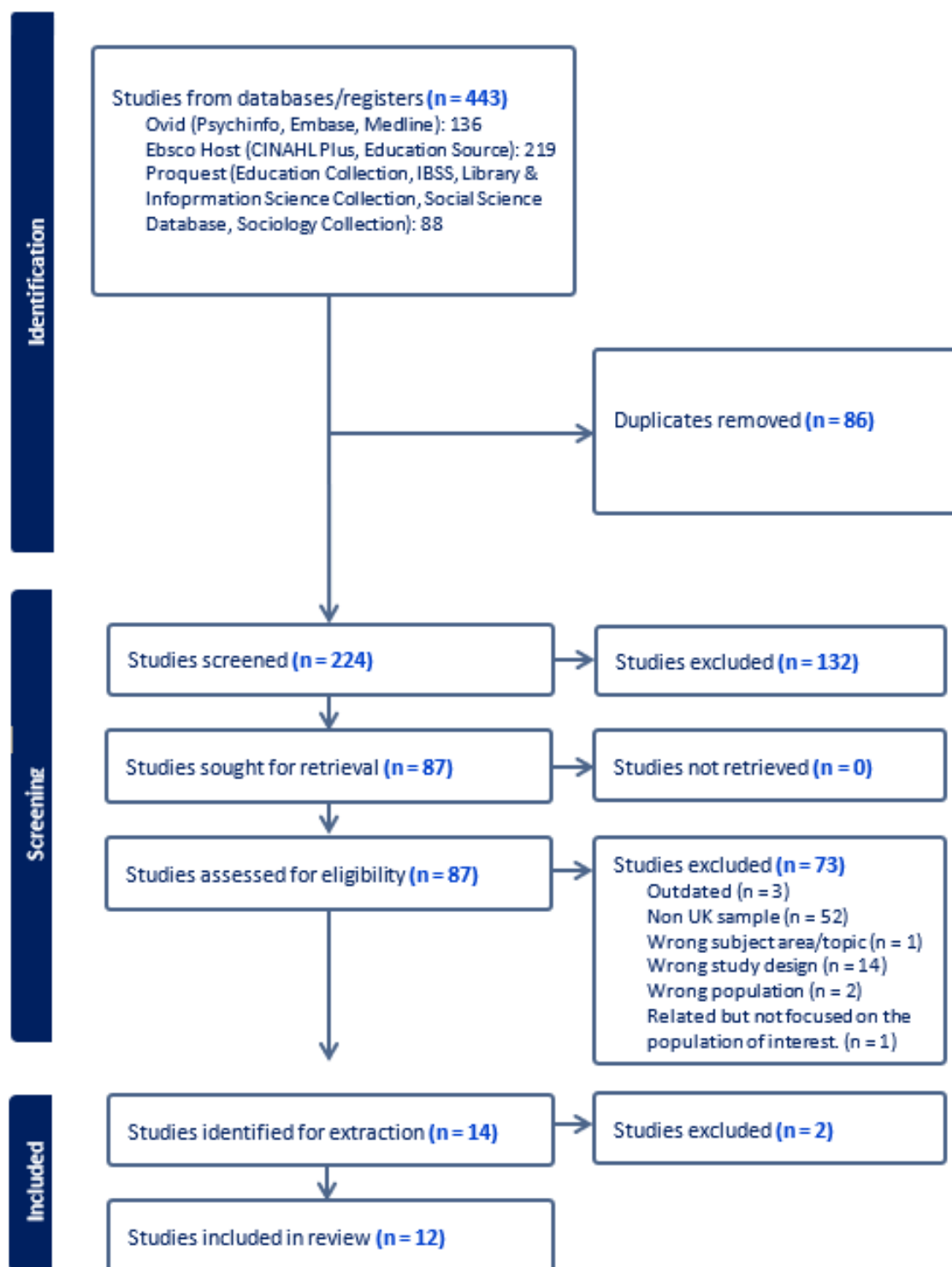
	Inclusion Criteria	Exclusion Criteria
Phenomenon of interest	Early career healthcare professionals' (ECHCPs) views and experiences of workplace bullying in healthcare.	-
Population/sample	ECHCPs including student, trainee, graduate, junior, and newly qualified healthcare professionals from across the multi-disciplinary team.	Non-clinical staff, HCPs in positions of seniority, supervision, or leadership (where there may be a power imbalance). HCPs who are not early career, students, or newly qualified (e.g., in the last 5 years).
Type of research	Original qualitative research (peer reviewed studies published in journal articles).	Non-qualitative, non-original research (e.g., quantitative research, literature reviews, theses, grey literature).
Region	UK specific	Non-UK based studies
Date	Between 2015 – present	Any research published prior to 2015.
Language	Published in English language	Research published in any other language.

Study Selection

Studies were screened using the Preferred Reporting Items for Systematic Reviews (PRISMA) updated protocol (Page et al., 2021) and the Covidence systematic review management tool (see Figure 1. for PRISMA diagram). An initial search across the databases identified 443 studies in total. Following removal of duplicates and papers not published in English, 224 studies were retained for title and abstract screening, which yielded 87 studies for full-text review. 73 studies were excluded at this stage (see Figure 1 for exclusion reasons), resulting 14 studies, two of which were removed as on closer inspection they did not meet inclusion criteria (one was exploring the experiences of bystanders, not victims/survivors; the other was not specific to ECHCPs' perspectives). The screening process identified 12 studies which met the criteria and were deemed suitable for this review.

Figure 1.

PRISMA Diagram



Quality Appraisal

In keeping with Cochrane Group guidance for health-related qualitative systematic reviews, the critical appraisal skills programme (CASP) tool was used for this review (Noyes et al., 2023). The modified-CASP (Long et al., 2020) was chosen as it addresses limitations of other appraisal tools that do not assess the ontological, epistemological, or theoretical underpinnings of qualitative studies. As per Cochrane guidelines, the author reviewed studies in terms of their strengths, limitations, and risk to rigour rather than attributing a numerical rating or quality score (Noyes et al., 2018). A second reviewer, also a trainee clinical psychologist, conducted an independent appraisal of a random sample of studies. The Cochrane group advise against calculating 'inter-rater reliability', as the process of discussing and reaching consensus is deemed more helpful to the overall rigour of appraisal in qualitative research (Noyes et al., 2023; J; Noyes, personal communication, June 26, 2023). The first author and second reviewer came together to discuss and resolve any discrepancies. GRADE-CERQual (2018) was used to assess the confidence of the review findings in terms of methodological limitations, coherence, relevance, and adequacy.

Data Extraction

Relevant data extracted from each of the studies, including the author(s), year of publication, aim(s), sample, methodology, analyses, main findings, and discussion, is summarised in Table 3. The results and discussion sections of the studies were then transferred to NVivo data management software for data synthesis.

Data Synthesis

Data was analysed using thematic synthesis (TS) (Thomas & Harden, 2008), as recommended by Cochrane group as the most suitable approach for a QES of this scale, resourcing, and expertise (Noyes et al., 2018; Noyes et al., 2023). TS is one of the most widely used and accessible approaches due to its clear, step-by-step process and transparent auditability this offers, making it a robust and evaluable synthesis methodology (Noyes et al., 2018). The combination of thick and thin data

obtained from this review was deemed suitable for TS, as this approach uses both integrative and interpretive synthesis techniques.

As research on WPB in healthcare is still in its infancy, the author decided against framework synthesis (Dixon-Woods, 2011) as the use of a pre-determined framework can bias the lens through which findings are interpreted.

The richness of data obtained in this review was somewhat limited by the preponderance of survey-based design studies. Cochrane guidelines state that meta-ethnography (Noblit & Hare, 1988) is a complex and resource-intensive approach that is less accessible to novice and intermediate qualitative researchers, recommended for use only by an experienced research team (Noyes et al., 2018). For these reasons, meta-ethnography was not deemed appropriate for this review.

Epistemological Stance

This review is underpinned by a social constructivist perspective, which holds that there is no one *absolute* truth or objective reality, but rather many different realities or perceptions of realities based on a person's interpretation of an experience and what this means to them (Rees et al., 2020). This posits that acquisition of knowledge is an active process, rather than something that is implicitly known or passively obtained. The social constructivist perspective is therefore a good-fit with QES, and in particular thematic synthesis, an approach which requires active engagement with and integration of key themes across the reviewed studies. This stance was borne in mind throughout the research process, both in terms of how participants' made sense of their experiences and the researcher's interpretation of this (i.e., a double hermeneutic).

Reflexivity

The researcher was mindful of their own personal experiences, background, values, and socio-political standpoints, and how these may have influenced each stage of the research process, from choosing the topic, to engaging with the literature, and making sense of the data. Instead of

minimising their views and experiences, the researcher aimed to make explicit their subjectivity and use this to enhance, rather than detract from, their engagement with and analysis of the data obtained from this review. They were also cognisant of minimising the potential for pre-conceived ideas and beliefs to unfairly influence or interfere with accurate and fair interpretation of findings. They maintained a reflexive stance throughout by keeping a reflective log (see Appendix G), engaging in supervision, and reflective practice.

The researcher is a trainee psychologist who has witnessed WPB, harassment, and misuse of power in healthcare, and therefore seen the severity, pervasiveness, and impact of this issue first-hand. The researcher had a natural allegiance with and empathy for the trainees in these studies, as well as a sense of responsibility to shine a light on the culture of WPB in healthcare. It is hoped that this research can help to promote greater awareness, prevention, and intervention in this area.

Being emotionally invested in and exercised by this topic also brought its challenges. For example, ECHCPs' accounts of being bullied at the hands of their supervisors were sobering to read. Having a natural allegiance with the trainees in these studies and a strong sense of injustice about the issue of WPB in healthcare meant that the researcher was close to the topic on a personal, professional, and political level. Although they sought to maintain an open and curious stance throughout, it was not possible for the researcher to assume a fully independent or outsider position given their personal and inside knowledge of the area.

The researcher was apprehensive about choosing a controversial topic that is not openly discussed within the field. They had fears of highlighting an issue that might cast HCPs in a negative light, especially as the persistence of WPB in healthcare over time may raise questions about collective or unconscious complicity. The researcher was mindful that highlighting the extent of the WPB culture in healthcare in case this may elicit feelings of discomfort in readers (and reviewers), especially if they feel they may have enacted or enabled any such bullying behaviours (passively or otherwise), or indeed been victimised by bullying themselves. Reflecting on this in supervision

helped the researcher to recognise the parallel processes between their feelings of fear and those of participants across the studies who were afraid to raise concerns in case doing so had repercussions. Working through this, the researcher made the decision that the need to give voice to those who have been adversely affected by bullying outweighed the potential for any discomfort or defensiveness in themselves, or indeed those who may read and critique this paper. Although this review may make for difficult reading, it is hoped that it can be justified by its contribution to research on WPB in healthcare and ways this issue can be addressed.

Results

Quality Appraisal

Most studies were deemed to be of high quality overall and contributed in a valuable way to research (see table 2 for summary of quality appraisal and Appendix C for examples of completed CASP appraisals). Study (9) provided insufficient detail across several criteria, while others were labelled as ‘uncertain’ when it was unclear if the issue was a methodological or reporting concern. Ethical considerations were often under-reported on, with five studies providing limited information (2, 10, 11, 12), and one (9) providing none. Four studies provided limited information on reflexivity (3, 5, 6, 8), and for others (2, 4, 9, 12), it was unclear if this information was missing or not reported on. Only two studies provided sufficient information on theoretical underpinnings, ontology, or epistemology (7, 11), while three provided brief but limited details on this (9, 10, 12). For the remaining seven, it was unclear if this was a methodological or reporting limitation. More broadly, there was a preponderance of survey-based designs, with relatively large sample sizes. The scale of these studies and breadth of findings seems to have lessened the richness of data obtained and depth of analysis (Vasileiou et al., 2018). However, the Capper et al. series of papers conducted rich analyses that yielded significant and meaningful findings, despite the large sample size, indicating that they may have had sufficient time and resources to manage this volume of data. Three studies (2, 8, 9) employed mixed-methods designs, the advantages and disadvantages of which are widely debated in the literature (Halcomb, 2019). However, in these instances, the use of mixed-methods seems to have obscured the focus somewhat, and in attempting to do too much, it is possible that this has come at a cost to the overall quality, cohesiveness, and methodological robustness of the study as a whole, and in particular the qualitative components. Using GRADE-CERQual (2018), the researcher found ‘high confidence’ in three of the review findings (see Appendix D).

Table 2*CASP Quality Appraisal Tool (Modified Version) (Long et al., 2020)*

CASP Questions												
Papers	1. Was there a clear statement of the aims?	2. Is the qualitative methodology appropriate?	3. Was the research design appropriate to address the research aims?	4. Was the recruitment strategy appropriate to the aims of the research?	5. Was the data collected in a way that addressed the research issue?	6. Has the relationship between researcher and participants been adequately considered?	7. Have ethical issues been taken into consideration?	8. Was the data analysis sufficiently rigorous?	9. Is there a clear statement of findings?	10. How valuable is the research/ Is the value of the research stated?	11. Are theoretical underpinnings clear, consistent and conceptually coherent?	Quality assessment grade
1. Brown et al. (2021)	Yes	Yes	Yes	Yes	Somewhat	Yes	Yes	Yes	Yes	Yes	Uncertain	High
2. Talash et al. (2022)	Yes	Somewhat	Somewhat	Somewhat	Somewhat	Uncertain	Yes	Somewhat	Yes	Yes	Uncertain	Medium
3. Capper et al. (2021a)	Yes	Yes	Yes	Yes	Yes	Somewhat	Yes	Yes	Yes	Yes	Uncertain	High
4. Capper et al. (2021b)	Yes	Yes	Yes	Yes	Yes	Uncertain	Yes	Yes	Yes	Yes	Uncertain	High
5. Capper et al., (2021c)	Yes	Yes	Yes	Yes	Yes	Somewhat	Somewhat	Yes	Yes	Yes	Uncertain	High
6. Capper et al. (2021d)	Yes	Yes	Yes	Yes	Yes	Somewhat	Somewhat	Yes	Yes	Yes	Uncertain	High
7. Smith et al. (2018)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High
8. Johnson et al. (2018)	Yes	Yes	Somewhat	Yes	Yes	Somewhat	Yes	Yes	Yes	Yes	Uncertain	High
9. Gafson et al. (2017)	Yes	Somewhat	Somewhat	Somewhat	Uncertain	Uncertain	Uncertain	Somewhat	Yes	Yes	Somewhat	Medium
10. Broad et al. (2018)	Yes	Yes	Yes	Yes	Yes	Yes	Somewhat	Yes	Yes	Yes	Somewhat	High
11. Riley et al. (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Somewhat	Yes	Yes	Yes	Yes	High
12. Thomson et al. (2017)	Yes	Yes	Yes	Yes	Yes	Uncertain	Somewhat	Yes	Yes	Yes	Somewhat	High

Study Characteristics

Study characteristics are summarised below in Table 3. This study aimed to include studies from the UK, as described previously (see rationale and inclusion criteria). Four of the studies (Capper et al., 2021a, b, c, d) had a sample consisting of UK and Australian participants. However, Capper et al. (2021) noted that they recruited from the UK and Australia because of similarities in the midwifery programmes, in terms of the course content, structure, and length of training. Given the importance of Capper et al.'s (2021) findings, and their significant contribution to the emerging evidence base on WPB, these studies were considered integral to this review. This was discussed in supervision and the studies were retained for synthesis.

All included studies used qualitative methodologies. Three employed a mixed-methods approach, but only qualitative data was extracted for this review (Broad et al., 2018; Gafson et al., 2017; Johnson et al., 2018). Three studies used in-depth interviews, seven used surveys and three used focus groups for data collection.

Thematic analysis was the commonly used method of data analysis, employed by eight studies. Smith et al. (2018) used 'template analysis' and Broad et al. (2018) used 'framework analysis'. Two studies did not specify the analyses used (Talash et al., 2022; Gafson et al., 2017).

There was a total of 500 participants across the studies, which consisted of trainee clinical psychologists (Brown et al., 2021), midwifery students (Capper et al., 2021), obstetrics and gynaecological trainees (Gafson et al., 2017), medical students (Broad et al., 2018; Johnson et al., 2018), foundation and junior doctors (Riley et al., 2021; Smith et al., 2018; Talash et al., 2022), and physiotherapy students (Thomson et al., 2017).

Table 3
Summary of Study Characteristics

#	Authors	Aim	Participants	Methods and Analysis	Main findings
1.	Brown et al. (2021)	To explore trainee clinical psychologists' experiences of WPB.	14 Trainee Clinical Psychologists from UK universities.	Semi-structured telephone interviews. Thematic Analysis	Four themes: • WPB triggered a 'threat response' (in CFT terms) in victims. • WPB can be traumatising, and victims can internalise criticism. • Power differentials were barrier to reporting WPB. • The importance of finding good supports (discussed in terms of CFT soothing and safety system), inside and outside of the workplace.
2.	Talash et al. (2022)	To explore how Foundation Doctors (FDs) in the UK view the idea of raising or reporting concerns in the workplace.	229 Foundation doctors (FDs) in the UK.	Online survey sent to all FDs in the UK between February and March 2018. Specific analysis not stated. However, the authors wrote "The qualitative responses were coded into themes."	Barriers to raising concerns: • FDs were afraid to raise concerns about WPB due to fear of repercussions (e.g., WPB getting worse, adverse effects on career). • Absence/unavailability of senior support • Power imbalances and 'fixed hierarchical' structures. Solutions: • Changes required at all levels of the organisation. • FDs need to feel safe and supported to raise concerns.
3.	Capper et al. (2021a)	To explore bullying of midwifery students, and how social culture within the maternity setting may play a role in this.	120 Midwifery students from Australia and the UK	Qualitative online survey Thematic Analysis	Overarching theme: • The organisational culture of acceptance. WPB took place 'in front of' other staff and patients. Subthemes: • 'brazen expression' • 'group buy-in'. • 'suppression of dissent', • 'collateral damage'. This study highlighted a culture of bullying in midwifery that adversely impacts students' learning, the care mothers and babies receive, and reputation of the profession.

4.	Capper et al. (2021b)	To explore midwifery students' perceptions of organisational factors that play a role in WPB and suggestions for change.	120 Midwifery students from the UK and Australia	Qualitative online survey Thematic Analysis	Organisational factors: • Poor mentorship by midwives. • Stressful work environment (maternity ward). • Difficulties with whistleblowing and reporting concerns. • Lack of transparency Potential solutions: • Greater recognition of the factors outlined above and efforts to address these. • Empowering students to have a say in what is needed to tackle WPB.
5.	Capper et al. (2021c)	To explore student midwives' views on the impact of bullying on mothers in the maternity ward and their families.	120 Midwifery students from the UK and Australia	Qualitative online survey Thematic Analysis	Impacts of WPB on mothers and their families on a maternity ward: • Direct and indirectly affected. • Mothers were used as 'pons', or weaponised, and implicated in WPB. • Relationships between students and mothers were negatively impacted. • Mothers lost faith in the students and the care team. • Mothers felt sense of responsibility to stand up for students subjected to WPB.
6.	Capper et al. (2021d)	To explore if age played a role in student midwives' experiences of WPB.	N = 40 n (younger students) = 20 n (older students) = 20 Midwifery students from the UK and Australia	Qualitative online survey Thematic Analysis	• Younger students had less power to older students. • Both groups had similar experiences of WPB in the main. • Some differences were noted: • Younger students experienced more overt and verbal WPB, more likely to respond passively.
7.	Smith et al. (2018)	To explore why foundation doctors (FD) are choosing to leave medicine in the UK after their foundation year 2 posts.	17 FD year two doctors (F2s) working in Scotland, who are considering leaving UK medicine after foundation training.	Online-video semi-structured interviews A constructivist approach was employed. Template analysis	Reasons for leaving medicine in the UK: • Exposure to WPB • Challenges in raising concerns Bullying included: • Being shouted at and humiliated in front of colleagues. • Ridiculed for showing emotions. • Harshly criticised/made to feel inadequate. WPB was mostly perpetrated by senior doctors.

8.	Johnson et al. (2018)	To explore experiences of medical students in relation to raising concerns at work.	24 UK Medical Students	Mixed methods (Qual and Quant) Survey and focus group. Thematic Analysis	Participants reported: • A toxic, problematic environment • Examples of students feeling publicly shamed and humiliate. • Discrimination and prejudice (e.g., sexism, racism) • Feeling undermined • Low morale. • Not being listened to or taken seriously when they tried to raise concerns. No action taken. • Cultural change needed to improve toxic blame culture, poor working conditions, and culture where it is accepted to patronise and bully students.
9.	Gafson et al. (2017)	To explore current and former obstetrics and gynaecology (O&G) trainees' attitudes towards attrition and reasons trainees are contemplating leaving the programme.	54 UK O&G trainees	Mixed methods (quantitative and qualitative) Qualitative: Free text responses in survey. Constructivist approach to qualitative analysis; constant comparison.	6 main themes capturing trainees' perspectives on the reasons for attrition in O&G training. • 'Morale and undermining' • 'Training process and paperwork' • 'Support and supervision' • 'Work-life balance/realities of life' • National Health Service environment • Job satisfaction. This study highlights that staff are overwhelmed and under-resourced, experiencing bullying, and inadequate supports at work.
10.	Thomson et al. (2017)	To investigate and empower physiotherapy students who are experiencing bullying and/or harassment on placement.	5 Physiotherapy students in the UK.	Participatory action research Focus groups Thematic analysis	Four themes were identified: • 'Negative experiences on placement' • 'Coping strategies' • 'The role of the visiting tutor' • 'The assessment' This study highlighted the potential for hierarchy and abuse of power to impact on the fairness of student assessments. There is a need for university and placement staff to put measures in place to protect students and the fairness of evaluation. Students need clear channels to report and access support if they are being bullied.

11.	Broad et al. (2018)	Aims: (i) To measure the types and prevalence of discrimination and harassment in one UK medical school. (ii) Explore students' experiences of reporting and raising concerns.	Convenience sampling 16 UK medical students who responded to call-out first were selected for focus groups.	2 Focus groups Framework analysis	Types of discrimination/harassment: - Students described 'everyday' discrimination and/or harassment. - Structural discrimination and/or harassment. - Exceptional' or extreme discrimination/harassment. Barriers to reporting/raising concerns: - The futility of reporting. - Fears of repercussions of reporting.
12.	Riley et al. (2021)	To explore factors contributing to workplace stress among FD and junior doctors.	21 junior/FD doctor participants who self-reported having stress, distress, anxiety, depression, suicidal thoughts or attempts (NHS England). Purposive sampling	In-depth interviews Thematic analysis	Four key themes: 'Workload and working conditions.' 'Toxic work cultures—including abuse and bullying, sexism and racism, culture of blaming and shaming.' 'Lack of support.' 'Stigma and a perceived need to appear invulnerable.'

Thematic Synthesis

The researcher followed the step-by-step process for thematic synthesis (TS) (Thomas & Harden, 2008), and related guides (e.g., Houghton, 2020; Thomas & Harden, 2022). NVivo was used in the coding and theme development process as this provided a clear audit trail, as well as a tool for validation and accuracy checks (Houghton, 2020) (see Appendix E and F). The researcher used 'line-by-line' coding to code the results, discussion, and abstract section where relevant. Initial coding was descriptive, staying close to the content participants reported and authors discussed (see Appendix E). Next, the researcher reviewed the codes across the studies, identifying key findings, patterns, or themes, including any similarities and differences that may be apparent. The researcher then used an iterative process of organising and re-organising clusters of codes into meaningful groupings or 'descriptive themes', which were ways of categorising or labelling a group of codes into a central organising pattern or theme. This was an iterative process, which involved collapsing and/or clustering codes into meaningful categories and groups. The researcher used NVivo (see figures 2 and 3 below), as well as drawing out thematic maps to help with the development of codes and themes (see appendix F).

Figure 2.

Thematic Synthesis: Line-by-line coding and theme development (NVIVO)

NVIVO
Systematic Review ...3.1).nvp (Edited)

Quick Access

- Codes
 - Coding 10 Capper et al Social Cultur...
 - Coding 11 Capper et al Organisation...
 - Coding 12 Capper et al. does age ma...
 - Coding 5 - Broad
 - Coding 6 - Smith et al. 2017
 - Coding 8 - Thomson
 - Coding 9 - Capper - The parents are...
 - Developing Themes
 - Study 1 - Brown et al**
 - Study 2 Coding -Riley
 - Study 3 coding Talash
 - Study 4 coding Johnson
 - Study Coding 7 - Gafson
 - Thematic Framework
- Sentiment
- Relationships

Study 1 - Brown et al

Name	Files	Refere
Blaming the trainee.	1	1
Blatant acts of discrimination.	1	1
Blocks to acknowledging and labelling the experience as b	1	1
Blocks to the idea of victimhood. Not wanting to see ones	1	1
CFT and trauma informed framework and model - to unde	1	1
Competitive culture is at odds with compassion, collaborat	0	0
Constant evaluation makes it difficult to open up fully.	1	1
Contradiction of caring role - irony, paradox, hypocrisy.	1	1
Covert bullying. More insidious	0	0
Clever and concealable	0	0
Leads to self-doubt, silencing, crazy making.	0	0
Unable to prove.	1	1
Crazy making	1	1
Creating self-doubt and self-criticism.	1	1
Disillusioned and cynical.	1	1
Disillusioned. Lost faith	1	1

In Code to

Unable to prove.

<Files\\Brown et al. 2021\\Workplace bullying from the persp
reference coded [0.59% Coverage]

Reference 1 - 0.59% Coverage

Sub-theme 2.1: challenges to identifying bullying. Trainees hi
nature of the bullying behaviours, as well as the element of p
challenging to identifying behaviours as bullying: In the begi
me. I guess it was always that like when does bullying becom
(Fiona)
It felt like it started quite gradually. And it started as a kind o
have been quite difficult to evidence. (Sara)

GK 163 Items

Figure 3.

Thematic Synthesis: Analytical and Descriptive Themes (NVIVO)

Developing Themes						Search Project
	Name	Files	References	Created on	Created	
[-]	○ The Shadow Side of Healthcare	0	0	02/06/2023 10:37	GK	
+	○ The shadow side quotes	0	0	27/09/2023 22:30	GK	
+	○ Bullying occurs in many different forms.	0	0	25/05/2023 16:40	GK	
+	○ The effects of bullying are significant and pervasive - 'bullying is everyone's busi	0	0	25/05/2023 16:44	GK	
[-]	○ What is giving rise to and keeping the problem going - power, fear, silence.	0	0	27/05/2023 10:49	GK	
+	○ Silence and being silenced	0	0	28/09/2023 09:31	GK	
+	○ Abuse of power and hierarchy	0	0	28/09/2023 09:32	GK	
+	○ Fear of reporting	0	0	28/09/2023 09:33	GK	
+	○ Poor working conditions and pressurised environment	0	0	28/09/2023 10:21	GK	
[-]	○ Time for change - a cultural overhaul is needed - hope for the future	0	0	27/05/2023 10:52	GK	
+	○ Cultural, organisational, and systemic overhaul - towards TIC.	0	0	28/09/2023 10:26	GK	
+	○ Clearer, more accessible, anonymous, independent, and supportive reporting syst	0	0	28/09/2023 10:48	GK	
+	○ A more safe, supportive, and nurturing learning and clinical environment.	0	0	28/09/2023 10:56	GK	
+	○ Implications for research	0	0	28/09/2023 11:24	GK	

The researcher then developed analytical themes, which involved ‘abstracting up’ from the codes and descriptive themes to consider the meaning of these findings and their implications in relation to the research question. This was a more in-depth analytical process, which required the researcher to ‘go beyond’ participants’ experiences and authors’ interpretations of these to explore the implications of these findings when taken together, as well as exploration of emotional nuances, tone, and subtext of what has been said and what this might suggest. To further illustrate the analytical process, earlier phases of thematic maps still in development can be found in Appendix F. The final thematic map can be seen in figure 4. Analytical themes were then constructed into a coherent narrative, allowing the researcher to ‘tell the story’ of the main findings in relation to the research question.

Three overarching analytical themes were developed: (1) The shadow side of healthcare; (2) Power with impunity: how WPB has prevailed; (3) A call for change. Analytical themes and descriptive themes (or sub-themes) are presented in figure 4 and table 4 below. In figure 4, a schematic diagram is used to illustrate the process and interconnectedness of the three analytical themes, as well as the descriptive themes and codes they are made up of. Analytical theme 1, ‘The shadow side of healthcare’, is presented first as this sets the scene for the synthesis findings, identifying the issue being discussed (WPB), the different types of WPB and its effects. The second analytical theme, ‘Power with impunity: how WPB has prevailed’, details the factors that have perpetuated the vicious cycle of WPB in healthcare over time. These include ‘misuse of power’, ‘fear’, and ‘silence’. The three is presented last as it represents proposed solutions to this crisis identified across this review, including (i) a cultural overhaul and (ii) the movement towards TIC.

Figure 4.

Illustration of themes

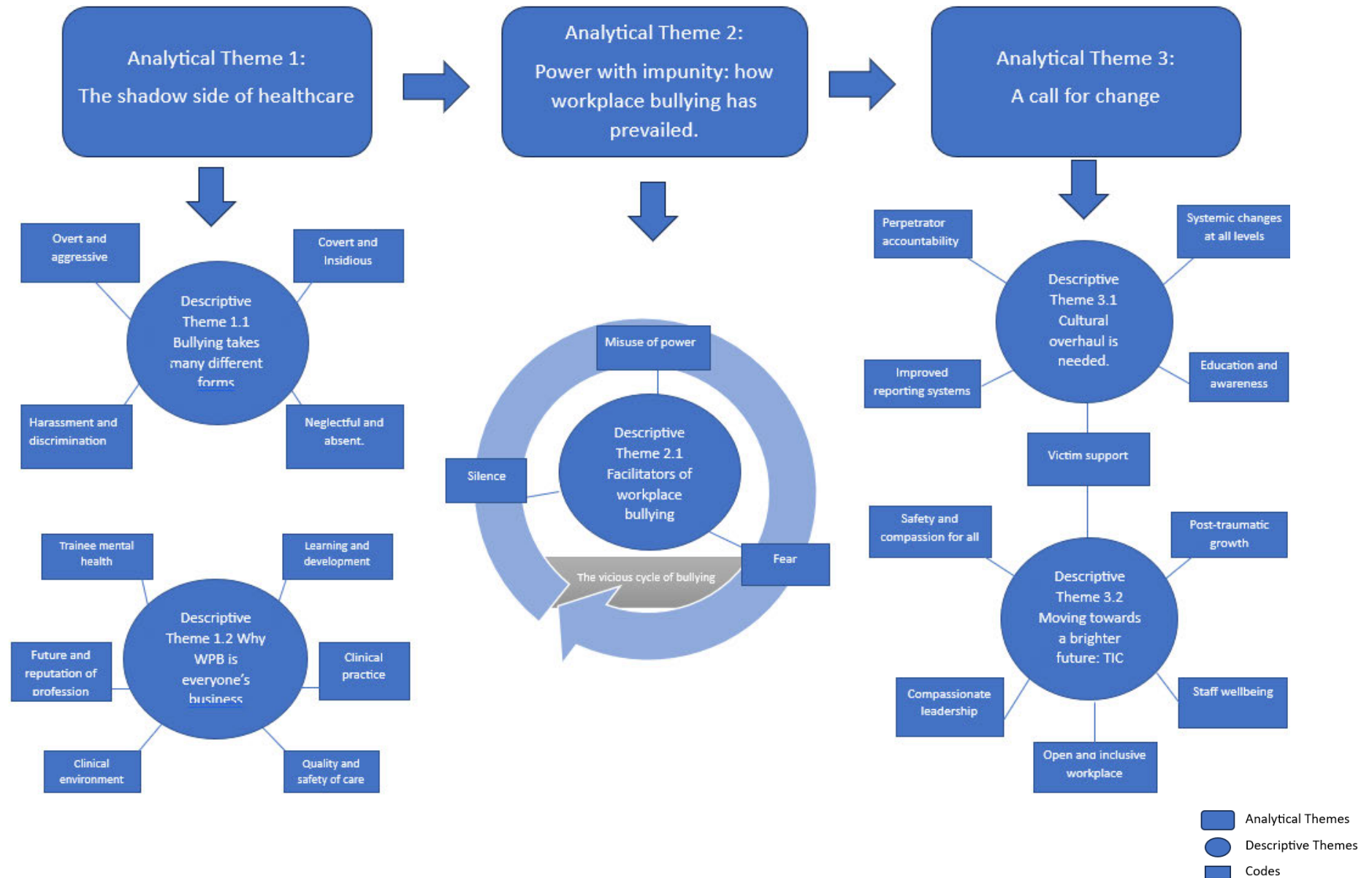


Table 4*Themes and sub-themes*

<i>Analytical Theme (Overarching Theme)</i>	Contributing studies
Descriptive Theme (Subtheme)	
Code	
1. <i>The Shadow Side of Healthcare</i>	
1.1 Bullying can take many different forms.	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12.
• Covert and insidious • Neglectful and abandoning • Harassment and discrimination • Aggressive and overt (in plain sight)	
1.2 WPB in healthcare is everyone's business.	1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12.
• ECHPs' mental health • Learning and development • Clinical practice • Safety and quality of patient care • Clinical environment • Future and reputation of healthcare profession.	
2. <i>Power with Impunity: How WPB has Prevailed.</i>	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12.
2.1 Facilitators of WPB	
• Abuse of power • Fear • Silence	
3. <i>A Call for Change</i>	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12.
3.1 A Cultural Overhaul is needed.	
• Perpetrator accountability • Improved reporting systems • Victim support • Education and awareness • Systemic changes at all levels	
3.2 Moving Towards a Brighter Future: Trauma-Informed Care.	
• Safety and compassion for all • Compassionate leadership • Open and inclusive workplace • Greater focus on staff wellbeing • Post-traumatic growth	

Theme 1: The Shadow Side of Healthcare

This synthesis highlighted a ‘silent epidemic’ of WPB in healthcare at present, with early career healthcare professionals (ECHCPs) seeming to be among the most victimised groups. Participants described this as a darker, ‘shadow’ side to healthcare that is at-odds with the often-idealised public perception and media portrayal of HCPs (e.g., ‘healthcare heroes’) (Cox, 2020). The researcher used the Jungian theory of ‘the shadow’ (Jung, 1971 [original work published in 1921]) to make sense of the phenomenon of WPB in healthcare and the conditions that have engendered this phenomenon. The ‘shadow’ is a Jungian psychoanalytic term, referring to the darker side of a person or thing; a part dystonic with someone’s values, beliefs, and self-concept (Bateman et al., 2021; Bolea, 2016; Casement, 2012; Papadopoulos, 2006). It is often a part of oneself that is unacknowledged and exists outside of conscious awareness. Participants described WPB in healthcare as a ‘shadowy’ phenomenon that can take many different forms, ranging from ‘covert and insidious’, to, ‘neglectful and absent’, ‘discriminatory and harassing’, and ‘overt and brazen’. One throughline of these findings was the extreme nature and severity of WPB, as participants provided sobering accounts of serious misconduct and abuse.

Descriptive Theme 1.1) Bullying can take many different forms.

Covert and Insidious. ‘Covert and insidious’ bullying is often less obvious to onlookers due to the more hidden, indirect, and often more considered way this is carried out. This might include, for example, psychological manipulation, exploitation, passive-aggression, underhand comments, and undermining behaviour. Covert bullying can be ‘shadowy’ and imperceptible to others, which can make it more perplexing for victims to deal with and difficult to report.

In the beginning I did not realise she was bullying me....it was ...like when does bullying become bullying?
Because it was quite insidious. (Brown, et al., 2021).

One participant described being subject to psychological manipulation, or ‘gaslighting’, when they tried to raise concerns with their supervisor. Rather than taking their concerns seriously, their

supervisor blamed them and discounted the credibility of their claims, attributing this instead to the trainee not being 'resilient' or 'reflecting' enough (Brown et al., 2021). The insidiousness of covert bullying was described, as it gradually wore trainees down and created an increasingly inhospitable environment to work in.

The...covert and insidious bullying tended to be more psychological in nature... and might include gradual but deliberate attempts to criticise and undermine trainees, passive-aggressive communication, and interpersonal style...a general atmosphere of disdain and hostility towards students. (Brown et al., 2021).

Another participant recalled how the trust she placed in her supervisor was exploited.

.... The reflective, personal nature of clinical psychology could itself be implicated in WPB within the profession, if misused: There's something abusive about being encouraged to be ...reflective or disclose quite personal things or get into a [...] professional but deep relationship with supervisors....when that trust is broken...it....feels like a....betrayal(Brown et al., 2021).

Midwifery trainees reported being 'used' to carry out 'free labour', in the form of menial duties their mentors did not wish to do, rather than supporting them in their education or training needs (Capper et al., 2021b). This prevented trainees from gaining necessary clinical skills and experiencing the more rewarding aspects of their role.

Behaviour.....drifted towards abuse. Niamh noted that 'certain midwives and a team leader exploiting us for free manual labour of mundane tasks, such as photocopying, printing, stripping beds . . . while we're in the middle of something and actually learning' (Capper et al., 2021)

Others described how their supervisors made no effort to conceal feelings of 'disdain' and 'hostility' towards trainees who were left feeling 'intimidated' and unsure of themselves (Brown et al., 2021; Capper et al., 2021b; Thomson et al., 2017). Across the board, trainees identified being undermined

and de-valued in their roles, often feeling like ‘a number’, and even a nuisance (Thomson et al., 2017).

... behaviours, often perpetrated by consultants, but also occasionally... nursing/midwifery staff, which were ...devaluing, undermining, patronising, intimidating and humiliating, ... often conducted in front of colleagues and sometimes patients. (Riley et al., 2021).

Participants described ‘mobbing’ behaviours, or being ‘ganged up on’, which involved staff being recruited by, or colluding with, perpetrators in the act of bullying. This could also be seen in clique cultures in healthcare, where trainees were made to feel like ‘an outsider, not part of the team.’ (Capper et al., 2021d).

Respondents also reported that the perpetrators either operated in groups and, at times, actively influenced peers to join them in bullying the student. ‘She (the mentor) is the bully of the unit; other staff join in to avoid being the next victim.’ (Capper et al., 2021d).

Participants indicated that staff in these circumstances may ‘go along with’ perpetrators to protect themselves from becoming the target of bullying.

Neglectful and Abandoning. Participants reported feeling neglected by their supervisors who were responsible for their safety and learning on placement. This could be seen in passive forms of negligence, whereby supervisors showed a general lack of support and indifference towards their trainee's learning experience and wellbeing. Others described being left to deal with highly complex clinical situations on their own, and the risks this posed to them and their patients.

...You're like, is this person dying? What am I going to do? They'd be like, 'I'm busy, sort it.' (Smith et al., 2018)

Some even believed that supervisors were intentionally exposing trainees to challenging and potentially risky clinical situations as a perverse way of testing their knowledge and resilience.

...this risk was not incidental, but deliberate.... students...being left to practise unsupervised as a way of being put "through their paces" and... 'testing' their competency. (Capper et al., 2021c)

Participants also described feeling abandoned by clinical tutors at the university, who they felt did not intervene or offer support when incidents of bullying were reported. They believed that course staff may have been driven by a more cynical agenda; to preserve relationships with hospitals and funders they relied on, over student wellbeing and perpetrator accountability (Thomson et al., 2017).

Students perceived universities as being in a conflict-of-interest position in relation to these placements: they need clinical placements to provide students with clinical experience during the course and are sometimes unwilling to disrupt positive existing relationships with hospitals which may jeopardise these by escalating complaints of bullying. (Capper et al., 2021)

Discrimination and Harassment. Participants described examples of discrimination and harassment towards students based on gender, race, ethnicity, age, orientation, and religious beliefs. There were several examples of sexual harassment perpetrated by senior male clinicians towards female trainees.

Persistent sexual jokes... that made me uncomfortable....

Uncomfortable touching and invasion of personal space by educators...(The gynaecologist] would be touchy-feely with all the females... I didn't see him doing it with any of his male students. (Broad et al, 2018)

Gender-based discrimination and misogyny were common, as women were often disrespected and made to feel less-than by their male colleagues.

There were concerns over prejudice, including sexism and racism, including one comment....."Maybe you should consider not doing this specialty because you are a woman." (Johnson et al., 2018).

Experiences of discrimination and harassment were often minimised as 'banter', as female victims' complaints were once again trivialised and dismissed. (Broad et al., 2018).

It's [surgery] so very male dominated... a girl can sometimes not be taken very seriously.
Riley et al. (2021)

Overt and Brazen. Participants described an ‘overt and brazen’ type of bullying which took place ‘in plain sight’ and was more aggressive and explicit in nature (Brown et al., 2021). ‘Teaching by humiliation’ is one such form of bullying, notorious in medical training, whereby students are publicly scrutinised and ‘put through their paces’, ‘in front of’ colleagues, other trainees, and/or patients. This was previously carried out under the guise of ‘pedagogy’ and framed as a legitimate form of teaching. However, increasingly, it has been recognised as an abusive practice employed to undermine students, with no educational merit or value.

‘There were....15 of us in the room; the doctor consistently picked on this one boy the entire session, for an hour and a half, two hours, and didn’t ask anyone else any questions, just constantly put him on the spot and was quite intimidating”. (Johnson et al., 2018).

Participants reported being exposed to verbal abuse and aggression, such as shouting, threatening, insulting and inappropriate comments and behaviour, which again took place ‘in front of’ other students and patients. This ‘led to ‘an amplified sense of humiliation and hopelessness’ among victims (Capper et al., 2021a).

She would come up to me and tell me not to ‘f***’ things up and ...shout at me and other students in front of patients if our knowledge of drugs... was not at the level she rendered acceptable for first year/second year students’ (Capper et al., 2021b).

There were even reports of physical aggression, as one participant described a disturbing incident whereby a midwife used physical force towards a student and a mother giving birth, and the severe harm caused by this.

‘...the treatment of women bordered on physical assault: ‘She physically barged me out of the way.... then proceeded to exert hard downward traction causing massive perineal damage. She then stalked off.... in front of the woman said “... THAT’S how you get a baby out.” (Capper et al., 2021a).

Many trainees commented on the 'brazenness' with which perpetrators conducted themselves, as they often seemed to have a cavalier attitude, showing no shame or remorse for the harms caused (Capper et al., 2021a).

This sub-theme demonstrated that WPB takes many different forms. WPB was not incidental, but rather a deliberate attempt to undermine, exploit, and harm trainees. The sobering accounts shed light on an often-unacknowledged aspect, or 'shadow side' of healthcare, highlighting the seriousness of this of issue and urgency with which it needs to be addressed.

Descriptive Theme 1.2) Bullying in Healthcare is Everyone's Business. The shadow side of healthcare is demonstrated here through the significant and pervasive effects of WPB, which extend beyond victims to include the clinical environment and patient safety, as well as the reputation and future of the healthcare profession. This sub-theme therefore details why WPB in healthcare is 'everyone's business'.

'Collateral damage'. This theme relates to the damage that occurs as result of bullying. The student's education, the care received by mothers/babies...the reputation of the midwifery profession...all adversely affected. (Capper et al., 2021a)

Participants described how bullying eroded their confidence and self-worth, as many felt that they had 'internalised' the critical voice of their perpetrators and started to see themselves as inadequate.

When someone is bullying ...saying this is something wrong with you...you start internalising that. (Brown et al., 2021)

For some participants, the extent of the bullying was such that they developed severe mental health difficulties, including depression, anxiety, and suicidal ideation. Some trainees felt their only 'way out' was to take their own lives ('the exit strategy they contemplated was suicide.' (Capper et al., 2021d); an extreme finding that highlights the severe effects of WPB, and urgency with which it needs to be addressed.

.... Some of the seniors and consultants...gave you a really hard time...and made you feel completely incompetent. It broke me. In fairness, it wasn't just me. When I talk to....my colleagues, they say it broke them too I just became really low, really depressed and suicidal again. (Riley et al., 2021).

Participants described being traumatised by WPB, and experiencing symptoms of PTSD (Brown et al., 2021), such as hypervigilance, flashbacks, avoidance, and self-criticism, as well as interpersonal and

physiological difficulties: 'I would be physically sick before entering placement.' (Capper et al., 2021b). Some even required specialist trauma therapy to process these experiences and learn ways to manage the symptoms of PTSD (Brown et al., 2021).

Bullying negatively impacted on trainees' learning and self-efficacy in their role, which had a knock-on effect on their clinical competence, and in turn, their ability to deliver patient care. Participants reported that intense pressure and scrutiny, coupled with fears of criticism and humiliation, made them extremely anxious, and therefore, unable to concentrate, retain information, or perform to the best of their abilities. Students need a safe, supportive learning environment in which they can learn and growth (Gafson et al., 2017). Under the weight of WPB bullying, the clinical environment was filled with tension and hostility, which led to greater risk of risk of clinical errors and compromised patient care.

My mentor expected far too much from me... Whenever I struggled to...grasp what was going on, made the same silly mistakes or asked repeated questions, I was made to feel stupid I hated every minute of a shift, couldn't retain information, felt unsafe, at risk. I came away feeling demoralised...like I'd made a huge mistake taking on the course. I felt it was all me, now I realise it was their methods taking me down." (Capper et al., 2021b).

Participants described how bullying took trainees' and perpetrators' focus away from what should be the 'priorities' of clinical work, making them less responsive to patients' needs, and ultimately posing a threat to patient safety and quality of care. (Capper et al., 2021c).

.... bullying occurring in their (mother's) presence ...will take the focus of the student away from their care, leading to elements that are both emotionally and clinically valuable being missed. (Capper et al., 2021c)

Bullying often took place 'in front of' patients, which resulted in them losing faith in trainees and their care providers more generally. Exposing patients to WPB not only conveys a complete absence

of professionalism, but also adds to the stress of an already anxiety-providing situation, thus increasing the risk of harm or complications during treatment.

Witnessing bullying damages...confidence in the student's ability.... may lead to significant clinical implications.... This eroded sense of confidence may lead to lower ...support and sense of control on behalf of the women, both of which have been associated with.... clinical outcomes such as increased pain in healthcare settings (Milberg et al., 2014; Skuladottir and Halldorsdottir, 2008). (Capper et al., 2021c).

Participants described how perpetrators showed little regard for the impact this had on patients in their care:

I was asked what on earth I think I am doing during the second stage – the woman looked scared and worried.... she thought I had no idea what I was doing....

She yelled at me in front of the bereaved mother (Capper et al., 2021c).

Trainees reported that perpetrators deliberately 'tested' them by leaving them alone to deal with highly complex clinical situations beyond their competencies (Capper et al., 2021c), exposing patients to suboptimal care practices and risks of harm. Participants reported that this was thinly veiled as a form 'pedagogy' but was evidently an act of extreme bullying, which highlighted the extent perpetrators were willing to go to exert power-over trainees.

Mentors took a 'sink or swim' approach, placing students and women in high-risk situations where they were out of their depth...These pedagogical approaches were being adopted more in the interest of enacting power-over the student, or making a dramatic 'point', in a manner characteristic of bullying (Shallcross et al., 2013). So, the use of women as 'props' in the 'theatre' of the maternity unit. (Capper et al., 2021c).

There were examples of patients being directly harmed by and even targets of bullying, harassment, and discrimination themselves.

... mothers not only witnessed bullying but were.... victims of bullying themselves....

'This mentor regularly turned up late, in...foul temper, which she happily took out on me and the women.'

(Capper et al., 2021)

In one disturbing example outlined previously, a participant described an incident whereby a midwife used excessive physical force and caused 'massive perineal damage' to a mother during childbirth. (Capper et al., 2021a).

Across the studies, participants reported experiencing burnout, de-moralisation, and shame in their professionalism identity as result of WPB, leading to many considering leaving the profession.

Disgusting behaviour and makes me embarrassed to be part of this profession...I was spoken to with no respect and humiliated in front of patients. I left...wondering whether I wanted to go into this profession, working with people like that. (Capper et al., 2021a)

The reputation and future of healthcare in the UK is at-risk due to WPB, as trainees are unable to sustain working in such hostile and emotionally-draining environments, the effects of which can be detrimental to staff wellbeing and patient care. A damaged reputation can impinge on staff attrition, recruitment, and retention, along with public confidence and funding. Staff shortages and lack of investment from key stakeholders increases the already significant supply-demand imbalance, and the perpetuation of poor working conditions and toxic cultures in which WPB has thrived.

Without addressing the challenges faced by FDs when raising concerns, we are at risk of allowing moral distress to propagate within our Trusts, which can lead to burn out and demotivation amongst staff resulting in loss of the

next generation of our workforce from the NHS. (Talash et al., 2022)

This sub-theme detailed the significant and extensive effects of WPB on trainees, the clinical environment, and patient care, as well as the reputation and future of the healthcare profession.

This 'shadow' side of healthcare is far-reaching and relevant to all members of society who, at some point, will inevitably require the support of such services for themselves or their loved ones. WPB in healthcare is fast becoming a public health concern, and why this is 'everyone's business'.

Analytical Theme 2: Power with Impunity: How workplace bullying has prevailed.

The second analytical theme describes the conditions in which WPB has been enabled to persist over time and remain 'hidden in plain sight'. Across the studies, participants described an '**abuse of power**', which perpetrators used to intimidate, instil '**fear**' in, and ultimately '**silence**' their victims from speaking out. Following on from the previous theme, WPB is a phenomenon that thrives 'in the shadows', hence the need to shine a light on this issue, and the factors that have emboldened perpetrators over time. The following subthemes will consider these factors in more detail.

Descriptive Theme 2.1) Abuse of Power. Abuse of power has been cited as playing a pivotal role in WPB. Participants reported that the NHS is a very hierarchical organisation, which can give rise to issues regarding power imbalance and structural inequality within the workforce. Across the studies, perpetrators of bullying were typically in senior positions, often occupying leadership and supervisory role in relation to their victims. They were therefore seen to have abused the power and responsibility they had been entrusted with. The power imbalance between supervisors and trainees made it difficult for victims to report bullying, due to fears of repercussions (e.g., being failed, blocked career advancement).

Hierarchy and power 'We [are]... at the bottom of the tree.... there's a clear pecking order'.....

'I thought I would have been thrown out of medical school [if I reported]' (Broad et al., 2018)

This highlights the problem with an 'apprenticeship model' whereby supervisors hold a dual role (both educational and evaluative), which can pose challenges in terms of fairness of appraisal, especially if there have been challenges within the supervisory relationship or indeed WPB. In these situations, trainees may be selective in how much they share with supervisors, in the fear that this may unduly bias or influence their overall grade. Therefore, trainees often feel they need to 'play the game' and keep their supervisors 'on side' to stay safe and pass their placement (Thomson et al.,

2017). Participants felt that perpetrators often exploited the 'gatekeeper' function of their role to exercise control and power over trainees. (Brown et al., 2021).

Hierarchy and repercussions were frequently mentioned. Staff keep their head down and just progress through their career...'scared to out their seniors...' (Johnson et al., 2018).

Perpetrators were rarely held to account for WPB, and because of this, many felt 'untouchable' and beyond reproach. This could be seen in their 'brazen' approach to bullying, which lacked any apparent shame or attempt to conceal misconduct from witnesses.

For the perpetrator, impunity reigned. 'Reported it [being bullied] ... absolutely nothing happened'. 'I feel like it's a known problem...midwives that have been allowed to get away with it for so long'. (Capper et al., 2021b)

Poor leadership, including lack of governance, accountability, and transparency, along with an apparent disconnect between management teams and staff on the frontline, seemed to enable perpetrators to feel 'untouchable' and entitled. As well, many perpetrators themselves held leadership positions, and therefore would be less open to or invested in genuine efforts to address WPB.

Another point raised was that of the role-modelling and the vicious cycle of victim-bullies, as some perpetrators, indoctrinated into a culture of bullying during their training, had gone on to victimise others.

Inappropriate role modelling, which includes bullying behaviour, perpetuates a culture...that does not meet professional expectation." (Capper et al., 2021)

The next sub-theme describes the fear trainees felt to raise concerns about WPB, especially in the

context of such significant power differentials, which were exploited and abused.

Subtheme 2.2): Fear. Participants across the studies expressed reluctance to raise concerns about WPB due to the likelihood of this not being taken seriously or acted on appropriately (Smith et al, 2017). Others were afraid to report WPB as they had legitimate concerns that this could negatively affect them and their careers, as well as the possibility that doing so would exacerbate the situation, leading to intensified bullying and victimisation. It seemed to be tacitly understood, but sometimes made explicitly clear through threats and intimidation, that trainees who raise concerns about senior clinicians will be heavily reprimanded.

Participants emphasised ...fear of potential consequences on their career should they speak up.... The person made me feel like they could ruin my career if I spoke out about it. (Brown et al., 2021)

Whistleblowing remains highly stigmatised in healthcare, with hidden costs or punishments such as negative feedback/lower grading, or deliberate attempts to impede career progression. One junior doctor described how bullying got worse when she tried to 'blow the whistle', and her career was tarnished through professional 'blacklisting' and reputational damage.

...I've got a blemish on my portfolio...a direct result of bullying.... and their inability to take feedback just put the blame on me because I've spoken up. (Riley et al., 2021)

Uncertainty about how to report WPB, coupled with the lack of independent, anonymous channels to do so, added to trainee anxiety and reluctance to raise concerns (Capper et al., 2021b).

These subthemes have detailed how perpetrators' abuse of power was pivotal in the cycle of bullying, as this created fear among trainees associated with whistleblowing or raising concerns. Trainees feared being reprimanded, marked down, or failing a placement, along with anxiety about

bullying getting worse, professional blacklisting, and being ostracised from one's professional community.

Descriptive Theme 2c): Silence. The interplay between abuse of power and fear resulted in victims being silenced, which allowed bullying to propagate and persist over time. Silence occurred in many different forms, such as victims not reporting bullying due to fears of repercussions, as outlined above. Silence could also be seen when trainees tried to raise concerns, these were met with incredulity, attempts to “actively repress” (Capper et al., 2021a), discount, and discredit their complaints. Dismissal of trainee concerns was a clear form of silencing, as they were invalidated and manipulated into believing that the bullying they experienced was ‘just banter’.

...A culture where medical ‘banter’ was a...‘rite of passage’ was a reason students gave for not raising concerns.

(Johnson et al., 2018).

....‘minimised bullying as being nothing more than harmless ‘banter’. (Broad et al., 2018).

Silence was also present when those in leadership roles failed to act or hold perpetrators to account, as well as passive bystanders who ‘looked the other way’ when bullying took place.

All the ...staff looked the other way or at the floor. No one stood up for me. In a room with at least 20 midwives, supposed professional advocates allowed her to scream at me that I was useless and stupid (Capper et al., 2021).

Silence could also be seen in the culture of ‘acceptance’ and resignation towards WPB, as victims felt they had no power to change this situation, leading to feelings of hopelessness and helplessness. This silence was reinforced by supervisors and colleagues, some of whom, possibly through their own experiences of WPB, had become desensitised to this culture, seeing it as a ‘rite of passage’, and something that trainees need to just ‘deal’ with.

Participants reported a cultural tolerance and acceptance of bullying in the workplace, where junior doctors were

expected to put up and shut up, including being expected to do this by their supervisors...‘it felt like, well, this is how the department is, suck it up and deal with it.’ (Riley et al., 2018).

Related to this was an ‘intolerance of vulnerability’ (Riley et al., 2021) among HCPs, a term used to describe a culture of stoicism and machismo in healthcare. Participants reported how they were discouraged from showing emotions and expected instead to remain ‘strong’ (i.e., silent) in the face of adversity, including WPB. Victims encouraged to suppress their emotions has further silenced them, disempowering them from seeking support and enabling the cycle of WPB in healthcare.

...participants described a culture of needing to appear invulnerable within medicine, where work-related distress were normalised and taking time off for physical or mental health is poorly tolerated....which poses a key barrier to seeking help or support. (Riley et al., 2021).

Theme three explored the conditions that have enabled WPB to become such a virulent and widespread issue in healthcare. There appears to be an ingrained culture of corruption and abuse of power by those in supervisory and leadership roles. Victims are reluctant to report bullying due to the futility and negative repercussions of doing so, which resulted in them ‘staying silent’. Perpetrators have been described as ‘brazen’ in their misconduct, showing no fear of punishment or consequences for their often egregious and abusive treatment of trainees. To address this entrenched culture of bullying, and the conditions in which this has proliferated, there is a need for a complete cultural overhaul, as will be discussed in the next theme.

Analytical Theme 3: A Call for Change

Increased recognition and open dialogue about WPB in healthcare has brought about feelings of indignation within the field and impetus for change. The findings of this review highlight growing resistance against the culture of bullying and harassment that has persisted in healthcare until now. This theme describes how, similar to campaigns in other industries (e.g., #MetToo, Time's Up), there is an increasing appetite for change and a mobilising movement towards cultural reform in healthcare.

Descriptive Theme 3.1) A Cultural Overhaul is Needed. Participants described WPB in healthcare as a complex systemic and organisational problem that has reached a critical point, such that a complete cultural overhaul and radical reform is needed (Gafson et al., 2017). Participants described a need for a whole-systems change, whereby whistleblowers are protected, and perpetrators of WPB are held to account. A clear message to all stakeholders is required; that WPB will no longer be tolerated in healthcare. These changes need to be implemented at all levels of the organisation, with those in senior positions leading by example and reinforcing such developments.

...organisations should encourage and protect whistleblowers (Vivekananda-Schmidt & Vernon 2014) provide an environment where FDs feel valued by senior members of the hierarchy and able to voice their opinion... to have a long-lasting impact, changes should be implemented at all levels, in particular organisation leaders (Talash et al., 2022)

One such improvement participants highlighted was that of clear, independent reporting systems that are anonymous and accessible to all. To do this, EHCPs need to be assured that all complaints will be listened to and taken seriously, with no risks of negative repercussions for raising concerns.

...‘the system’ needs to change so that clear avenues of complaint were created, and publicised, and ideally independent ombudsmen or auditors should handle the complaints process...greater resources for both students and midwives.... greater accountability (and consequences) for perpetrators (Capper et al., 2021b).

Participants reported that raising concerns about WPB needs to be normalised and encouraged across the workforce, especially given the implications this has on victim wellbeing and patient safety.

It's important to creating a culture where students are ...empowered to raise concerns, therefore impacting patient safety. (Johnson et al., 2018).

If WPB has 'thrived' in a culture of fear and silence, an organisational climate that prioritises staff wellbeing, openness, and transparency is needed to tackle this. Participants also highlighted that 'improved working conditions' (e.g., staffing, resources, morale), are essential to the systemic and organisational transformation needed to reduce toxic workplace cultures and WPB in healthcare.

To promote awareness about WPB and the devastating impact this has on the workforce and ultimately patient care, training and education is needed for all stakeholders. Training is also needed on how to prevent, recognise, report, and respond to WPB, as well as active bystander training and ways to be an ally at work. Improved guidance is needed for staff on how to respond to disclosures of WPB, including information on how to support and signpost survivors of WPB to relevant information and support services. Increasing awareness and education will help to promote a more timely, sensitive, and targeted response to the crisis of WPB in healthcare.

The research highlights the need for training...about workplace bullying. This could be included in the training of practice placement educators, clinical placement supervisors and course staff, as well as in the induction for trainees. Training should include processes for reporting and responding to bullying and... the importance of responding with empathy and attending to the emotional impact. (Brown et al., 2021).

The hierarchical structure of healthcare in the UK has given rise to the abuse of power and

exploitation of trainees, and thus the perpetuation of WPB over time. This review highlighted that to address this, a fairer, more egalitarian organisational structure is needed, which promotes equality and inclusion across the workforce. Participants suggested that the use of bi-directional, anonymous feedback, and more independent auditing and evaluation systems, as ways of redressing the power-imbalance, promoting impartiality, and giving students a voice (Johnson et al., 2018; Thomson et al., 2017).

... the opportunity to provide anonymous feedback on mentors students are in a position...of being judged, without a symmetrical opportunity to provide feedback on the systems around them. If these systems were.... visible and functional, and allowed complaints to be stored in a database...the incidence of bullying behaviours would likely be reduced. (Capper et al., 2021b)

Participants highlighted that ineffective leadership and poor-quality supervision can be instrumental in WPB, especially when these HCPs lack the specialist training and aptitude to carry them out effectively. Currently, taking on trainees seems to be an expectation for HCPs, rather than a choice. Participants in one study made the point that not all clinicians can or 'should' teach (Capper et al., 2021b), as they felt that only those who truly have a desire to guide and nurture students in their development should take on the vocational role of education and mentorship. Participants provided examples of supervisors who did not hide their disdain and resentment towards trainees, making no effort to support their learning and development.

'(The midwife) proceeded to say it wasn't her job to teach me and that she disliked having students'. (Capper et al., 2021a)

Participants emphasised that supervisors should be required to undergo continued professional development and training on how to provide good quality supervision and mentorship, as well as having protected time and resources for this specified in their job plans (Gafson et al., 2017).

A positive supervisory relationship that is trauma-informed is essential to trainees having a

supportive learning environment in which they can develop the clinical competencies needed to deliver safe and effective patient care (Knight, 2020; Snowdon et al., 2016).

Descriptive Theme 3.2): Moving Towards a Brighter Future: Trauma-Informed Care. Participants described how, given the severity and extent of WPB, the shift towards trauma-informed care (TIC) is long overdue. A trauma-informed organisation is one that emphasises emotional and physical safety for staff and patients, as well as positive working relationships based on trust, collaboration, and empowerment (NES, 2016; 2021). Participants discussed the need for a more compassionate and caring culture, not only towards patients, but also internally towards staff and one another.

Participants referred to the positive regard and support from others when reporting WPB, eliciting a sense of safeness.... a more compassionate sense of self, which challenged self-criticism associated with bullying (Brown et al., 2021).

They highlighted a need for greater prioritisation of student support and staff wellbeing (Smith et al, 2018), which can protect against bullying. For example, participants emphasised the need for greater availability and utilisation of measures such as reflective practice groups, supervision, and peer support.

...participants identified that support could counteract some of the negative effects of workplace bullying. (Brown et al., 2021).

Schwartz Round, a large group reflective forum.... allowed fifth year students to discuss raising concerns in a confidential and safe space. (Johnson et al., 2018)

In keeping with the TIC movement, this review highlighted that compassionate leadership is essential to the development of a positive workplace culture, where staff feel valued and supported in their roles, and empowered to deliver safe and effective patient care (NES, 2021; Talash et al.,

2022; Smith et al., 2018). It is essential that those in leadership roles work collaboratively with and are accessible to staff at all levels of the system, promoting a culture where openness and feedback are encouraged. This is in stark contrast to the 'command-and-control' style leadership and abuses of power seen across the studies in this review, as well as the silence and resignation that enabled WPB to persist until now.

The presence of a positive role model has been demonstrated to play a key role in students clinical experiences, development of confidence, skills, and positive attitudes towards their midwifery practice (Capper et al., 2021).

Participants also suggested the need for a more open and inclusive workplace environment, whereby positive team dynamics, cohesiveness, and peer support are actively encouraged. This contrasts with the "competitive" (Brown et al., 2021) and often "cliquey" (Capper et al., 2021) culture that feeds into problems of exclusivity and inequality, commonplace in healthcare today. This also helps to decrease hidden or pre-existing "alliances" between institutions which give rise to conflicts of interest, and issues such as complicity and collusion, all of which act as barriers to reporting and responding effectively to WPB.

This is made particularly difficult when the manager has existing alliances with those that they are required to address bullying behaviours with.....this leads to a conflict of interest and reluctance to address bullying behaviours with midwives. (Capper et al., 2021b).

They also expressed the need for greater efforts to reduce discrimination and promote diversity and representation across the workforce. This can help to promote a trauma-informed, culturally-sensitive workforce, and thus improve the standard and scope of services for people from diverse backgrounds and minority groups.

By openly evaluating and addressing discrimination and harassment, educators can lead the way in promoting inclusion, well-being, and resilience in medical education, thereby supporting the development of a diverse population of doctors able to meet the needs of their patients. (Broad et al., 2018)

In keeping with the move towards a more trauma-informed organisation, there was an emerging sense of hope among participants for a brighter future for trainees and the patients they care for. Some described looking forward to a time when they will be able to take back their power and redress what happened to them.

This sense that 'one day' they will rectify the situation themselves... 'I promised myself that once I qualify, I will escalate these matters to HR and the [national midwifery governing body] because this is not on!' (Capper et al., 2021d)

Some described post-traumatic growth, whereby the bullying they experienced emboldened their fight for justice and radical reform.

...their response escalated to outright defiance, with students resolving to push on in the profession despite the obstacles placed in their path...students were plotting revenge of sorts: intent to reform the profession (Capper et al., 2021d).

One participant reported that her experiences of bullying inspired her to become a team leader, with a view to making positive changes at a wider cultural and organisational level from within the system. She was determined to protect future generations of students from WPB and the suffering she experienced as result of this.

[I want to become] a team leader so I can become in charge and make sure that new students aren't treated the same way. (Capper et al., 2021d)

This theme demonstrates that there is a new wave of healthcare trainees who are prepared to

challenge the status quo, using their combined and prospective power to influence positive changes in their profession and the field overall. The shift towards a trauma-informed-organisation, where bullying will not be tolerated is an encouraging one for the future of HCPs and the patients they care for. In order for such changes to be successful, they need to be implemented at all levels of the organisation and supported by those in leadership positions and policymakers.

Discussion

This review explored ECHCPs' experiences of WPB in the UK. A total of 12 studies were included, which captured the views and experiences from an overall sample of 500 trainee and ECHCPs.

Using thematic synthesis to analyse the data, three overarching analytical themes were developed: (1) The shadow side of healthcare; (2) Power with impunity: how WPB has prevailed; and (3) A call for change. Theme 1, 'The shadow side of healthcare', outlines the different types of bullying reported by ECHCPs and their effects. WPB is described here as 'the shadow' side of healthcare as it represents a perverse and often unacknowledged culture within this field; a dark side that is under-reported in research and practice, and which sits in contrast to public opinion about HCPs (Kline, 2022; Rhead et al., 2021). This theme highlighted a range of bullying behaviours described by victims, many of which were extreme in severity and extent, along with corruption and concealment from within the field. Also described were the pervasive effects of WPB in healthcare, and how this is 'everyone's business'. Across the studies in this review, participants reported that WPB was carried out by staff in senior or supervisory positions, highlighting an abuse of power, which enabled perpetrators to bully, intimidate, and silence their victims. These findings were consistent with previous research that has too identified power as playing a crucial role in WPB in healthcare (Averbuch et al., 2021; Lee et al., 2022). The range of bullying behaviours described in this review, from neglect and psychological abuse to sexual harassment, humiliation, and physical aggression, were in keeping with Shorey and Wong's (2021) findings on the 'the many faces of bullying', which detailed a similarly broad spectrum of WPB reported by nurses across 27 international studies. The second sub-theme in this section detailed the significant and pervasive effects of bullying; in other words, 'why bullying is everyone's business'. Participants across the studies reported the deleterious effects of bullying on them themselves, their learning, patient care, the clinical environment, and ultimately the reputation and future of the profession as a whole. Trainees were adversely impacted in terms by WPB in terms of stress, burnout, and demoralisation,

as well as depression, anxiety, and PTSD. For some, the effects were so severe that they contemplated suicide. These findings were in keeping with earlier reviews of WPB in healthcare, which reported that the mental health and wellbeing of victims were negatively affected, as many experienced psychological distress in response to bullying (Averbuch et al., 2021; Lee et al., 2022; Shorey & Wong, 2021). These findings highlight the extent of the problem and urgency with which a radical intervention is required.

WPB also impacted on ECHCPs' acquisition of knowledge and skills, which compromised their confidence and ability to deliver safe and effective patient care. Participants described how WPB created a tense and hostile environment to work in, with low morale and high rates of staff turnover, which impacted the reputation of the service, along with recruitment and retention. This finding is in keeping with previous research that has highlighted the impact of WPB on HCP performance at work, staff turnover, and the quality and safety of patient care (Lee et al., 2022; Shorey & Wong, 2021).

The second theme, 'Power with Impunity: How WPB has prevailed', described the conditions in which WPB has thrived and remained 'hidden in plain sight', such as abuse of power, fear, and silence. These findings are consistent with previous reviews which also highlighted power and hierarchy, fear of repercussions, and silence as playing a major role in the development and maintenance of bullying in healthcare (Averbuch et al., 2021; Lee et al., 2022; Shorey & Wong, 2021). Previous research described the various ways in which victims were silenced, for example through threats and intimidation, dismissing the credibility of victim reports, minimising WPB, and inaction on the part of bystanders and leaders (Averbuch et al., 2021; Lee et al., 2022; Shorey & Wong, 2021). Silence could also be seen in the defence mechanisms and ways of coping victims adopted, such as denial, resignation, and stoicism (e.g., 'just get on with it').

This study builds on previous findings by identifying a new theme ('A call for change'), which demonstrates a growing resistance and unwillingness to tolerate the culture of WPB that has prevailed in healthcare for too long. There is a call to action, or movement towards, a more trauma-

informed workforce (NES, 2021), which will require intensive and radical cultural overhaul at all levels of the system. There are examples of similar movements, such as the #MeToo and Time's Up campaigns that have brought about significant changes in the entertainment industry, giving victims/survivors a voice, and holding perpetrators of abuse to account. It appears that the healthcare workforce is on the precipice of its own, long overdue, #MeToo movement.

Another novel finding in this review was that, in keeping with the TIC framework, there is a need for a compassionate culture, whereby all staff and patients feel emotionally and physically safe and supported (NES, 2021). Participants also highlighted that efforts are needed to reduce the power imbalances and healthcare inequalities that have played a significant role in bullying, harassment, and discrimination. They described a much-needed shift towards a warmer and more welcoming workplace environment, whereby ECHCPs are supported to learn and develop the skills they need to deliver safe and effective healthcare. This is likely to improve staff morale, team cohesion, and peer support, as well as reducing burnout, de-moralisation, and staff turnover (NES, 2021). A positive workplace environment where staff feel valued and supported is conducive to greater job satisfaction and wellbeing at work, which, in turn improves the quality and safety of patient care, reducing the likelihood of clinical errors due to burnout, distress, and fatigue (Hall et al., 2020; NES; 2021; Sizmur & Raleigh, 2018; Teoh et al., 2023).

To the author's knowledge, this study was the first to make sense of WPB in healthcare using the Jungian psychoanalytic concept of 'the shadow' (Bateman et al., 2021; Jung, 1971). 'The shadow' refers to a darker, and often unacknowledged part of a person or phenomenon, that typically exists outside of conscious awareness and is ego-dystonic. In this context, WPB can be seen as a symptom or artefact of the 'shadow' side of healthcare, which is often under-reported and maintained over time through silence, fear, and abuse of power. In keeping with the idea of 'shadow work', or therapy, participants reported that shining a light on this issue will help to educate and inform key stakeholders on ways to prevent and address WPB in healthcare going forward. Participants also stated that there needs to be greater acknowledgement of the bullying crisis in

healthcare, particularly by those in leadership and governance roles, as well as a culture of openness and transparency to be adopted in place of the surreptitiousness that had dominated to date.

Strengths and limitations

Previous reviews included a larger number of studies, which limited the depth of analyses and findings. Of the studies included in this review, many used survey-based designs and had relatively large sample sizes for qualitative research, which meant that findings were somewhat descriptive in places. Therefore, the depth of analysis possible for this review was somewhat constrained by the richness of data obtained in the original studies. With that in mind, the author paid particular attention to the scope and scale of this review by focusing the research question and carefully considering the population, phenomena, and context of interest, which helped to refine the inclusion/exclusion criteria and key search terms. This strategy allowed for a comprehensive but manageable set of data, and thus a more in-depth review and synthesis of findings, which is a notable strength of this study.

The ‘phenomenon of interest’ for this review was ECHCP’s views and experiences of WPB in healthcare. This review identified a combination of studies which specifically explored ECHCP’s experiences of WPB, and those which examined WPB in the context of broader research questions and findings (e.g., studies investigating factors contributing to workplace stress and attrition). This demonstrates the importance of careful and comprehensive searches and screening in QES, as studies that may not appear obviously relevant can include pertinent findings that are crucial to the quality and usefulness of the overall review (Boland et al., 2017).

Thematic synthesis enabled the author to follow a step-by-step process, which allowed for a clear audit trail and verification checks, thus optimising the transparency and evaluability of this research. To ensure accuracy and fairness of interpretation, the researcher reviewed their coding and theme development against data excerpts with their supervisor and the second reviewer. Using the GRADE-CERQual (Lewin et al., 2018) and obtaining feedback in supervision also helped to ensure

confidence in the findings of this review, and overall credibility and robustness of this synthesis (see Appendix D).

Another strength of this study was the use of the modified-CASP, which addresses gaps in previous quality appraisal tools by including an additional question on the philosophical underpinnings, epistemology, and ontology of the qualitative research being studied, as well as an option to choose an additional response option when it is unclear if the limitation is a methodological or reporting one (Long et al., 2020). Although the use of quality appraisal tools in qualitative research is debated, recent guidance recommends using a quality appraisal system, albeit one that is adapted for qualitative research (Noyes et al., 2018; Noyes et al., 2023). Therefore, in keeping with Cochrane guidelines, the modified-CASP was used to explore the strengths and limitations of each study, rather than assigning a numerical rating system (Noyes et al., 2018; Noyes et al., 2023; Mays & Pope, 2020).

This review may be compromised by self-selection biases, as the original studies were made up of participants with views and/or experiences of WPB in healthcare. Given that role that fear, silencing, and stigma can play in people not coming forward or reporting WPB in healthcare, it is possible that these barriers also prevented some ECHCPs from participating in the original studies. The findings of this review may be reflective of a subset of victims who, for various reasons, felt willing and able to participate in research on WPB. Thus, there may be a proportion of ECHCPs who did not feel able to participate in research on WPBs, whose voices are not included or represented by the findings of this review. As this study was focused on ECHCPs, the views and experiences of HCPs in senior or supervisory positions are not represented here. Although most original studies included in this review recruited samples of ECHCPs with direct and/or indirect experiences of WPB, others did not require participants to disclose this information. Therefore, the findings of this review are based on ECHCPs whose experiences of WPB may have been mixed, which could influence their reflections on WPB. Despite potential variability in the sample and mixed exposure to WPB,

participants across the studies were consistent in their concerns about the significance, pervasiveness, and impact of this phenomenon in healthcare.

This QES included experiences of ECHCPs across the MDT in an attempt to resolve gaps in the evidence base, as many previous reviews were primarily focused on the views and experiences of medically-trained HCPs, with other disciplines having less of a voice in the literature. This review was also interested in the experience of those in lower-powered positions in healthcare, such as those in early career and training roles, who are at greater risk of exploitation and abuse. Future studies of discipline-specific ECHCPs may help to illuminate any unique factors contributing to WPB in that professional group.

Practice and Policy Implications:

- Updated Inquiry into WPB in UK Healthcare Services: Previous reports, including the Francis inquiry of Mid Staffordshire NHS Foundation Trust (Francis, 2013) and the 2012 investigation into NHS Lothian's management culture (Bowles, 2012), highlighted the negative effects of WPB, coupled silence and 'non-reporting', on the workplace and patient care. Despite these large-scale investigations, the findings of this and previous research demonstrate that WPB has persisted and, in some cases, increased over time (Rhead et al., 2021). This, coupled with the sobering findings of this review, highlight the need for an updated public inquiry into WPB in UK healthcare settings, as well as increased audits and service evaluations in this area. Such investigations are needed to determine the prevalence, severity, and extent of WPB in UK healthcare services, as well as guidance for stakeholders on how to prevent and address this crisis. Clear, targeted strategies to prevent and address WPB in healthcare: This review highlights that WPB remains a serious concern and significant barrier to the successful implementation of TIC. To address this, there is a need for independent, anonymous reporting systems where victims and witnesses of bullying can report concerns without fear of repercussions. A dedicated service within each organisation should be appointed to

provide confidential information and support to those who have been impacted by or witnessed WPB. Improvements in awareness-raising and education on WPB in healthcare is needed, as well as anti-bullying campaigns, zero-tolerance WPB policies across all organisations. There is a call to change and grass-roots movement building momentum in the UK healthcare workforce, which can be seen in recent high-profile reports on sexual violence in surgery, and what has been described as a ‘#MeToo moment’ for healthcare (Begeny et al., 2023; Grierson, 2023). This campaign can be mobilised and strengthened as increasing victims/survivors from across the profession come together in a campaign to end WPB, abuse, and harassment towards HCPs (Choo et al., 2019).

- The National Trauma Training/Transformation Programme (NTTP) (NES, 2016; 2023) makes clear the need for positive workplace environments in healthcare, where safety and compassion for all is prioritised. TIC is a framework currently being implemented across health and social care services as part of the NTTP, a Scottish Government and NHS Education for Scotland (NES) (2023) initiative which aims to create a culture of care that is more sensitive to the needs of people who have experienced trauma, and supportive to those providing such services. A key part of TIC is the importance it places on organisational climate, relationships, and staff wellbeing. TIC recognises the need for staff to feel valued and supported in their roles, as well as the importance of peer support, safety, and wellbeing in the workplace. This protocol aims to create a safe, positive environment, whereby staff are supported to work together and deliver high-quality, trauma-informed care. Therefore, the adoption of TIC as a national strategy and key systemic, and paradigm shift within healthcare may provide a useful framework in which WPB can be considered and addressed.

Research Implications:

- This study applied the psycho-analytical concept of ‘the shadow’ to help make sense of WPB healthcare, and ways in which this might be addressed. Brown et al. (2021) interpreted WPB and victim’s responses to this, as well as strategies to cope with WPB, through the lens of the CFT model (Brown et al., 2021). Future research is needed to build on application of these or other relevant theories and frameworks that can help to explain WPB, and the underlying psychological and sociological mechanisms in which this phenomenon is developed and maintained.
- More research is needed on measures to prevent and address WPB in healthcare. As outlined above, one organisational intervention that may help to reduce bullying and promote a more compassionate workplace culture is that of Trauma-Informed Care (TIC). As the national implementation of TIC is in its infancy, there is a need for more research examining its effectiveness, as well as how it has been received and experienced by key stakeholders. Future research applying the TIC framework to the issue of WPB in healthcare may help to improve our current understanding of and response to this problem.
- As the implementation of TIC across Scotland is a novel initiative, there is a need for future research which aims to explore the feasibility, acceptability, and effectiveness of this, as well as views and experiences of how this implementation is going from the perspective of key stakeholders, with particular consideration given to its role in reducing WPB.
- The evidence base on WPB in healthcare is still in its infancy, and additional quantitative and qualitative research is required. The lack of an agreed-upon definition of WPB means that there is variability in how bullying is operationalised and measured across the literature (Brown et al., 2021; Halim & Riding, 2018). Therefore, the development of an agreed-upon definition, and psychometrically-sound measurements of WPB are needed. This will improve the overall robustness and credibility of the evidence base, as well as future research in this area.

- Future qualitative studies in this area may be improved by employing study designs that promote greater richness and depth of analysis (e.g., semis-structured interviews, IPA).
- Most research in this area has understandably focused on victims of WPB. However, less is known about perpetrators of bullying, many of whom have experienced bullying, adversity, or trauma themselves (i.e., 'bully-victims') (Coyne et al., 2004). To understand this phenomenon more comprehensively, research is needed that explores the perspectives of those who have perpetrated WBP, as well as bystanders and witnesses to WBP.
- Although not formally assessed, Broad et al. (2018) indicated that WPB may be disproportionately represented in certain disciplines (e.g., midwifery, obstetrics, gynaecological doctors, and surgery) (Broad et al., 2018). Future research is needed to establish rates and experiences of bullying across different healthcare disciplines in the UK.

Conclusions

This review synthesised qualitative research on ECHCPs' experiences of WPB in the UK healthcare sector. Findings revealed that WPB is a significant and pervasive issue with serious implications for all stakeholders. WPB is a hidden epidemic, perpetuated over time by problematic power dynamics, fears of reporting, and silencing of victims. There appears to be growing resistance towards WPB among ECHCPs, as well as a shift towards a more trauma-informed, compassionate organisational climate, and workforce overall. This calls for a cultural overhaul, whereby victims of WPB and whistleblowers are protected, and perpetrators held to account. Clinical implications such as improved education, awareness-raising, anti-bullying campaigns, independent reporting systems and supports for victims/survivors were identified. Implications for future research, including audit and service evaluation were discussed.

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Chapter 2. Bridging Chapter

Chapter 1 highlighted that WPB is a significant concern in healthcare, the effects of which can be detrimental to the health and wellbeing of the workforce, and ultimately the safety and quality of patient care. These findings raise questions about how toxic workplace cultures such as these have continued at a time when there is such a strong focus on staff wellbeing and TIC. Following the recommendations outlined in Chapter 1, the next chapter is an empirical study which aims to explore HCPs' views and experiences of TIC, a system-wide framework which seeks to promote a safer, more compassionate and responsive healthcare service and organisational climate for all. It is hoped that this study will contribute to the growing evidence base on TIC and shed light on how key stakeholders are experiencing this paradigm shift in practice.

Chapter 3. Empirical Research

‘The Paradox of Trauma-Informed Care’:

An Interpretative Phenomenological Analysis of Psychological Practitioners’ Experiences of the Implementation of Trauma-Informed Care

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Abstract

Aim: The implementation of trauma-informed care (TIC) has been prioritised by NHS Education for Scotland (NES) and the Scottish Government. However, little is known about the effectiveness and experience of this from the perspective of key stakeholders. This study aims to explore psychological practitioners' experiences of the implementation of TIC when working with people who have experienced complex trauma.

Method: Participants (N = 7) were psychological practitioners recruited from adult mental health and substance use service in NHS Scotland. Data was collected by way of semi-structured interviews and analysed using interpretative phenomenological analysis (IPA).

Results: Three themes were identified: (1) The paradoxical implementation of trauma-informed care (TIC); (2) Issues with the measurement of TIC; and (3) Putting the 'CARE' back in healthcare.

Conclusions: The findings revealed that staff are facing challenges with *how* TIC has been implemented, rather than TIC itself. Staff need to feel adequately resourced and supported in their roles before they can engage meaningfully with TIC training programmes. Issues with internal policies, systems, and workplace cultures need to be reconciled with the principles of TIC. Improvements in the measurement of TIC, and ways to promote TIC across the workforce are discussed.

Keywords: Trauma-informed care, staff perspectives, experiences, interpretive phenomenological analysis.

Wordcount: 16,341

1. Introduction

Over the past 30 years, there has been increasing recognition of the significant deleterious impact of trauma on the mental health and wellbeing of victims and survivors (Felitti et al., 1998; Sweeney et al, 2018). This has led to widespread implementation of trauma-informed care (TIC) across health and social care services worldwide. In 2016, the Scottish government, together with NHS Education for Scotland (NES), developed the ‘National Trauma Training Programme’, an initiative which aims to promote a trauma-informed workforce across Scotland, and in doing so, improve the safety and quality of health and social care services for survivors of trauma (NES, 2016). This comes at a critical time in Scotland, as substance use difficulties and drug-related deaths, often occurring in the context of complex trauma and adversity, are among the highest in Europe (Scottish Government, 2023). The Scottish Government (2023) reported high rates of trauma and adverse childhood experiences (ACEs) in the Scottish population, with 70% of adults identifying at least one ACE, and 15% reporting four or more ACEs. These findings highlight the seriousness of this problem and urgent need for trauma-informed research and service developments in Scotland.

Psychological trauma is defined by the American Psychological Association (APA) as an “emotional response to a terrible event like an accident, rape, or natural disaster” (APA, 2022, para. 1). However, variability exists about what constitutes a traumatic event, as people can experience and be affected by the same incident in different ways (Huang et al., 2014). A person who experiences significant ‘single-event trauma’, such as a road traffic accident or other life-threatening event, can develop post-traumatic stress disorder (PTSD) (DSM-V [APA, 2013]), symptoms of which include flashbacks, hypervigilance, intrusive memories, avoidance, and/or numbing behaviours. Complex-PTSD (C-PTSD) (ICD-11 [WHO, 2022]) is a ‘sibling disorder’ more commonly associated with repeated experiences of developmental and/or relational trauma, such as emotional, physical, sexual abuse, and/or neglect, which can include symptoms of PTSD, along with emotional dysregulation, negative self-concept, and interpersonal difficulties (Karatzias et al., 2017).

Research has shown that people who experience complex trauma and adverse childhood experiences (ACEs) are at greater risk of developing serious mental and physical health difficulties, along with reduced functioning, quality of life, and life expectancy (Felitti et al., 1998; Sweeney et al., 2018). Published in 1998, the ACEs study (Felitti et al., 1998) was groundbreaking in its contribution to how people with trauma are understood and treated. Prior to this, services were often poorly equipped to deliver care in a way that is sensitive and attuned to the needs of survivors of trauma and adversity, often resulting in iatrogenic harm (Butler et al., 2011; Sweeney et al., 2018). The ACEs study, coupled with advancements in the field of trauma more broadly and greater awareness of risks of re-traumatisation, gave rise to the development of 'Trauma-Informed Care' (TIC) (Harris & Fallot, 2001; Sweeney et al, 2018). 'Trauma-Informed Care' (TIC) is a term coined by Harris and Fallot (2001) to describe a paradigm shift in healthcare towards a model of care that is more sensitive and attuned to the needs of people who have survived trauma. This has involved an extensive re-design and, in some cases, a complete overhaul of systemic, organisational, and cultural practices in healthcare no longer fit for practice. The five main principles of TIC are safety, trustworthiness, collaboration, choice, and empowerment (Harris & Fallot, 2001). Chiefly, TIC is an approach that seeks to promote relationship building and safety for all in healthcare. The Scottish Government and NHS Education for Scotland (NES) (2016; 2023), as part of the National Trauma Training/Transformation Programme (NTTP), aim to implement TIC as an organisational framework across NHS Scotland, and in doing so, improve the safety and quality of healthcare services for people who have experienced trauma. This framework aims to (i) improve HCPs' understanding of the pervasiveness and effects of trauma, and (ii) equip staff with the knowledge and skills needed to support survivors of trauma to respond differently to symptoms of C/PTSD and build effective coping skills, and (iii) prevent re-traumatisation. The objective of the NTTP is to implement TIC more widely as an organisational framework, embedding this across all levels of the service, including policy, practice, culture, and environment. TIC is a system-wide intervention made up of multiple components including trauma-informed service design and delivery; staff training, support, and

wellbeing; collaboration with people with lived experience; leadership and organisational culture; policy, finance, and resources; and quality assurance and improvement (NES, 2023).

TIC and complex mental health difficulties

Studies have shown that despite people with severe and complex mental health difficulties (e.g., substance use disorder [SUD], borderline personality disorder [BPD]), being among the most traumatised populations in society (Bozzatello et al., 2022; Leza et al., 2021), these individuals remain highly stigmatised, often facing discrimination and hostility from HCPs (Friehe, 2020; Mendoza-Meléndez et al., 2018; Ring & Lawn, 2019; Sweeney et al., 2018; Van Boekel et al., 2013). TIC offers a more compassionate lens, whereby people are understood more comprehensively in the context of their life experiences, including traumatic and adverse life events (NES, 2022; Sweeney et al., 2018). This is a move away from a purely diagnostic model of mental illness, which has been criticised for its de-humanising and stigmatising effects on people, as well as its oversimplification of what are often complex and multilayered human experiences (Johnstone & Boyle, 2018). However, TIC is relatively novel in its implementation, and stigma towards people with mental health difficulties can be seen in the denigrating language, attitudes, and mistreatment that continues to this day. For example, research has shown that people with BPD continue to be harmfully labelled as “manipulative” and “attention-seeking” by HCPs (Klein et al., 2022), and the use of terms like “addict” and “substance abuser” can negatively affect how a person is viewed by HCPs and the public (Werder et al., 2022). Language and views such as these further stigmatise these individuals, discrediting and de-contextualising their distress and experiences of complex trauma (Day et al., 2018; Sharp et al., 2021). These findings demonstrate that although there is a strong conceptual basis and organisational support for TIC, its principles are yet to be fully implemented at a strategic level or in practice.

TIC and Staff WB

The implementation of TIC has shone a light on staff wellbeing, as there is greater recognition that, in the absence of adequate staff support and resources, HCPs working with people who have experienced trauma are at greater risk of work-related stress, burnout, and vicarious traumatisation (NES, 2021; Skar et al., 2023). Burnout in HCPs is associated with heightened absenteeism and staff turnover, as well as risks to patient safety and quality of care (Hall et al., 2016; Johnson et al., 2018; McNicholas et al., 2020; Søvold et al., 2021). Despite growing awareness of the importance of staff wellbeing, high rates (e.g., 30 – 40%) of work-related stress and burnout remain a significant issue for HCPs (De Hert et al. 2020; Girma et al., 2021; Khasne et al, 2020; NHS Staff Survey, 2022; Prasad et al., 2021). The mental health and wellbeing of HCPs was at greater risk during the Covid-19 pandemic, as staff faced heightened exposure to illness, distress, and trauma, combined with shortages in staffing and resources (British Medical Association, 2022; Vera San Juan et al., 2020; Søvold et al., 2021). During this time, HCPs were expected to deliver care during a global crisis in the absence of appropriate working conditions, infrastructure, and supports (Gilleen et al., 2021; Greenberg, 2020). Mental health professionals faced unique challenges as they supported frontline workers experiencing vicarious traumatisation, moral injury, and burnout (Billings et al., 2021), as well as patients experiencing heightened distress and PTSD (Jimenez et al., 2021; Taggart et al., 2021).

Empirical evidence on TIC

While there is much written about TIC as a conceptual framework, empirical investigation of the feasibility, effectiveness, and experience of TIC has been limited (Champine et al., 2019; Dawson et al., 2021; Robey et al., 2021). Critics have argued that in the absence of a strong empirical basis, the widespread investment in and implementation of TIC, as is currently underway, may be imprudent (Berliner & Kolko, 2016). In response to criticisms about the reported lack of empirical support for TIC, Sweeney et al. (2018) contended that TIC is not a simple or standardised intervention that can be evaluated as such, but rather a paradigm shift that will require system-wide

organisational and cultural change. They posited that, in keeping with critical psychology perspectives and The Power-Threat-Meaning framework (Johnstone & Boyle, 2018), TIC cannot be sufficiently analysed or evaluated through quantitative research alone. Given its complex, dynamic, and relational focus, TIC may be better suited to qualitative methods of inquiry and exploration (Bracken & Karter, 2019).

Critics of TIC have argued that it is indistinguishable from general principles of ‘good care’, already established and in-place across healthcare services (Hanson & Lang, 2016). Sweeney and Taggart (2018) refuted this claim, calling attention to evidence of harmful, insensitive care practices that continue to this day. This can be seen in the many anecdotal and empirical reports of patients feeling silenced, oppressed, and even re-traumatised by negative experiences of healthcare (Clark et al., 2014; Oram et al., 2022; Sweeney & Taggart, 2018). Studies have shown that people can be re-traumatised, for example, by involuntary psychiatric admissions, whereby they feel disempowered, without any real choice or agency in their treatment (Jones et al., 2021; Murphy et al., 2017). Harmful practices were also evident in research that highlighted how patients’ disclosures of pain, distress, and abuse were not listened to or taken seriously by HCPs (Epstein, 2020; Peppard et al., 2023; Tseris et al., 2022). Studies have demonstrated too that structural inequality, discrimination, and stigmatisation towards patients in minority groups exists (Hamed et al., 2022; Keys et al., 2021; McDermott et al., 2021; Patel et al., 2020; Rowe et al., 2021; Saif-Ur-Rahman et al., 2021; SteelFisher et al., 2019), providing further evidence of harmful and trauma *un*-informed care practices currently in place.

In a review of six studies on staff training in TIC, Hanson and Lang (2016) reported some improvements in staff knowledge, attitudes, and clinical practice. Barriers to validating and evaluating TIC included the lack of a clear, agreed-upon definition of TIC and its core components, as well as insufficient guidance on how this framework can be implemented into practice. The findings of this review were specific to an American context and limited by self-report biases, and the lack of control group or follow-up data.

In a more recent systematic review of 23 studies on TIC training and organisational interventions, Purtle (2020) reported improvements in trauma-informed knowledge, attitudes, and practices in staff across 12 studies, as well as improvements in patient-reported outcomes in five studies. These included reductions in the use of harmful practices, such as 'restraint' and 'seclusion' in psychiatric hospitals, along with improvements in patient-experiences of care, communication, rapport-building, and collaborative decision-making. Sustained improvements in patient-outcomes were supported by policy-level reinforcement and staff training. Studies in this review were again limited by lack of control groups, follow-up measures, and variability in TIC measurement. Purtle acknowledged that TIC is still a relatively new phenomenon and more qualitative research is needed on staff experiences of TIC.

In a secondary analysis of a survey of 760 health, social, and educational professionals, Robey et al. (2021) reported the following as facilitators of the implementation of TIC: staff feeling collaborated with and seeing the value of TIC; adequate supports and resources; a culture of openness to change within the organisation; flexibility to adapt TIC to the needs of the target population; and commitment to ongoing evaluation and improvement. Specific components of TIC (e.g., staff training) were more likely to be successful when delivered as part of organisational and system-wide implementation of TIC. Barriers to implementation included poor leadership, communication, and staff retention. The use of secondary data from a primarily American sample limited the generalisability and transferability of these findings to a UK context.

In a 2021 scoping review, O'Dwyer et al. analysed eight qualitative studies exploring HCPs' experiences of delivering TIC in acute psychiatric inpatient settings. HCPs able to reflect on the iatrogenic harms caused by historical practices were more inclined to adopt TIC. HCPs across the studies expressed concerns about the lack of clear planning, policy, leadership, support, or guidance on how to implement TIC in practice. They noted a lack of consideration given to how TIC can be successfully implemented into a complex, dynamic system made up of different parts and paradigms. Other barriers included HCPs' concerns about their ability to respond appropriately to

disclosures of trauma and fears of inadvertently re-traumatising patients. Across the studies in this review, there was evidence that HCPs held negative attitudes towards female patients, with examples of HCPs, who were predominantly male, using denigrating, misogynistic, victim-blaming language which discredited and dismissed women, and their experiences of trauma. This study highlighted a lack of research on the implementation of TIC in acute psychiatry, particularly in relation to gender-based violence, despite the pervasiveness of this issue in psychiatric settings.

Isobel et al. (2021) used thematic analysis to explore 13 psychiatrists' views and experiences of TIC. There were mixed responses to the perceived value of TIC, as some felt that psychiatry has always recognised the role of trauma, whereas others viewed TIC as a significant paradigm-shift offering potential improvements in how services are delivered. Participants acknowledged that while the principles of TIC are conceptually sound, issues around its implementation and limited empirical evidence have led to them questioning the value and robustness of this framework, wondering if instead this becoming a "buzzword" or something that services are merely paying "lip-service" to. Some psychiatrists agreed that recognising the role of trauma can be helpful to patients in 'making sense' of their difficulties, and for clinicians, in terms of being mindful of and seeking to avoid re-traumatisation in their practice. However, many felt that TIC did not apply to the role of psychiatry, for example, in an acute psychiatric setting, where their priority is often crisis management and stabilisation. Psychiatrists were concerned that opening up a conversation with patients about trauma, in the absence of sufficient follow-up services and support, could be harmful. There were mixed views about the role of trauma in mental illness, with some describing this link as quite tenuous, particularly, in the case of psychotic illnesses, which they believed had a strong biomedical basis. They argued that framing psychosis as a predominantly psycho-social disorder which focuses solely on a person's environment or upbringing may risk a return to earlier conceptualisations of mental illness which gave rise to significant parental stigma and shame. Some psychiatrists viewed TIC as divisive in its de-valuation of the role of psychiatry in mental health care, which created apprehension within the profession towards this framework. Participants believed that TIC was part

of the wider anti-psychiatry movement, which aims to dismantle the dominant bio-medical model. This study highlighted that TIC has not been universally embraced across the MDT. Stakeholders need to consider more fully facilitators and barriers to TIC implementation.

Rationale for current study

The above review of the literature highlights that while there has been widespread promotion and implementation of TIC, empirical evidence is lacking (Champine et al., 2019; Dawson et al., 2021). Although there is emerging evidence on the implementation and benefits of TIC, researchers elsewhere have questioned the originality and added value of this approach. There has been a preponderance of quantitative research on TIC, much of which has focused on patient-outcomes. Given its complex, dynamic, and relational nature, as well as difficulties defining and evaluating TIC, quantitative research alone is insufficient, particularly in this early phase of implementation. Qualitative studies conducted thus far have generated novel and nuanced findings, offering richer insights into the views and attitudes of key stakeholders towards TIC and its implementation. This study aims to build on these qualitative findings by using interpretative phenomenological analysis (IPA) to conduct an in-depth exploration of how HCPs are *experiencing* the implementation of TIC in complex adult mental health settings and *making sense of* this. Previous research in this area has been primarily conducted in an American context, which may limit how generalisable and transferable these findings are to healthcare services in the UK. This study aims to address this gap in the literature by exploring the experiences of psychological practitioners in UK-based complex adult mental health services; specifically, a community mental health and a substance use service. Previous studies have focused on one component of TIC (e.g., staff training), whereas this study will explore the implementation of TIC in its entirety as a system-wide organisational framework.

Research Question: What are psychological practitioners' experiences of the implementation of TIC in adult mental health and substance use services in NHS Scotland?

2. Methodology

Design

TIC is a relatively novel and comprehensive framework, which has not received much empirical support or been explored through phenomenological research. Therefore, a qualitative research design was chosen to explore psychological practitioners' views and experiences of the implementation of TIC. Interpretative phenomenological analysis (IPA) (Smith, 1996) was used to gain a rich insight into participants' individual and shared experiences of TIC. IPA enables the researcher to conduct an in-depth analysis of participants' lived experiences, exploring perceptions and sense-making at both an individual and group level (Smith et al., 2021). The researcher then takes this information and constructs a narrative ('tells the story of the data'), in a way that represents individual and group-level analysis, and captures the complexity, nuance, and implications of findings in relation to the research question. IPA was chosen over other qualitative methods, for example, thematic analysis, as it gives voice to the individual lived experiences of participants, while also capturing commonalities across the group. Whereas TA usually involves developing themes across the dataset as a whole and does not allow for in-depth case analysis of each individual's unique experience (Chatfield, 2022). IPA was also chosen over grounded theory, as the researcher was not seeking to develop a theory, but rather to gather initial findings on staff perspectives' using an idiographic and hermeneutic process (Chatfield et al., 2022).

Participants

Seven psychological practitioners (male = 1; female = 6) were recruited by way of purposive sampling from a local adult mental health and substance use service in Scotland. The decision to recruit from one discipline was made with the view to promoting the homogeneity of the sample. All participants were white, third-level educated, and aged between 25 and 54. This sample size was deemed sufficient for doctoral-level IPA research, while also allowing for in-depth analysis of data (Clarke, 2010; Smith et al., 2022).

Procedure

A flyer (Appendix N) advertising the study was disseminated across these two services and staff were given an opportunity to contact the researcher if they had any queries or wished to take part. Participants were deemed eligible if they were NHS psychological practitioners, aged 18 years or older, spoke fluent English, worked with survivors of complex trauma in adult mental health/substance-use services, and had some experience of the TIC framework and its implementation into services. Interested participants were sent a participant information sheet (PIS) (Appendix L) and consent form (Appendix K) prior to the interview being conducted. The researcher developed a semi-structured interview schedule (Appendix M) based on the literature and principles of TIC, which was refined in consultation with the research team. The use of semi-structured interview schedule provided a flexible framework, which allowed participant-led reflections and rich, in-depth discussions to take place (Smith & Nizza, 2022). The researcher explained the aims of the project at the start of the interview. They provided a definition of TIC and its main principles as a reminder for participants, which they could refer back to during the interview if needed. The researcher conducted the interview in a warm, relaxed manner, building rapport and creating a safe environment for participants to reflect on and share as much, or as little, of their experiences as they felt comfortable to. Interviews lasted approximately 50 – 90 minutes and took place via MS teams or in-person at the participant's workplace, depending on their preference. Four participants chose to take part in the interviews via MS teams, while three took part in-person. Interviews were recorded via an NHS-encrypted recording device for the purposes of secure data collection, transcription, and analysis.

Ethical Considerations

Favourable ethical opinion was obtained from the School of Health in Social Science at the University of Edinburgh and NHS Management (Appendix H and I). Participant data was treated with strict confidentiality and data protection protocols. Participants were given PIS and asked to sign informed consent forms prior to taking part in the study. Participants were fully briefed, and consent

was obtained again verbally at the start of the interview. Participation was voluntary, and participants were given opportunities to take breaks or discontinue the interview at any point. Participants were de-briefed, given an opportunity to ask questions and/or to share any feedback on their experiences of the interview at the end. Although no distress was reported, participants were signposted to information and support services. Participants have been given pseudonyms to protect their anonymity.

Analysis

In keeping with IPA guidelines (Smith et al., 2021; Smith & Nezza, 2022), the researcher transcribed interviews verbatim and conducted an in-depth analysis of each individual transcript, making exploratory notes initially, which were then developed into experiential statements, and personal experiential themes (PETs) (see Appendix O). They then moved to a cross-case analysis, identifying and developing Group Experiential Themes (GETs) from patterns of convergence and divergence across the data (see Appendix P). This process was iterative and multi-layered, as the researcher sought to identify descriptive, linguistic, and conceptual codes, patterns, and observations within each interview on its own and across the dataset as a whole. PETs and GETs were developed and refined over time, using diagrams, reflective practice, discussions with supervisors, and in the process of writing up the analysis.

Ontological, Epistemological, and Theoretical Assumptions

This research was underpinned by a critical-realist ontology and interpretivist epistemology, which holds that there is no one single 'truth' or objective reality, but rather different versions or experiences of reality which depend on how a person perceives and makes sense of an event or experience (Cuthbertson et al., 2020). This can be influenced by many factors, including a person's background, culture, education, socialisation, biases, and affective state. In keeping with interpretivist underpinnings, IPA emphasises the active role the researcher plays in making-sense of participants' experiences, and how this will also be influenced by the researcher's background, experiences, values, and biases.

Reflexivity

Throughout this project, the researcher maintained a reflexive stance, holding in mind the ‘double hermeneutic’ that plays a role in IPA. In qualitative research, and IPA in particular, the researcher’s own reflections and experiences are not seen as a limitation or something to be ignored or denied. Rather, it is the researcher’s duty to examine and acknowledge their views, experiences, and standpoints, in terms of how these may influence each stage of the research process, from choosing the topic and design of the study, right through to the analysis and reporting of findings. For that reason, subjectivity, when it is made explicit and harnessed correctly, is considered a strength in qualitative research (Tuffour, 2017).

Commentary on Reflexivity and Reflections

The researcher is a trainee clinical psychologist who has experienced the devastating effects of complex trauma, both personally and professionally. I have witnessed how complex trauma can be exacerbated by, and in the context of, social disadvantage and deprivation, as well as colonialism, inequality, oppression, and discrimination. These views and experiences have shaped their passion to work with, support, and be an ally to survivors of trauma and abuse, as well as their interest in the topic of TIC. This research was an attempt to shed light on the TIC movement, as the implications of this are of vital importance to survivors and those who support them.

Participants in this study were psychological practitioners, professionals who are naturally aligned with the principles of TIC and therefore may be less likely to be critical of this framework or implementation. As a trainee clinical psychologist, the researcher was mindful of the potential challenges and opportunities that could come from being part of same profession as the participants in this study. Although the researcher made efforts to not be *unduly* influenced by personal and professional biases, they recognised that it was impossible to be fully independent or to assume an outsider perspective in this research. Rather, they sought to be aware of how their sense-making of participants’ accounts was informed by their own lived experiences, reflecting on this as part of the double hermeneutic process throughout. It is possible that having an insider perspective and being

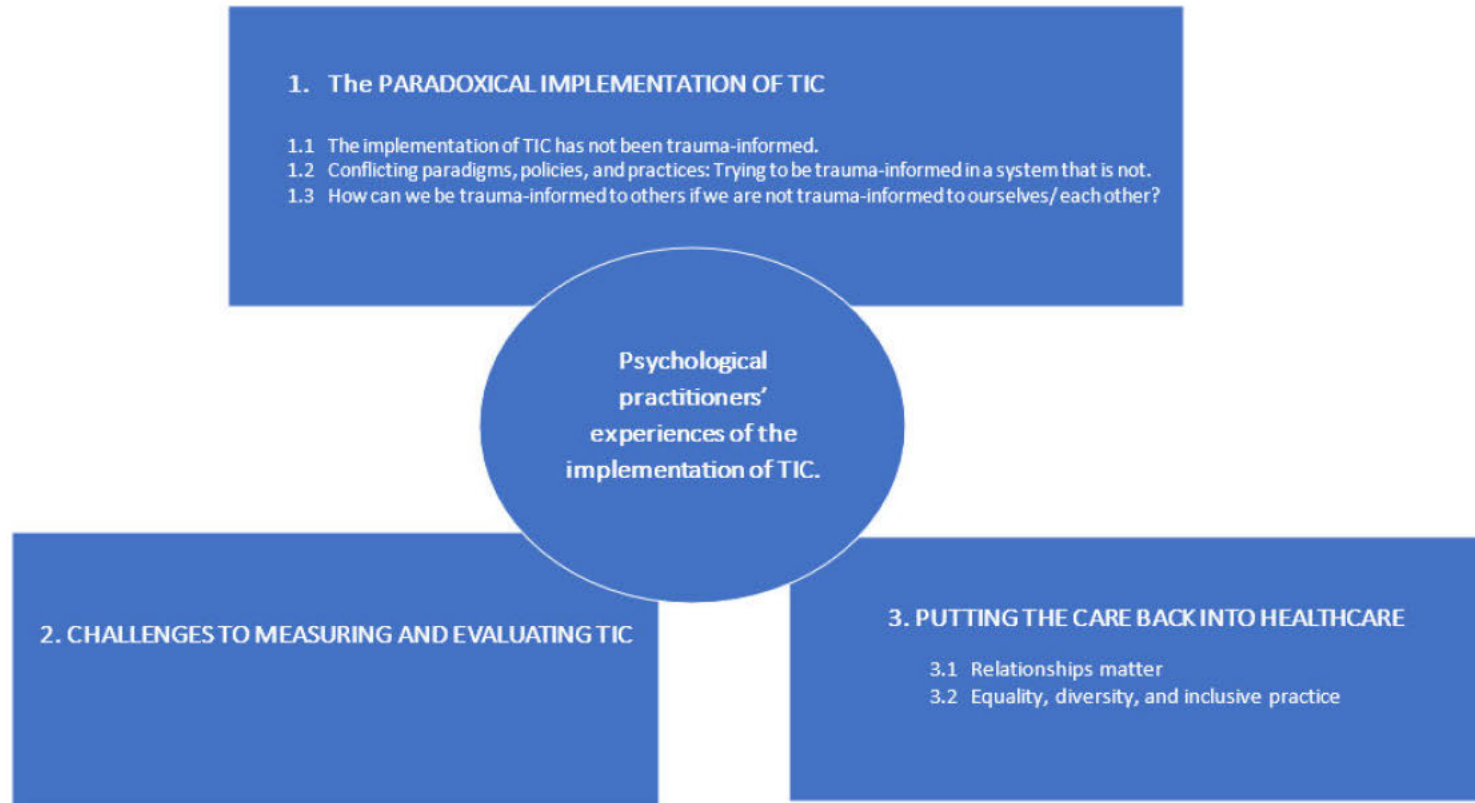
an ally may have fostered a sense of familiarity that enabled participants to reflect more openly and freely. However, being this 'close' or related to the sample also could have had the inverse more restricted in what they were able to share. Efforts were made to support participants to feel safe and at-ease during the interview, such as briefing them on confidentiality and anonymity at the start, and conducting the interview in a warm, relaxed atmosphere. At the end, participants all reported feeling comfortable to reflect on their experiences openly and honestly. Overall, they described this as a positive and validating experience, giving them insight and ideas for their work going forward.

3. Results

Seven interview transcripts were analysed, and from these three overarching themes were identified: (1) The paradoxical implementation of trauma-informed care (TIC); (2) Issues with the measurement of TIC; (3) Putting the '*care*' back in healthcare (see figure 1. for illustration of group experiential themes and subthemes).

Figure 1.

Illustration of themes and subthemes



THEME 1. THE PARADOXICAL IMPLEMENTATION OF TRAUMA-INFORMED CARE

1.1 The Implementation of Trauma-Informed Care has not been Trauma-Informed

Participants expressed favourable views towards the value and clinical utility of TIC as a framework. It was the *implementation* of TIC, rather than TIC itself, that participants reported challenges with. Participants felt frustrated that TIC has, paradoxically, *not* been implemented in a way that is “trauma-informed” or consistent with the underlying ethos of this framework, and the perceived hypocrisy of this. Sarah’s statements below suggested that implementing such significant organisational changes at a time when services are “crashing” and doing so in a way that is not sensitive or attuned to the current climate in healthcare was not only ill-judged but also an unfair and untimely ask.

[In the NHS] ...I think trying to implement change...in the current state of stress and burnout...staffing and resources and ...people just crashing.... What is the function of that resistance, for some people it might be: ‘You are asking too much of me, I am burnt out, and I can't do anymore.’ (Sarah)

She highlighted that healthcare services have not yet fully stabilised since the global pandemic, with many HCPs feeling overwhelmed and under-resourced. According to Sarah, staff are experiencing significant stress, burnout, and secondary traumatisation, as she pointed out “people are just crashing”. Sarah indicated that HCPs being expected to implement such fundamental and extensive changes at a time of extreme upheaval has understandably been met with “resistance” from staff teams. There was a sense of urgency in Sarah’s voice, as she shifted from the third to the second person, seeming to momentarily inhabit the perspective of staff who are affected by this. When doing so, she appealed directly to those responsible for the implementation of TIC and her message was unequivocal as she said, “you are asking too much of me, I’m burnt out...I can’t do anymore”. This gave an insight into the level of exasperation being felt on the frontline, as well as Sarah’s concern for her colleagues in this position. Sarah’s account indicated that if TIC continues to be implemented in a way that is not attuned to the needs and limitations of HCPs, this is not only at-

odds with the guiding principles of the framework, but could also have the inverse effect, becoming harmful rather than helpful to staff wellbeing and, in turn, patient care.

Sarah went on to describe the poor working conditions of a ward she worked on, and how hypocritical it was to expect staff who are not feeling safe in themselves or their environment to promote feelings of safety and containment for others.

.... the ward was...very under-staffed... a negative culture...feeling really unsupported by the organisation, at-risk on the ward... they weren't feeling safe and there was a lot of issues I had with the way people spoke about patients... that dismissive or blaming...not taking a psychological approach to understanding their difficulties (Sarah).

Sarah indicated that in the absence of adequate supports and safe staffing levels, HCPs feel overwhelmed and under-valued, and the culture becomes toxic to work in. She noticed that staff felt exasperated, unsafe, and “at-risk” in their roles, which lessened their capacity to understand and treat patients in a compassionate or ‘trauma-informed’ manner. For example, Sarah described feeling uncomfortable about the “dismissive” and “blaming” way HCPs viewed and spoke about patients, as this was not only at-odds with trauma-informed way of working, but also, her own personal and professional values and ethical standards. Considering this from a psychological perspective, it is possible that staff under such extreme pressures may have projected or misdirected their resentments towards the people they are being expected to deliver TIC to, rather than those in charge. In the absence of clear and accountable leadership and forums where staff can express how they are feeling, patients seemed to become inadvertent scapegoats or targets of frustration. Sarah’s point demonstrated further evidence of issues with, and indeed the irony of, the current implementation of TIC. This shows that in order for TIC to be successfully implemented, it needs to be embedded across all levels of the system, including organisational culture and attitudes towards staff wellbeing. HCPs need to feel safe and supported in their roles before they can deliver safe, effective healthcare and engage meaningfully with change-based initiatives such as TIC.

This view was echoed by Vicky and Isabelle, who shared concerns about their colleagues, particularly those in nursing, who, because of their intensive workloads and pressures they are facing, do not have the time, resources, or support to engage with the TIC training programmes or put these skills into practice.

...if you were to say to a CPN, 'would you like to come on 1/2 day trauma-informed course'...I think they'd love to but I think they'd really struggle to justify the time... to be supported by their management. (Vicky)

I know that [nurses] have very big caseloads and.... it's all about medication mainly... it must be more difficult for them to be trauma-informed ...because they have less time to see patients...(Isabelle).

They expressed concern for their colleagues who have less time to focus on the relational aspects of their role or to engage in a meaningful way with TIC developments. This suggests that the role of nursing is at-risk of becoming a more procedural one, with greater focus on the prescription and paperwork than the person in front of them.

Participants described how TIC has felt imposed on staff teams, rather than being implemented in way that feels collaborative or empowering to HCPs. The mandating of TIC as a standard that must be achieved seems to have had the inverse effect, as staff experience this as yet another target to be scrutinised against. Below, Anita described how this has become a source of immense pressure, leading to her becoming more critical of herself and ultimately feeling a sense of failure in her role.

...it adds to that pressure... because you could *ALWAYS* be more trauma-informed....[it]...adds to that: 'is this good enough?'... it can make you think about things more and pay more attention to subtle interactions. It could also go the other way – you know, being hypercritical of yourself, and that's not trauma-informed...because you're a human being... we can't be perfect. (Anita)

Anita's statements indicated that the implementation of TIC, when delivered in a way that felt pressurised and evaluative became 'just another stick' for staff to beat themselves with. This was another example of the paradoxical implementation of TIC, as it has been rolled out in a way that

runs counter to the intended aims and ethos of this framework. Anita's message stressed the need for implementation groups to recognise that HCPs are "human beings" and therefore "can't be perfect". This represents a shift away from the idealisation of 'healthcare heroes', a label that can perpetuate unrealistic expectations of and, in effect, de-humanise HCPs.

Similarly, Samantha highlighted that *obligating* staff to engage with reflective practice groups as part of the implementation of TIC is at-odds with the spirit of TIC, which, at its core, is about fostering *choice*, safety, trust, collaboration, and empowerment.

...reflective practice isn't for everyone and ...we can say to people 'oh reflective practise... you need to go and reflect on how difficult this work is'... but I think we have to acknowledge that not everybody wants to do that with work colleagues. (Samantha)

Samantha made an important point, as she highlighted that mandated attendance of TIC initiatives, particularly those that may elicit difficult emotions, is unlikely to foster willing participation or engagement. Just as TIC is not a one-size-fits-all approach for patients, so too is the case for staff who should be able to choose which wellbeing and reflective practice tools are best-suited to them.

Sarah highlighted issues with generic training on TIC that is not tailored to the specific needs of the patients or staff teams it is being delivered to. This is, again, at-odds with the TIC framework, which emphasises that TIC needs to be *adapted* to the target population and context. Below, Sarah demonstrated very powerfully the risks of merely churning out TIC in a uniform manner that does not carefully consider the specific needs and sensitivities of the patient group for whom it is being delivered.

... people who have abusive backgrounds... who have never experienced compassion or have only experienced compassion by...perpetrators of their abuse... then compassion can be really threatening. So, you're being a compassionate person and they're going "fuck off, you're about to rape me. I'm not touching you like...why are you doing this?"...Our response is to be *more* compassionate. (Sarah)

Sarah highlighted that a well-intended act of compassion can be experienced in a very different way by someone who has only ever experienced 'compassion' in the context of exploitation or abuse. She illustrated the perspective of a survivor who might feel distrustful of and even threatened by compassion, saying "f**k off...you're about to rape me!". The immediacy and intensity of the language used here demonstrated how strongly Sarah feels about this issue and the urgency with which it needs to be addressed. Sarah's reflections here highlighted that TIC, if not delivered in a way that is sensitive and attuned to the individual or group for whom it is intended, may paradoxically be trauma *un*-informed and even harmful.

1.2 Conflicting paradigms, policies, and practices: Trying to be trauma-informed in a system that is not.

Participants voiced the challenges of trying to implement TIC into a system with conflicting policies and procedures. For example, Sarah shared her grievances with how harmful and ill-considered certain practices in healthcare continue to be. Specifically, she spoke about how (re)-traumatising the process of involuntary admission to a psychiatric ward can be.

... the relationship dynamics that play out in trauma...there's usually something around control, power.....criticism.....humiliation...Lack of power and control is often.....key... and actually when you're being detained, when you're dictated to by strict ward policy...you *have to behave* in a certain way. That can be really difficult and... really triggering for people. (Sarah)

Sarah's reflections illustrated that the process of detention, by its very nature, strips people of their choice, autonomy, and freedom. This often involves and is facilitated by way of oppressive strategies such as restraint and sedation, which can be re-traumatising for people who have experienced trauma and abuse. Sarah's choice of words here were noteworthy, as she described how patients are "dictated to" and "*have to behave in a certain way*", indicating an absence of patient safety, collaboration, and empowerment in such environments. She spoke to the irony of this, as the intervention intended to keep patients safe can have the inverse effect, leading to them feeling re-triggered and re-traumatised. Sarah's reflections here give a sense of the inner-conflict and turmoil she felt working in a system that is actively re-traumatising the people it is claiming to treat.

Below, Anita described a lack of joined-up thinking from implementation groups regarding how infeasible it would be for HCPs to successfully embed TIC into a system with such contradictory policies and procedures.

There's a lot of contradiction ...a lot of processes in a system like the NHS...don't seem informed by complex trauma theory...a certain number of sessions ...DNA policies...it must feel quite punitive for patients. (Anita)

In particular, she voiced frustration about strict DNA policies which she feels can be "punitive" and even rejecting to people, as they often fail to consider individual circumstances and the complexity

of patients' needs. This was also true of the limited number of sessions, another NHS policy, which is at-odds with the need to adapt and individualise treatment to patient need, a principle that is central to the TIC framework. Anita's exasperation indicated that asking HCPs to implement TIC in the system as it is currently, with such conflicting policies and procedures, is impracticable.

Samantha expanded on this view as she noted that it can take longer for patients who have experienced trauma to build safe and trusting relationships with HCPS, which is why an untimely, abrupt, or ill-considered ending imposed by NHS policy rather than clinical judgement could have detrimental effects.

It can take time to build up rapport with people ...then feeling pressure to move them on or complete therapy.... there's a waiting list, there's HEAT targets... when people have complex trauma it's not just a case of: 'Oh, you can offer 6 sessions of therapy, 12 sessions, whatever'. (Samantha).

Samantha contended that pressure placed on HCPs from senior management and NHS policies to 'move [patients] on' and 'complete therapy' is based on a target-drive agenda rather than patient need. She was of the view that this distracts from and is incompatible with the principles of TIC, potentially reducing the quality of care and therapeutic effectiveness.

Isabelle commented on the rigid and harsh way that discharge policies were enforced:

I was struck by the discharge policy.... when hearing about people being discharged for essentially not turning up....it just didn't feel...right...or...fair, especially with substance misuse knowing that people's lives are very chaotic, they do struggle, so it's not that they don't want to come, and they don't need help. They just struggle to have any sense of structure; and they're very anxious in this bubble of affliction. (Isabelle)

She described how these strict discharge policies did not feel "right or fair", particularly when working with people who, because of issues with trauma and related difficulties, often have difficulties with attendance and engagement. Isabelle pointed to the injustice of a policy that fails to consider the complexity of a person's circumstances and how these might affect their engagement with services. This spoke to the idea of 'hard to reach' services versus 'hard-to-reach' patients (Bucci

et al., 2019), which argues that the onus should be on services to make themselves more individualised and accessible to patients, rather than the other way round. Isabelle too questioned the widely-held concept of 'readiness' for treatment, arguing instead that psychologists should be willing to meet people where they are at and support people at various stages of the change cycle (Prochaska & DiClemente, 1986).

...There is an issue of this concept of people being '*ready*'...I know that as a psychology service we have to work with people who *want* to work with us and are ready to take this work on.... but I feel we still have some role with people struggling to engage; and maybe not able to take it *fully* on.

She critiqued the logic of the current system, which stipulates that patients need to be 'stable' and 'ready' to change before they are deemed eligible for therapy. Whereas, in reality, people often require therapeutic support to establish the degree of stability and preparedness required to engage fully in treatment. This becomes a circular argument, which again speaks to a dissonance within the system, as current NHS policies are at-odds with psychological and trauma-informed models of change, which recognise the non-linear nature of recovery and the importance of meeting people where they are at.

Isabelle also emphasised that services to be fairer, more flexible, and considerate to the needs of the populations they are working with; meeting people where they are at, rather than the other way around:

.... from the policy level, they should be making allowances for things like sending people reminders or engaging with people with long-term issues, not just through letters but through other means – text messages. (Isabelle)

She suggested ways of improving patient accessibility and engagement, such as more open and inclusive referral criteria; fairer, more clinically-informed discharge policies; greater use of technology-mediated communication (e.g., text reminders); outreach; openness to adapting and finding creative ways of supporting people in their recovery.

Participants also commented on the challenges of trying to integrate the TIC framework into a predominantly medical model of healthcare. They described difficulties trying to work within and reconcile two competing paradigms. Anita and others recognised that, as psychologists, they were more naturally aligned with trauma-informed ways of working, as this is consistent with their training, ethos, and approach to clinical practice.

For a psychologist... you can't *not* agree with that (TIC)...it's the way it should be ... it's extremely important.

(Anita)

Participants noticed however that for other disciplines, the mere suggestion that they might need to become more trauma-informed seems to have elicited complex and even defensive responses. Anita explored this further as she considered what these reactions may be revealing:

... when I work within the MDT, I think there's a lot of ...the idea that it's quite insulting like people aren't doing their job right or 'how are we not TI?' So maybe seen more as a bit of an insult or ...punitive – like there's something not going right. These are things you hear. (Anita)

Anita described how some staff seem to have experienced the TIC implementation as “insulting” or patronising, as the subtext of this implied to them that what they have been doing until now has not been good, or trauma-informed, *enough*. This is another example of how something intended be helpful can have the inverse effect if not delivered in a way that is sensitive and attuned to the target audience. There appeared to be an attitude of resentment and distrust towards the implementation of TIC among some professional groups. Sarah wondered if they may feel threatened by a framework that calls into question some of how they have been trained to practice, thus undermining the value and integrity of the care they have been delivering to date.

...In retrospect, we could have threatened their sense of 'working self' or ...making them feel criticised... probably triggering something within that individual.... they were just resistant to that change in practice... ...they were really... 'agro' like “I just don't agree with this, I think what we're doing works.” ... (Sarah)

Sarah spoke to how staff seemed to struggle with such fundamental changes to practice as these may have been perceived indirectly as a criticism of their life's work and professional identity. This

may explain why some HCPs have been “resistant to” and even in some cases angered (“agro”) by the implementation of TIC, feeling the need to vehemently defend the legitimacy of their current practice and reject the potential value of TIC. This demonstrated how systemic resistance to change often runs deeper than it seems on the surface and can be influenced by a complex interplay of personal, professional, and political factors.

Participants voiced how psychiatry as a discipline, in terms of its underpinning philosophy and approach, can feel fundamentally at-odds with the TIC framework. Jean described how, the psychiatrists she has encountered have had a more rigid (“black and white”) view of people’s difficulties, and way of working. She contended that humans are complex beings, who need to be understood more comprehensively in the context of their life experiences.

Psychiatry...is very black and white..... I like to look at the bigger picture, more of a holistic approach to people, considering the past, the links to the past is forever there. (Jean)

Jean referred to the longstanding tension between psychology and psychiatry, which she believes may be rooted in key differences in how these two disciplines understand and treat human suffering.

...there is that push-pull between psychology and psychiatry. We are looking at the same thing from two different perspectives..... diagnostic criteria – personality disorders, EUPD - my feeling is that we look at that diagnosis *very differently*. We look at that going ummm that person has a history of complex trauma...

Jean noted that psychiatrists typically use a diagnostic classification system (e.g., DSM-V) to inform clinical decision making, whereas psychologists tend to view people more holistically using a psychological formulation, which considers their background and experiences that have shaped them. The psychological way of working therefore tends to be more naturally aligned with the trauma-informed framework and approach to care.

John too voiced his support for a trauma-informed, rather than a purely categorisation-based, model of care:

When you place it in a trauma context, you're able to go well - that's exactly how we'd expect this person to be feeling and behaving given the trauma history ...(John)

John made the point that, when a person's mental health difficulties and coping responses are considered in light of 'what's happened' to them, they invariably make more sense, both to the individual themselves and their treatment provider.

Samantha too shared concerns about what can feel like a rigid and even reductionist approach to clinical decision making in psychiatry:

...not a lot of thought [about] why they're struggling to attend. Just taking it as "well, they're not attending so we'll just discharge them" ...: "Reduce them off the prescription", "discharge them...they can go back bottom of the waiting list", "That's not acceptable behaviour". We need boundaries...but at times I think people can veer towards becoming punitive, perhaps as a way of managing the complexity of people...(Samantha)

She voiced feelings of discomfort about clinical decisions that can feel quite reactive, even at times bordering on "punitive" to patients who have had difficulties with attendance and/or engagement in treatment. Samantha reported witnessing this happening in the absence of due consideration toward individual circumstances or barriers to treatment. However, Samantha was able to consider both perspectives, as she also empathised with her medical colleagues, wondering if they may have become more "black-and-white" in their decision making in response to working in an area as complex and unpredictable as substance use services can be. She considered the possibility that HCPs might become rigid, over-controlled, or authoritarian as a way of coping or trying to re-gain a sense of control in an environment that can feel uncertain and, in many ways, out of control.

Samantha acknowledged that some patients, when highly distressed can exhibit extreme or agitated behaviours, for example, becoming "demanding" or "angry" towards HCPs.

... people do present sometimes in a way that is quite difficult; they can be demanding; they can be angry; turn up late, demand to be seen ... people are chaotic, which means they don't engage with a boundaried NHS service. So, when they don't attend their appointment for example.... how do we respond to that? do we keep in mind

that chaos? or do we...say, 'you know what, they're not showing up... that's the third time I've offered them an appointment. I'm just going to discharge them.' (Samantha)

She appreciated how difficult it must be for staff to remain 'trauma-informed' when feeling disrespected or threatened in this way. However, Samantha also noted that for some people who have experienced trauma, distress can present in the form of maladaptive externalising behaviours, such as aggression, or internalising behaviours, such as avoidance, behaviours which are poorly understood by rigid frameworks and approaches to care. This creates a situation whereby people with high levels of trauma and distress are likely to elicit even more negative experiences of care and barriers to treatment, which can reinforce feelings of distrust and disillusionment.

John introduced a more nuanced and integrated perspective, which seems rooted in his wisdom gained over years of experience. He spoke about how his views have become more flexible and balanced over time, as he now recognises that TIC and the medical model can co-occur and even complement one another.

...I've probably modified my views over the years...because you have to work with medical staff as well as psychological staff.... I now may be more inclined to see that the two things co-exist - that someone's complex trauma history has radically altered their personality traits. They are more suspicious...maybe more chaotic.... dangerous towards themselves.... impulsive...but these changes ...have occurred in their personality *because* they have been abused and neglected. So, I try to look at how these two different worlds can kind-of live together a bit easier. (John)

To John, TIC and the medical model do not have to be mutually exclusive, as he noted that "the two things co-exist" and are interconnected. He posited that people who experience complex trauma can experience significant disruptions in their psycho-social and emotional development, as well as coping responses and interpersonal functioning, which can present as mental health difficulties and diagnoses later in life. In bringing these two perspectives together, John shone a light on how two seemingly conflicting paradigms, such as the medical model and TIC, can be integrated more cohesively in a way that facilitates a more comprehensive MDT approach to understanding and treating trauma.

1.3 How can we be trauma-informed to others if we are not trauma-informed to ourselves and each other?

Participants decried the hypocrisy of being expected to become more trauma-informed, while working in systems and under leadership that are not trauma-informed to them.

If we're not being trauma-informed to staff, how are staff meant to be trauma-informed...if we're not looking after our own/each other, then how can we look after others?....(Sarah)

In Sarah's view, HCPs simply cannot care effectively for others if they are not caring for themselves or being cared for by their employers and in the system. She noted that HCPs need to 'put their own oxygen mask on first', as staff wellbeing and self-care are often overlooked by healthcare professionals, partially due to a tendency to put others' needs ahead of their own, but also due to the pressures of their role. Despite increasing discourse about staff wellbeing as part of the wider TIC movement, this is something that seems to be noticeably absent from the implementation of TIC in its current form:

Part of being trauma-informed is protecting staff members as well... ... people are so burnt out ...they're probably not managing to show compassion to themselves so how the hell are they meant to do it to anyone else?...Who's being trauma-informed to them? (Sarah)

Sarah expressed frustration about the TIC implementation group's seeming lack of due regard for HCPs who she can see are "so burnt out" that they are barely able to care for themselves, let alone anyone else. Her exasperation was evident in her use of language and expression, as she asked, "How the hell are they meant to do it to anyone else?", a question which seems directed at the implementation group themselves. After a pause, Sarah then used a rhetorical device as she challenged stakeholders to consider 'Who's being trauma-informed to them [staff]?'. The implication of this being that HCPs are not being treated in a trauma-informed manner, either by themselves or those in management. Sarah's statements highlight that for the TIC implementation to be successful, this needs to be adopted and embraced at all levels of the system, particularly by implementation

groups and those in management, in terms of how they treat staff and service providers. It seems that if staff do not feel sufficiently supported and cared for at work, they will not be able to engage with the implementation of TIC, which is perceived as an additional burden, rather than an aid or enhancement to them in their role.

Anita described how the pressures created by the implementation of TIC have paradoxically become the very barriers preventing her from engaging with this framework. She described how she does not have the time or capacity to access staff wellbeing initiatives offered as part of TIC.

It's just genuine time... all the duties needing done by all these processes we have to do stops me from accessing anything that is good for my wellbeing. (Anita)

This again highlighted that staff need time, resources, and managerial support to be able to engage with the various aspects of TIC. This will require TIC implementation groups and service managers to consider ways in which they can reduce pressure on the workforce, such that they are freed up to engage with TIC strategies and supports made available to them.

Jean was also of this view, as she emphasised the need for greater onus on management, rather than individual staff members, to create the right conditions for HCPs to engage with staff wellbeing and service development strategies.

that can feel that that's just our responsibility but actually it's management, it's the NHS responsibility. If you want us to continue in this job, we *need* to have the time, resources, CPD...to do so effectively. (Jean)

It is interesting to note that Jean, similarly to Sarah, seemed to address management directly here. For both Jean and Sarah, there was a sense of urgency to their message, as well as a need to be heard. The directness of their comments may have been driven by feelings of frustration, as well as a desire to speak out for themselves and other HCPS who have not had a voice in any such changes.

Participants reported on examples of professional discord within the MDT, including tensions and problematic power dynamics, for example, between psychology and psychiatry, which can adversely affect team functioning and clinical practice. This is at-odds with the move towards a more trauma-informed organisation, which aims to promote staff wellbeing, positive working relationships, communication, and teamwork in healthcare. Jean shared that she has not felt valued or treated like an equal (“on that same level”), by the psychiatrists she has worked with, which she described with seeming sadness at first, followed by feelings of frustration.

....as a professional that you're not necessarily valued and on that same level ...there seems to be the stance that 'I am the psychiatrist, so this is how its going to be' ... that can be difficult when.... professional courtesy is not given. (Jean)

She indicated that many psychiatrists she has worked with have assumed an authoritarian role within the MDT and way of holding power that has left her feeling disrespected and de-valued. Jean described how even the most basic level of “professional courtesy” was not afforded to her, and how difficult it is to work in an atmosphere of such contempt.

All participants commented to some degree on the often contentious and even rivalrous relationship between psychiatry and psychology. Vicky reflected on this in the context of a traditionally hierarchical healthcare system that has been predominated by the medical model.

... the culture in teams... tends to be traditionally hierarchical and led by psychiatry... if your psychiatrist is psychologically-minded then life ...those conversations are way easier than if you're fighting a *purely* medicalised view. (Vicky)

Going beyond the surface-level content to consider the tone and subtext of what Vicky was saying, there were palpable feelings of frustration, as well as indication of ongoing professional strife and “fighting” at an inter-disciplinary level. This can be seen above in how Vicky used the term “psychologically-minded” as a positive quality or attribute, while the term “medicalised” is used to

denote something negative or less-than in some way. The word “fighting” is interesting as it conveys just how much of a struggle it has been for HCPs to challenge and introduce novel ways of thinking into a predominantly medical model of care, which can feel entrenched and resistance to change.

Jean noted below that inter-disciplinary relations and, crucially, communication between psychology and psychiatry needs to be improved for these disciplines to work together in a trauma-informed, harmonious manner.

We need open lines of communication to be able to sit and not just listen but properly hear and maybe re-evaluate....is this the best way of working for our patients? Because that's what we're there for. ...(Jean)

Jean declared that these different parts of the system are not truly listening or “hearing” one another, which, may be to the disadvantage or even detriment of patient care. When she stated: “because that's what we're there for”, this seemed to be a plea to her colleagues; to remind them of the reasons they came into the healthcare profession in the first place and how far from this they have come when caught up in professional power-struggles.

Sarah described an “us and them” dynamic that can exist between clinicians delivering TIC training and staff teams. Interestingly, Sarah's use of language could be construed as inadvertently perpetuating this dynamic, as she described how training was delivered “to” rather than something that is rolled out in collaboration “with” staff teams.

As psychology coming into other staff groups and delivering training and trying to help implement change on the wards or There is very much an 'us and them' ... that is ...a barrier ...we don't understand what it's like to be in their shoes ...and...they're going: 'this is all great but how are we going to do this?' ...and we try to put the onus back on them...that's really tricky... (Sarah).

She described how patronising it can be for staff to have a psychologist “coming into” an environment or team they have no experience working with, delivering training and, effectively,

telling staff how they *should* be working. There was a sense that psychologists in these situations came across as out-of-touch and condescending, which contributed to staff feeling less seen, understood, or supported. Sarah's reflections here demonstrate that clinicians should take time to get to know staff teams and work *with* them to consider ways they can adapt and assimilate TIC training to best meet the specific needs and challenges of their service.

THEME 2: CHALLENGES TO MEASURING AND EVALUATING TIC

All participants' accounts revealed a theme of uncertainty about whether the implementation of TIC has been successful. They viewed the implementation of TIC as a multi-faceted paradigm-shift, rather than a singular intervention that can be measured and evaluated as such. Below, Vicky articulated how difficult it is to measure or quantify some of the trauma-informed initiatives currently underway, such as consultancy-based working, training, and efforts to improve staff wellbeing.

It's difficult to measure because ... it's more about the presence of psychology within the wider teams and how we utilise skills in consultation, formulation. It's frustrating...because...I can see the benefit of that work....but it's harder to quantify and it's being looked at less...when we're focusing on waiting times and throughput. It doesn't fit neatly within an audited system (Vicky).

Vicky expressed frustration towards the overfocus on interventions that she feels are crudely measured by way of “waiting times” and throughput”, to the remiss of equally valuable clinical work, which may be less easily measured by standardised measurement tools based on binary questions or numerical rating systems. Her reflections here demonstrated an inner conflict she seems to be facing, as although Vicky sees this work as important and worthwhile, there is an undercurrent of perceived futility and de-moralisation as the system fails to recognise her or the value of what she is doing.

Anita was also of the view that target-driven outcome measures are not fit-for-purpose as measures of TIC as they do not adequately capture the experiences of key stakeholders or the most clinically pertinent information. She critiqued the over-reliance on quantitative research and RCTs, which have largely informed the design and delivery of healthcare services, as well as outcome measures upon which targets are based.

... 'RCTs' they're measuring 'success' under very strict conditions. That just doesn't reflect the real-life condition. There's all these inclusion/exclusion...we just don't meet people like that... that's not reality. So ...they form decisions and policies based on a very skewed perception of reality. (Anita)

Anita's narrative indicated that due to the highly controlled nature of RCTs, they are not representative of "real-life" clinical populations or the complexity of patients she sees in practice. Anita's feelings of frustration were palpable as she described working under the direction of stakeholders who are out of touch with the "reality" of challenges on the frontline and reliant upon flawed measures of "success".

Samantha highlighted anecdotal evidence of improvements in practice, such as more staff being trained in trauma-informed interventions, developing greater knowledge and skills to support people who have experienced trauma.

...People are feeling more skilled-up to work alongside somebody who's experiencing trauma...offering interventions like mindfulness or decider skills... around how to manage aspects of trauma...
...whether patients have a different experience I'm not sure. (Samantha)

However, TIC interventions, such as staff training and promotion of psychological skills within teams, have not been routinely recorded or evaluated in terms of effectiveness or the experience of key stakeholders. For Samantha, the absence of evaluation and feedback made it difficult to say whether these interventions have translated into patient-reported outcomes or experiences of treatment. It seemed that Samantha, similarly to Anita and Vicky, has found it difficult and even demoralising doing so much work that is not recognised or evaluated in a way that can demonstrate its value and utility.

Samantha noted that in response to this absence of adequate measurement tools, her colleague has developed a patient survey that will gather information about their experience of TIC interventions and support.

...Our colleague has developed a service user survey ...and we'll be saying to patients 'what's their experience of our service?.' ...we might sit here...say we're offering this, we're offering that; we're doing things differently ...but actually, is that how the patients experience it? (Samantha)

In Samantha's view, there is no point in making claims about purported improvements in practice if these are not substantiated by patient feedback and experiences of treatment. There is a clear need to address this gap by ensuring the various interventions being offered as part of the TIC implementation are captured and evaluated in a way that can justify the need for and benefit of this framework. Key stakeholders should consider nuanced and mixed methods approaches to audit and evaluation, encompassing the views and experiences of all stakeholders, particularly in these early stages of implementation.

THEME 3. PUTTING THE CARE BACK INTO HEALTHCARE

3.1 Relationships matter. One of the main contributions of the TIC movement, according to participants, is the renewed focus it has placed onto *care* and *relationships* in healthcare. With increasing pressure on services, HCPs have had less time to build relationships with patients and provide truly person-centred care. This, coupled with growing demands on HCPs to get through waitlists and meet targets has led to a deprivation of humanity in healthcare, as services have become more impersonal and, in effect, industrialised. Jean reported that, for her, the most crucial aspect of psychological therapy is the value it places on the human relationship:

... when I am here in a therapy room with you, it's one person sitting opposite another: one human sitting in front of another... showing you compassion...(Jean)

Jean recognises the value of humanity first and foremost, and because of this, attempts to minimise power differentials that can exist and even stifle the therapeutic relationship. To Jean, the most fundamental part of her role as a therapist is her capacity to sit alongside another human being in their suffering and offer them compassion.

For Anita, the humanity of healthcare has been lost in the wider systemic and organisational factors that have become more corporate, competitive, and hierarchical in nature. She commented on what she sees as the ironic use of the word 'partnership' to describe cross-agency working.

they talk about that 'it's a partnership'... like, there's all the different organisations feeding into the care for somebody. Whereas I think the word 'partnership' makes you think about a lot of this relational stuff – trust, communication, openness. I think in terms of that structure it doesn't really feel like that. It feels... more like a ...*hierarchical* structure that just feels like: '*this is the way it is and that's it*' type thing. (Anita)

Anita highlighted that the term “partnership” here suggests that systems are working together as equal partners; whereas, in reality, these systems feel more hierarchical, with certain parts of the system having a louder, more authoritarian voice, while others are left feeling silenced and sidelined. Here, Anita has shone a light on yet another contradiction within the system, which also runs counter to TIC, a model which promotes a more of a collaborative model of care whereby all members of the system are valued equally and empowered to have a say in service-level operations. Anita’s reflections highlighted that good relationships are essential for successful teamwork and inter-agency working. The absence of relationship building in these so-called partnerships, and the resultant lack of “trust”, “communication”, and “openness” between different parts of the system seems to have added to a feeling of de-humanisation in healthcare.

Isabelle introduced another dimension to this, as she described how essential it is that HCPs do not lose their sense of humanity or humility when working therapeutically with people.

... important for people we work with to feel that we are *also human*; that there isn't a power imbalance; that we are this professional who will tell them how to do and what to do, you know? (Isabelle)

She described how she makes an effort to minimise the power imbalance inherent in the clinician-patient relationship. For Isabelle, connecting with and conveying one’s own humanness is a powerful way of relating to and building respectful, trauma-informed relationships with people. She highlighted that for many people who have a background of complex trauma, their experiences of care, including that of health and social care services, have been so adversarial that forming trusting alliances or safety in relationships can be extremely challenging. Many have been so let down by people in positions of power that they have developed an “anti-authority” position, which can be reflected in generalised distrust and wariness of others, particularly those in the establishment.

A lot of people...because they had such a bad experiences in the past, including with professionals, they come with this...*distrust* and resistance...maybe a bit *anti-authority* almost...Even if they wouldn't be, I think it's just always good to come across as *reliable*. I think you get more from the therapeutic work you do with the person, if they can relate to you.

Isabelle emphasised that it is crucial for clinicians to meet people at a human level, being warm and personable, rather than assuming an expert or authoritarian role in this relationship. She highlighted that being able to relate and be related to can enhance the quality of the therapeutic alliance and, thereby the intervention.

Isabelle reflected on how a seemingly small gesture, like offering someone a hot drink, can create an atmosphere of warmth, safety, and comfort. Fostering a more therapeutic and trauma-informed environment in this way can greatly enhance a person's experience of care.

So even simple things...like being able to offer the client something hot to drink at the beginning of the session. That would be a very nice personal touch and is not always something that we do —...but there has to be a scope for it, if it's service policy that we don't do that then obviously there's no flexibility for that. (Isabelle)

This, as Isabelle puts it, is not routinely offered or supported within the traditional parameters of psychological therapy, some of which, when examined in light of contemporary frameworks, such as TIC, seem outdated and inflexible. For example, earlier conceptualisations of psychotherapy often encouraged extremely fixed boundaries and a strictly neutral or 'blank canvas' approach, which contributed to the power imbalance and de-humanisation of both parties involved. Isabelle's reflections highlight that some of the current practices and policies in place are based on more antiquated models of care, thus preventing HCPs from working in line with more up-to-date, evidence-based frameworks such as TIC.

Samantha also emphasised the importance of relationships, both in psychological therapy and the delivery of TIC. She reported that, despite the challenges she and her colleagues have faced in their physical environment being less-than-ideal from a trauma-informed perspective; the individual HCPs are deeply caring, compassionate people, who strive to do their best by their patients and deliver the highest quality of care.

... I suppose it's the people, it's the relationships that make it...the environment, the building is important.... but if people develop safe, trusting relationship with somebody...well that's...the best we can offer really isn't it...
... as a service...we're doing pretty well on the relationship side of things; you know there's a lot of compassion...but the other stuff feels a bit outwith our control; caseload size, environments, demands, lack of funding...(Samantha)

Given the extraordinary pressures on their service, Samantha noted that when it comes to delivering safe, effective, trauma-informed care, particularly in terms of the more human, relational, and emotion-focused aspects of this work, her team are doing exceptionally well. The challenges they continue to face are those outside of their control, such as caseload size, lack of funding, and the physical building they are working in. In other words, Samantha feels that what the service may lack in terms of the physical environment, resources, and working conditions, it makes up for in humanity and heart.

Vicky and John both felt that an essential part of being trauma-informed is recognising one's own humanness; that they as HCPs are not immune to the effects of psychological trauma, be that their own or that of others.

Supervision is a really good place to be able to reflect on these things....particularly if somebody is affecting *us* and that's about their *less* helpful responses to their own trauma... whatever they're bringing... we are human; we can be triggered by things, we can be irritated by things, we can want to, you know, reject people or discharge them because they're tricky... not turning up or whatever. (Vicky)

Vicky highlighted that it is normal to feel triggered by the often challenging and emotive nature of this work. Reflecting on her own humanness, Vicky recognised the need to have time and space in supervision to process the complex feelings that can arise in this work. In the absence of adequate supports and supervision, HCPs can become overwhelmed and at-risk of responding in ways that are unhelpful and even potentially harmful to patients.

John noted that for HCPs with personal experiences of trauma, the potential to be triggered and re-traumatised in this work can be greater:

...of course...if you've got your own trauma history, it takes very little for that to be triggered if you're listening to trauma stories, especially if you're listening to them day after day.... (John)

It is therefore essential for HCPs, particularly those with lived experience of trauma, to engage with regular supervision and supports to protect against vicarious traumatisation, distress, and burnout.

Like others, Vicky highlighted the importance of humanity not only in relationships with colleagues and peers, but also in leadership and management:

...It goes back to the people you're surrounded with.... your colleagues are so important...If you have management who are approachable...accessible ...human and care and are interested in you... that's what you want isn't it. (Vicky)

Her reflections highlighted the need for trauma-informed leadership in healthcare. Managers who value, care about, are accessible to and supportive of their staff help, while also leading in and bringing about positive change, help to cultivate a more compassionate and caring organisational culture overall.

3.2 Equality, Diversity, and Inclusive Practice

TIC calls for greater awareness of and efforts to tackle structural and intersectional inequality, oppression, discrimination, and abuse. A central premise of TIC is the need to promote cultural-sensitivity and improvements across all matters relating to equality, diversity, and inclusion in healthcare. Choice is one of the key principles of TIC, in recognition that often survivors of trauma have been made to feel powerless, without any real choice or sense of control over what is happening, or has happened, to them. Isabelle highlighted that because of the lack of diversity and representation of minority groups within the psychology workforce at present, it is not always possible to offer patients *true* choice, in terms of, for example, the therapist they would feel more comfortable working with.

When you look for a therapist privately...you have *choice*, but when your therapist is chosen by NHS you are just assigned a clinician ...there isn't really much choice for the patient...I think trying to make more diverse and representative... I know it's a bigger issue in psychology as a discipline...it's very female, white, middle-class dominated but I think each team should try to become more diverse so that people who come to the service have more choice. (Isabelle).

Isabelle made the point that psychology is a homogeneous and hegemonic profession, which lacks diversity and representation of people from different backgrounds. People coming into a service that lacks cultural-sensitivity and awareness of the issues they face, could end up feeling less understood and even potentially re-traumatised in the process. People accessing psychological support through the NHS are typically “assigned” a therapist based on personnel availability. Isabelle’s description of this gives the reader the sense that, for people who do not have the financial means, the whole process of trying to avail of psychological support can be disempowering and, thus, re-traumatising from the outset. Survivors of trauma who are also from minority groups are therefore at-risk of being further disadvantaged and discriminated by the very systems intended to support them.

Isabelle offered suggestions about ways services could improve diversity and inclusive practice, for example, by widening access to the profession for people from different backgrounds, cultures, and minority groups, as well as making greater efforts to recruit and involve the expertise of people with lived experiences.

... we should be doing more peer support...involving people with lived experience...they bring in really valuable perspectives that we ourselves might not have. I also think our client group because they can be distrusting of professionals, they could have much better engagement with a peer-worker or someone they know has been through the same thing... we should have more, and they should be in all the teams. (Isabelle)

Isabelle described how people with lived experience are often able to relate, empathise with, and form trusting relationships with patients in a way that other HCPS may not. The relationship between peer-worker and patient may also be a more open, collaborative alliance, less influenced by intrinsic power imbalances that can exist in the 'doctor-patient' dynamic.

Samantha highlighted that addiction and trauma do not discriminate when it comes to social demographics or background, as these are human conditions affecting people from "all walks of life".

...We're really open...working with people from whatever background they're from and I think that's how we work with people. I think the addictions, we're exposed to all walks of life.... we certainly work with people who would fit the broad range of classes... I think that's the nature of the work.

[the third-sector organisation] work well on all aspects of that... they employ staff who have lived experience, from a range of backgrounds. (Samantha)

She made the point that that, just as HCPs need to become more culturally-competent practitioners, the wider services *too* strive to embrace diversity and inclusion in the workplace, for example, in

terms of recruitment and representation of people from diverse backgrounds and groups, including people with lived experience.

Vicky reflected on the various ways she and her colleagues endeavour to be culturally-sensitive, inclusive practitioners, in terms of being informed and aware but also, crucially, having humility and the ability to recognise their own limitations and gaps in knowledge. She highlighted that central to cultural competence is the ability to be respectful, curious, and open to learning *with* people about their experiences of difference and diversity.

...how do we keep up-to-date and knowledgeable about...people from different backgrounds of faith, class, culture. I think.... it's about us being informed as much as we can but we can't be experts on everything. And, what we can do is try to build good therapeutic relationships that are respectful, and respectful within the limits of what we know but then we can be curious and find out about these things alongside your patients. (Vicky)

Vicky emphasised the importance of not making assumptions about people based on preconceived ideas or beliefs, as this could result in prejudiced and ultimately unhelpful care practices.

... I'm interested to hear about somebody's experience from their perspective and what that means for them. And for me not to make assumptions ...so... checking out people's experience and perspective, even if we *assume* to know what that might look like. (Vicky)

Here, Vicky illustrated that while there can be common or cultural-factors to bear in mind when working with people from different backgrounds and minority groups, there will always be individual differences and diversity within this, highlighting the need to treat each person as an individual with their own unique experiences and needs.

Theme 3 illustrated that despite the challenges participants have faced with the implementation of TIC, they still perceive the TIC framework in itself as important and something worth working towards. They felt that one of the most valuable contributions of the TIC movement is the renewed

focus it has placed on putting the 'care' back into healthcare, and the importance of humanity and relational safety for all. The importance of these qualities seems to have been lost over time, possibly due to increasing preoccupation with meeting targets and numerical indices of 'success', to the remiss of the more humanistic and relational qualities of care. Participants also discussed the emphasis TIC has placed on equality, diversity, and inclusive practice, recognising this as being essential to the delivery of high-quality, person-centred care for all. Greater representation of people from different backgrounds is needed to ensure diversity within the workforce, and in doing so, a more accessible, trauma-informed, and culturally-sensitive service for all.

4. Discussion

This study provided an insight into a group of psychological practitioners' views and experiences of the implementation of TIC. Like previous research (Isobel et al., 2021), participants expressed concerns about the *implementation* of TIC, rather than TIC itself, which they viewed as conceptually sound. They described how the implementation of TIC has failed to uphold the philosophy and guiding principles upon which it is based. Participants viewed TIC proposals as untimely and insensitive to the current climate in healthcare, with many staff teams overwhelmed, under-resourced, and therefore unable to take on such additional training and demands (McDaid, 2021). Participants also described the challenges of trying to be trauma-informed towards patients, while working within systems that are inherently trauma *un*-informed. They discussed trauma un-informed practices which continue to this day, including the process of involuntary hospitalisation, which, by its very nature, can be traumatic; and instances whereby HCPs become overwhelmed and respond to patients in unhelpful and even punitive ways. In the absence of adequate supports and supervision, HCPs are at greater risk of, inadvertently or otherwise, engaging in harmful care practices. These findings are consistent with previous research which highlights that, despite a growing shift towards TIC, iatrogenic harm and re-traumatising practices in healthcare remain a significant concern (Friehe, 2020; Jones et al., 2021; Mendiola et al., 2018; Ring & Lawn, 2019; Sweeney et al., 2018; van Boekel et al., 2013).

Participants identified problematic power dynamics and discord within MDTs, which has a knock-on effect on shared decision-making, team functioning, and ultimately the prioritisation of patient-centred care. Participants described challenges integrating TIC into a predominantly medical model of healthcare. Previous research on hierarchy in healthcare has identified that because consultant psychiatrists are often seen as the most senior, legally-accountable members of the MDT, they tend to assume leadership and authority over decision-making (Baker et al., 2011; Barnes et al., 2022; Haines et al., 2018; Rogers et al., 2023). Rogers et al. (2023) reported that doctors in their

study often had “the final say”, while other HCPs had less of a voice and even felt “invisible” within the MDT. The medical model is traditionally clinician-led, focused on diagnostics, treatment-planning, and prescribing (Haines et al., 2018), whereas TIC is patient-centred, with greater emphasis on *choice* and *collaborative* decision-making. The findings of this study are therefore consistent with an increasing evidence base on problematic power dynamics and dysfunction within MDTs, and the ripple effect of these issues on workplace culture, safety, and patient care (Averbuch et al., 2021; Lee et al., 2022; Rogers et al., 2023 Shorey and Wong, 2021; Talash et al., 2022).

Participants reported that although staff wellbeing is emphasised as part of the TIC framework (NES, 2021; Skar et al., 2023), this was not something they had seen prioritised or protected in the services they worked. This provides support for previous research which highlights that despite improved awareness of the harms associated with work-related stress and burnout, the health and wellbeing of HCPs remains a critical issue that has yet to be addressed (Skar et al., 2023; NHS Staff Survey, 2022). These findings, taken together, highlight the paradoxical nature of the current system in healthcare. If not addressed, these issues are likely to act as a barrier to the successful implementation of TIC, while also posing significant risks to the wellbeing of HCPs, and thus the safety and quality of patient care. HCPs need to feel safe, supported, valued, and adequately resourced in their current roles before they can successfully take on the implementation of TIC. It is only when such fundamental needs are met that HCPs would be able to meaningfully engage in service development strategies such as these. These findings are consistent with research conducted during the global pandemic which highlighted that, in accordance with Maslow’s (1943) hierarchy of needs, HCPs needed their basic needs met (e.g., to feel safe at work, have proper breaks) before they could consider engaging with the psychological supports offered at this time (Cole et al., 2020). This is also in line with the National Trauma Training Programme, which identifies physical and emotional safety for all staff and service-users as an *essential* requisite of TIC (NES, 2016).

In keeping with previous research (Dunning et al., 2021; O'Dwyer et al., 2021), participants discussed the challenges of trying to implement TIC into a system made up of policies and procedures that run counter to those being recommended. For example, they identified the challenges of trying to be trauma-informed and accessible to all while simultaneously being asked to uphold strict referral and discharge policies that do not take into account complexity or individual circumstances. They described the challenges of trying to offer individualised, patient-centred interventions while working under pressure to meet waiting-times and throughput targets. This study adds to previous research by giving a voice to participants who are struggling to navigate complex and often contradictory healthcare systems (Dunning et al., 2021). These findings highlight the need for more joined-up thinking, with key stakeholders from all parts of the system coming together and coordinating the implementation of TIC, so that it can be integrated more seamlessly into wider system and infrastructure at-large.

Another key issue identified was how the implementation of TIC is being measured and evaluated. Participants argued that target-driven outcome measures currently in use fail to adequately capture the effectiveness or experiences of TIC from the perspectives of key stakeholders. They emphasised a need for services to employ more valid ways of measuring and evaluating the implementation of TIC, such that they are obtaining crucial information and feedback from key stakeholders. These findings are consistent with research that has highlighted a lack of empirical studies (i) exploring staff and patient perspectives on the implementation of TIC; and (ii) evaluating its effectiveness (Champine et al., 2019; Dawson et al., 2021). In keeping with previous research, the findings of this study demonstrate a need for more qualitative studies exploring the implementation of TIC, as this is a paradigm-shift requiring widespread systemic, cultural, and organisational changes, rather than a singular intervention that can be measured and evaluated as such (Bracken & Karter, 2019; Johnstone & Boyle, 2018; Purtle, 2020; Sweeney et al, 2018).

Despite these challenges, participants were of the view that TIC is overall a positive and worthwhile framework, which has inspired a re-humanisation of healthcare. There has been a

renewed focus on understanding patients as whole human beings, who need to be listened to and cared for as such. This finding is a novel take on a previously made criticism of TIC – that TIC is synonymous with the general principles of good care, and not something innovative or groundbreaking (Hanson & Lang, 2016). The findings of this study suggest that although TIC movement might be, in some ways, a simple framework and one that re-visits some of the original and core principles of good care, this does not negate the value or necessity of this framework in contemporary healthcare services.

Another important finding was the need for greater representation of diversity at all levels of healthcare. Previous research has demonstrated that the psychology profession, for example, is predominantly white, middle-class, and female (Ahsan, 2020) and healthcare in general is largely made up of a homogenous and privileged sub-group of people who are white, middle-class, and therefore unrepresentative of society as a whole (Moberly, 2016; Pride et al., 2022; White, 2015). Given this issue of homogeneity and hegemony in healthcare, it is likely that services have been designed and delivered in a way that is biased towards a particular set of attitudes, norms, and beliefs. For example, current healthcare policies and procedures, developed by a disproportionately privileged subgroup of society, are likely to be influenced by their socio-political and cultural values about what is deemed acceptable and normative. This is an important finding, especially considering the pervasiveness of racial, ethnic, age, LGBTQ+, and gender-based discrimination of HCPs and patients (Hamed et al., 2022; Keys et al., 2021; McDermott et al., 2021; Patel et al., 2020; Rowe et al., 2021; Saif-Ur-Rahman et al., 2021; SteelFisher et al., 2019). This can be seen in, for example, strict discharge policies, which, as reported in this study, often fail to consider the complexity of peoples' circumstances, particularly those facing social, emotional, and financial deprivation and instability. It can also be seen in social and cultural attitudes towards what is deemed a 'normal' response or coping style, which, in an upper-class British society, is a stoic and 'stiff-upper-lip' mentality is often favoured over emotional expressiveness and vulnerability (Valliant, 2012.). Norms about what is considered an 'appropriate' emotional response and way of coping (and therefore

what is classified as 'disordered'), differ across social class, culture, and society, and can be influenced by race, ethnicity, age, religion/spirituality, gender, and sexual orientation (Gopalkrishnan, 2018). Perhaps the most salient example of this can be seen in what is often referred to as the (mis)diagnosis of borderline personality disorder (BPD), which critical and feminist theorists have argued is an oppressive, gender-biased diagnosis with misogynistic roots and implications (Berger, 2014). With the advancement of TIC and other more psychological, formulation-based approaches (e.g., the Power-Threat-Meaning Framework, [Johnstone & Boyle, 2018]), there has been a shift to re-conceptualise highly stigmatised diagnoses such as BPD through a more trauma-informed lens, which recognises that emotional distress and interpersonal difficulties in the context of complex trauma are normal and valid responses to abnormal and often abusive experiences.

Strengths and Limitations

This study built upon a body of qualitative research exploring the implementation of TIC from the perspective of key stakeholders, shedding light on the challenges, opportunities, and implications of this. The richness of data obtained, and in-depth analysis were, in keeping with the criteria of high-quality IPA, notable strengths of this study (Nizza et al., 2021). The researcher spent time building rapport with participants and interviews were conducted in a warm, relaxed manner. Steps were taken to ensure participant safety (e.g., briefing/de-briefing participants, offering opportunities to take breaks/discontinue the interview if needed), empowerment, and choice (participants were encouraged to share as much or as little as they felt comfortable to) throughout the interview process.

The researcher adopted a reflexive approach throughout this project, which they maintained by way of keeping a reflective log, engaging in reflective practice, peer support, and supervision. They were mindful of the 'double-hermeneutic', actively reflecting on this as part of the analytical process.

The researcher conducted credibility checks by way of response validation, whereby a sample of participants were given a section of the transcript and asked to verify the accuracy of corresponding analysis.

Participants were a homogenous group of psychological practitioners working with survivors of complex trauma. Homogeneity is considered a strength in IPA as it facilitates an in-depth analysis of a particular groups' experiences of a phenomenon under study (Noon, 2018). However, participants in this study were all white, predominantly female, and between 30 – 54 years of age, reinforcing the lack of diversity within healthcare and research. These findings therefore may not represent the views and experiences of people from different backgrounds, whose reflections too need to be considered as part of the TIC implementation.

This study may be limited by self-selection biases. For example, those who opted not to participate may have views and experiences of the TIC implementation that are not captured in this research. To reduce the likelihood of systemic bias, or patterns emerging that are more specific to a particular institution or service under study, this study was conducted across two services.

Participants were from the same health board in Scotland, and therefore findings may be more transferable to people within this geographical setting and professional context. Participants were psychological practitioners whose training and background were largely consistent with that of the TIC framework. Thus, the findings may be limited to this specific discipline who are already largely bought into the framework under study. Participants considered the perspectives of third-parties (e.g., nursing and psychiatry colleagues), and therefore their observations may not reflect the personal interpretations or lived experiences of these people or groups. Qualitative research exploring the implementation of TIC from the perspectives of all HCPs across the MDT is needed. Participants were given the option to be interviewed in-person ($n = 3$) or via MS teams ($n = 4$) to promote participant choice, engagement, and accessibility. This did not seem to influence the quality or depth of interviews obtained, but rather seemed to facilitate individual preference and flexibility.

The comprehensiveness of the TIC framework can be considered a strength as it takes into

account the system as a whole and various avenues for change. Its breadth, however, can pose challenges in practice and research, as it can be difficult to operationalise, implement, and evaluate. This is arguably a limitation of this study and qualitative research in general, which lacks the internal validity and specificity of a quantitative experimental design.

Research implications:

- Future qualitative research may benefit from a more in-depth analysis of a specific aspect or component of the TIC framework in isolation and therefore more detail than the framework as a whole.
- More research exploring patients' perspectives of the TIC framework and implementation is also needed. Despite collaboration with people with lived experience being central to this framework, there remains a notable absence of the patient's voice in the literature.
- Future research is needed to develop a measure of TIC that enables more empirical validation and evaluation of this framework, along with its implementation into practice.

Practice and Policy Implications:

- For TIC to be successfully implemented, there needs to be consistency across internal organisational policies, practices, and procedures. In accordance with the Scottish Trauma Informed Leaders Training (STILT) (NES, 2021), there is a need for leaders and policymakers from different parts of the system to come together and reconcile discrepancies that exist between internal directives and changes proposed by the implementation of TIC. TIC is a system-wise, organisational framework that needs to be implemented and embedded across all aspects of the healthcare service from leadership, culture, communication, MDT functioning, and intra-agency working, to service-user involvement and provision of care. The implementation of TIC therefore requires both top-down and a bottom-up processes of change.
- The findings of this study call for significant improvements to be made in staff wellbeing. Greater efforts are needed to ensure HCPs feel safe, supported, and adequately resourced in

their current roles before they can engage with TIC initiatives. It is only then that staff will be able to deliver on the aims and objectives of the TIC framework.

- TIC is unlikely be successfully adopted and implemented by a team who are operating in an atmosphere of tension or incivility. Efforts are needed to address problematic power dynamics and discord that exists within MDTs. This might involve the promotion of a more egalitarian structure, whereby all members of the team feel valued and collaborative decision-making is encouraged. Other strategies might include strategies to bolster team cohesion, morale, peer support, as well as policies and procedures which outline clearly that professional misconduct and misuse of power will not be tolerated.
- Measurement and evaluation of TIC could be improved by more routine collection of TIC-specific outcome measures and feedback from key stakeholders, as well as ongoing audits, service evaluation, and quality improvement projects on TIC. A broader review of treatment targets may be needed as there is a shift away from relying solely on symptom-reduction measures, which alone can be insufficient (Connors et al., 2021; Neale & Strang, 2015; Vera San Juan et al., 2021). A wider range of measurement tools and techniques to gather feedback and information from key stakeholders, particularly patient-reported outcomes and experiences, may help to improve service evaluation and development.
- Healthcare services need to reconnect with the humanity and person-centred values upon which the profession is based. Participants felt that the 'humanness' of the caring profession has been lost in the corporatisation and industrialisation of healthcare (e.g., becoming overly focused on meeting 'targets', less focused on the individual care experience). They suggested simple but effective ways of creating an atmosphere of warmth and safety in the relationship between HCPs and patients, as well as the wider clinical environment. Participants in this study were psychological practitioners and therefore naturally aware of the importance of a therapeutic relationship based on empathy, genuineness, and positive regard (Rogers, 1951). However, they noted that some of the current policies and

procedures in healthcare have acted as a barrier to working in a truly trauma-informed and person-centred manner. Chiefly, participants criticised strict discharge policies that fail to consider individual circumstances that might be impacting a person's attendance or engagement in services. NHS policymakers need to liaise with NES and other relevant stakeholders of TIC in the re-design and development of a trauma-informed organisation that is coherent and cohesive, such that the internal policies match the principles being set out by this framework. TIC is a system-wide intervention that requires time and cultural buy-in from all parts of the organisation to be successful in its implementation.

- Services are not currently set up in a way that promotes choice, diversity, and inclusive practice. A lack of diversity in the workforce means that patients often do not have an opportunity to choose treatment type or provider characteristics. This is at-odds with the TIC framework which highlights the importance of patient choice and empowerment, as well as the prevention of re-traumatising care practices. This finding emphasises the need for greater accessibility and equal opportunities in healthcare, as the workforce remains unrepresentative of the wider population, and therefore limited in terms of diversity and inclusive practice.

Conclusions

Seven psychological practitioners provided rich insights into their experiences of the implementation of TIC in adult mental health and substance use services. Using IPA, three overarching themes were identified: (1) The paradoxical implementation of trauma-informed care (TIC); (2) Issues with the measurement of TIC; and (3) Putting the ‘*care*’ back in healthcare. There was a consensus among participants that it was the *implementation* of TIC, rather than TIC itself, that was flawed. They highlighted that TIC has been rolled-out to staff who are overwhelmed and under-resourced, and therefore unable to engage in such training programmes. Participants described the challenges of trying to implement the principles of TIC in a system with conflicting policies and practices. These findings revealed that in order for the TIC implementation to be successful, staff need to feel adequately supported and resourced. Leaders and policymakers need to ensure that the internal systems, policies, and procedures of the healthcare organisation are in keeping with those of the TIC framework. Participants also reported the need for improved measurement and evaluation of the implementation of TIC, as current outcome measures are not providing rich or meaningful information from the perspectives of key stakeholders. The findings revealed a need for services to reconnect with the values upon which healthcare is based; that is, the importance of human relationships in the delivery of person-centred care. Humanity in healthcare can also be promoted through the development of a more compassionate, culturally-sensitive, and inclusive environment for all. These findings need to be considered by all relevant stakeholders, including staff, patients, policymakers, and those in leadership roles, as successful implementation will require a cultural overhaul and systemic changes across all levels of the organisation.

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Appendix A

The Qualitative Report Journal Guidelines

'Aims & Scope

Manuscript Criteria

Papers submitted for review to The Qualitative Report must be original works on the part of the authors, must not have been published previously, and must not be under review with another publication at any time during the review process. A wide variety of submissions are welcomed to The Qualitative Report. Given the richness and diversity of qualitative research and researchers from around the world, papers reflecting scientific, artistic, critical and clinical postures are all fitting contributions to the electronic pages of this journal. Methods depicted in these papers may be qualitative, comparative, mixed, collaborative, action-oriented, appreciative, and/or critical in nature. Papers may be qualitative research studies, commentaries about the conduct of qualitative research, prescriptive pieces on carrying out qualitative research, "back stage" essays in which authors give a perspective on how they created and crafted a particular project, presentations on technological innovations relevant to qualitative researchers and their inquiries, and any other issues which would be important for practitioners, teachers, and learners of qualitative research.

The length of submitted works may vary greatly. Since The Qualitative Report is not restricted by the economics of paper, contributors can concentrate on the particularities of their paper at hand and let those considerations shape the length of their narrative rather than an arbitrary limit of words or pages. Having said that, it is important for authors to remember TQR publishes article-length manuscripts and not book-length manuscripts so authors should give careful consideration to manuscripts over 45 pages. In such instances, the author should consider whether or not the manuscript reflects ideas for two separate papers and then edit the manuscript so the text is more focused before submitting it to TQR. In such cases, the author might consider submitting two papers after the revisions are done on the original opus.

Given the ways in which a style guide can shape the writing choices made by an author, we want to assist you as you prepare your submissions by letting you know that we use The Publication Manual of the American Psychological Association (APA; 7th ed.) as a guide for contributors to The Qualitative Report. This means that we ask authors to look to APA recommendations regarding the

title, abstract, and headings used in the paper, as well as the format of references and citations within the text. We also request some writing practices we think improve the reporting of qualitative research methods and results, such as the use of active voice and the inclusion of the researcher's context as it relates to the topic under study. Otherwise, style is a matter of choice on the parts of authors. We recognize that the style of writing for contributions to *The Qualitative Report* is a matter of particularity for authors, and we welcome a range of writing styles.

Even though *The Qualitative Report* is based on a textual metaphor, nontextual forms of representation are also welcomed. Graphics, pictures, sounds, moving images, and hyperlinking may all be features in works presented in this journal.

Contributors to *The Qualitative Report* can also engage in a process known as "Living Documents" (Ives & Jarvenpaa, 1996) with their published works in the pages of the journal. In the "Living Documents" approach to writing, authors can nurture their published works and cultivate them as new developments arise within the scope of the paper, as hyperlinked resources located in the paper are updated or changed, and/or as the author's thinking evolves on the topic. Authors wishing to participate in this living scholarship approach with any of their writing in *The Qualitative Report* need only to email the editor and the process of enlivening the text can ensue.

If you have any questions regarding the submissions process please email Editor in Chief Dr. Ron Chenail at ron@nova.edu

Conclusion

If we are successful in our labors, we will create a sustainable learning community that will foster growth in qualitative researchers and improvement in qualitative research. We trust authors find this new beginning an intriguing opportunity to learn and consider joining us in this pursuit.'

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Appendix B

Systematic Search Strategy

ProQuest:

Name: No name added yet [Add name](#)

Searched for: (Workplace bullying OR harassment) AND healthcare AND qualitative AND (UK OR NHS) AND (Train* OR student OR junior OR graduate) AND stype.exact("Scholarly Journals") AND at.exact("Article") AND la.exact("English") AND (location.exact("United Kingdom UK") AND la.exact("ENG") AND pd(20150101-20230326) AND PEER(yes)) AND location.exact("United Kingdom UK") AND pd(>20151231)

Limited by: Date: After 2015
Source type: Scholarly Journals
Document type: Article
Language: English

Databases: 5 databases searched [Hide list](#) ▲

Education Collection
International Bibliography of the Social Sciences (IBSS)
Library & Information Science Collection
Social Science Database
Sociology Collection

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Comment
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Set	Search Statement
1.	(workplace bullying or harassment).mp. [mp=ti, ab, hw, tn, ot, dm, mf, dv, kf, fx, dq, tc, id, tm, bt, nm, ox, px, rx, ui, sy, ux, mx]
2.	(health* or clinical).mp. [mp=ti, ab, hw, tn, ot, dm, mf, dv, kf, fx, dq, tc, id, tm, bt, nm, ox, px, rx, ui, sy, ux, mx]
3.	(train* or student).mp. [mp=ti, ab, hw, tn, ot, dm, mf, dv, kf, fx, dq, tc, id, tm, bt, nm, ox, px, rx, ui, sy, ux, mx]
4.	(UK or NHS).mp. [mp=ti, ab, hw, tn, ot, dm, mf, dv, kf, fx, dq, tc, id, tm, bt, nm, ox, px, rx, ui, sy, ux, mx]
5.	Qualitative.mp. [mp=ti, ab, hw, tn, ot, dm, mf, dv, kf, fx, dq, tc, id, tm, bt, nm, ox, px, rx, ui, sy, ux, mx]
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☐ S3	S1 AND S2	
☐ S2	qualitative	
☐ S1	(Workplace bullying OR harassment) AND (healthcare OR clinical) AND (train* OR student)	Expanders - Apply equivalent subjects Search modes - Find all my search terms

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Appendix C

Quality Appraisals: Examples of Completed Modified CASP Tools (Long et al., 2020)

Please note: all 12 completed quality appraisals are available upon request.

Workplace bullying from the perspectives of trainee clinical psychologists (Brown et al., 2021)

Quality assessment grade: High

1. Was there a clear statement of the aims of the research?
Yes Goal: "The purpose of this study is to explore the experiences of workplace bullying from the perspectives of trainee clinical psychologists." Importance/relevance: Research has highlighted a high prevalence of reported workplace bullying in health care compared to other employment sectors (Zapf et al., 2020; Fevre et al., 2012), with health-care trainees at a particularly heightened risk of bullying (Berry et al., 2012; Stubbs and Soundy, 2013). ...There is a lack of studies that focus on bullying prevalence rates of trainee mental health-care professionals, although there are two examples investigating trainee psychiatrists. There are no known studies investigating the impact of workplace bullying on trainee mental health-care professionals. There are also no known studies investigating workplace bullying specifically within clinical psychology, including of trainee clinical psychologists. A recent report highlights the lack of research on factors that influence the well-being of trainee psychologists in the NHS, including workplace bullying (NHS Health Education England, 2019). There are also no known studies on workplace bullying of pre-training clinical psychologist roles, such as assistant psychologists, who may also be at risk given their relative lack of power in their pre-qualified status in the workplace.
2. Is a qualitative methodology appropriate?
Yes "Most research in workplace bullying has focused on quantitative studies, despite calls from within the field that more qualitative perspectives are needed to provide a fuller understanding of the phenomenon and processes (Rai and Agarwal, 2016; Samnani, 2013). A qualitative approach was used in this study to reflect the open and exploratory nature of the research question, and to contribute to the small body of qualitative work on workplace bullying of trainee health-care professionals."
3. Was the research design appropriate to address the aims of the research?
Yes, this study was a qualitative design, using semi-structured interviews. WA semi-structured interview schedule was developed, informed by existing research on workplace bullying in line with the research aims of the project (see Appendix). Questions focused on the process of bullying, reporting bullying, the impact of bullying and reflections on the experience of bullying. Interviews were conducted on the telephone by the primary researcher, and were recorded and transcribed verbatim with consent. Interviews lasted between 50 and 92min." Reasons for choosing interview design over other methods (e.g., survey, focus group) not outlined, nor were reasons provided for choosing TA over other methods of analyses (e.g., IPA). More discussion of this or explicit justifications for the design would have been helpful. However, semi-structured interviews are generally considered optimal in qualitative research for obtaining rich, meaningful data.
4. Was the recruitment strategy appropriate to the aims of the research?
Yes

"Participants were recruited through email contact with programme directors of British clinical psychology courses (not including the primary researcher's own course to maintain confidentiality within the research team). Over half of the courses (15 out of 29) agreed to share information with trainee clinical psychologists associated with their programme. Participants self-identified as having experienced workplace bullying from other staff as a trainee clinical psychologist or in a pre-training psychology role. A total of 14 participants were recruited. Nine identified bullying experiences as a trainee psychologist and five in roles prior to clinical psychology training (Table 1)." "While the gender and ethnic demographics of participants were similar to the population of British trainee clinical psychologists in terms of female to male ratio, and White trainees and trainees of colour (Clearing House for Postgraduate Courses in Clinical Psychology website, 2020), this also meant that the sample was predominantly female and White. Furthermore, other demographic information such as sexual orientation, disability and socio-economic background were not requested, and therefore it is unclear how diverse the sample was in relation to these characteristics. Studies have shown that minority groups within clinical psychology face particular challenges (Shah et al., 2012; Wood and Patel, 2017). Future research on bullying could focus on the perspectives of trainees in mental health professions who identify with one or more minority groups."
5. Was the data collected in a way that addressed the research issue?
Yes Setting: telephone (It is assumed that this was to protect anonymity and possibly promote accessibility/engagement. However, this is not clearly stated). How data collected: Semi-structured interview. Methods chosen justified: reasons for choosing a qualitative method justified. However, the reason for choosing telephone interviews or TA is not discussed explicitly. Methods are made explicit: researchers provide information on how interview schedule developed and provide the interview schedule in the appendix. Form of data is clear: "Interviews were conducted on the telephone by the primary researcher, and were recorded and transcribed verbatim with consent. Interviews lasted between 50 and 92min." Saturation: Nil.
6. Has the relationship between researcher and participants been adequately considered?
Yes "An initial transcript was coded separately by the researcher and principal supervisor, and then discussed to explore interpretations, commensurate with Braun and Clarke's (2019) "reflexive" analysis. The primary researcher's experience as a trainee clinical psychologist meant that she held an "insider" research perspective with the participants of the study with potential advantages and disadvantages to the research (Hofmann and Barker, 2017). A reflective diary was used prior to and during the data collection period to "bracket" assumptions and beliefs on the topic (Ahern, 1999). Supervision with the other researchers helped to develop awareness of other perspectives on the data, which were incorporated into the analysis." "Participants were recruited through email contact with programme directors of British clinical psychology courses (not including the primary researcher's own course to maintain confidentiality within the research team)."
7. Have ethical issues been taken into consideration?
Yes Approval: "Ethical approval for the study was granted by the primary researcher's university ethics committee." Key issues considered were: "confidentiality and anonymity, along with possible participant distress given the nature of the research topic." "Participants were recruited through email contact with programme directors of British clinical psychology courses (not including the primary researcher's own course to maintain confidentiality within the research team)."
8. Was the data analysis sufficiently rigorous?
In-depth description of analysis process: Yes Thematic analysis is used and it is clear how themes were derived from data. Researcher explains how the data presented were selected from original sample to demonstrate analysis process - provides context/narrative around the quotes chosen. Sufficient data are presented to support the findings (quotations, a thematic map). Complexity, nuance, and contradictory data and accounts are provided: "For some participants the reflective, personal nature of clinical psychology could itself also be implicated in workplace bullying within the profession, if misused." "Participants also spoke about how the difficulties of the bullying situation clarified their values and boundaries for the future, as well as how they hope to practise as a psychologist." Researcher indicates that they critically examined own role etc. However, more examples of where this came up and how it was resolved might have been helpful.

9. Is there a clear statement of findings?
Findings explicit: yes Researchers provide evidence for and against arguments in the results, but do not provide as much evidence 'against' arguments in discussion. Credibility of findings: use of supervision, more than one analyst, reflexive journal. Authors did not report on triangulation or respondent validation.
10. How valuable is the research?
Researcher discusses contribution of study to knowledge and practice: "This research emphasises the importance of wider recognition of workplace bullying within clinical psychology, and potentially within the broader mental health workforce...." "To the best of the authors' knowledge, this is the first known study of workplace bullying specifically within clinical psychology. The research has implications for guidance for training institutions and professional bodies associated with trainee mental health professionals." "While there exist workplace bullying prevalence studies of trainee psychiatrists, further research may provide clarification of the processes underpinning workplace bullying in this population." "Future research on bullying could focus on the perspectives of trainees in mental health professions who identify with one or more minority groups." "Further quantitative research could investigate the prevalence rates of workplace bullying within trainee populations in clinical psychology and among other mental health professionals in comparison to other occupational groups. Quantitative data could also identify specific behaviours that are most prevalent within these contexts to inform future interventions."
11. Are the study's theoretical underpinnings (e.g. ontological and epistemological assumptions; guiding theoretical framework(s)) clear, consistent and conceptually coherent?
Unclear; not reported.

Attitudes towards attrition amongst UK trainees in Obstetrics and Gynaecology: A mixed-methods analysis of survey responses (Gafson et al., 2017)

Quality Assessment: medium

1. Was there a clear statement of the aims of the research?
Yes
“This study aimed to explore attitudes towards attrition in O&G training in the UK, and the reasons trainees have for thinking about leaving training (for whom we coined the term “peri attrition).”
2. Is a qualitative methodology appropriate?
Yes/somewhat
This study used a mixed methods (quantitative/qualitative) design. The authors indicated that they used qualitative methods to “analyse free-text responses.”
They stated that they wanted to “explore attitudes towards in O&G training in the UK, and the reasons trainees have for thinking about leaving training (for whom we coined the term “periattrition).”
While this is not wrong, there is limited information/background/justification for this decision.
3. Was the research design appropriate to address the aims of the research?
Yes/somewhat.
The authors did not provide a rationale on why they chose to use a questionnaire/survey design for the qualitative part of this study (“analyse free-text responses”). It is assumed that this was chosen for convenience as the questionnaire included quantitative and qualitative questions. However, lack of rationalise and/or justification provided for choosing this over, for example, interviews or focus groups.
While this is not wrong per se, there is limited information and rationale provided for these decisions. As stated previously, the use of mixed methods approaches can compromise the quality and depth of the qualitative research, for example, in terms of the richness of data obtained and depth of analysis.
4. Was the recruitment strategy appropriate to the aims of the research?
Somewhat
The authors stated: “We conducted two questionnaires: the ‘peri-attrition questionnaire’ (PAQ) for current O&G trainees; and the ‘attrition questionnaire’ (AQ) for former trainees who left the specialty training programme before completion.”
The authors sent the peri-attrition questionnaire to 182 O&G trainees who had opted n to receive regular newsletter from Health Education North Central and East London (HENCEL) O&G Trainees Committee (elected body of representatives). However, they indicated that they were unable to obtain a list of trainees who had already left training: “HENCEL administrators were unable to give us a list of trainees who had left training. Thus, the HENCEL O&G Trainees Committee formulated a list of people known to have left training in recent years (2009 – 2015). We sent the AQ to these people directly.”
This is less clearly described, and it raises questions about potential biases in who was contacted/was in touch with current trainees.
In total, they stated: “The electronic PAQ and AQ were sent by email to 183 trainees and 10 former trainees in September 2015, as previously mentioned.”
5. Was the data collected in a way that addressed the research issue?
Uncertain
The authors state the following: “The questions were devised by three of the authors, who were actively serving members of the trainees’ committee. Questions and option lists were checked against previous questionnaires into recruitment in O&G (Currie, Huggins et al. 2013, Whitten, Higham 2007). Content was reviewed by the chair of the Training Programme Management Committee (TPMC), the body responsible for overseeing O&G training in HENCEL. It was felt that a formal pilot phase was not necessary.”

However, examples of the kinds of questions asked were not provided, and the added value of these open-ended questions was unclear.
6. Has the relationship between researcher and participants been adequately considered?
Uncertain This has not been discussed.
7. Have ethical issues been taken into consideration?
Uncertain The authors have not discussed ethical approval; if this was approved, what considerations they took.
8. Was the data analysis sufficiently rigorous?
Somewhat: Data analysis section: “We adopted a constructivist approach to analysis of free text responses (Charmaz 2006) in order to acknowledge that part of our research team were themselves trainees. All free text responses from both questionnaires were labelled and combined to create a dataset. Following immersion in the dataset, we created an initial set of codes to describe the entire dataset, which we independently grouped into themes. We used the process of constant comparison to create and reach consensus of themes and codes. Any disparity was discussed and resolved.” It sounds as though they used thematic analysis. However, this is not clearly stated or referenced as such.
9. Is there a clear statement of findings?
Yes, themes are presented, with participant quotations. Findings are discussed in relation to research question. They have discussed credibility of their findings (e.g., independently grouped codes into themes; constant comparison, agreeing on consensus of codes and themes)
10. How valuable is the research?
HINT: Consider - If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research based literature: Yes: “The complexity of issues outlined in this study may explain how a simple reduction of working hours through EWTD implementation has not resulted in eradicating the problem of attrition and periattribution.” Sheds light on trainee anxiety and pressure due to the “elaborate framework of assessment for doctors”, and the issue of junior doctors/trainees needing to decide at a very early stage in their career, their specialisation. Highlights the importance of good supervision and improvements in trainee “welfare”. Need to improve work flexibility/training flexibility. Yes - If they identify new areas where research is necessary: Not apparent - If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used: Yes: findings discussed in terms of clinical and policy implications. For example: “The quality of educational supervision can greatly influence a trainee’s experience in a particular placement. .Currently, GMC guidance stipulates that only consultants with formal training in educational supervision should become educational supervisors, with time allocated in consultant job planning to perform this role.”
11. Are the study’s theoretical underpinnings (e.g. ontological and epistemological assumptions; guiding theoretical framework(s)) clear, consistent and conceptually coherent?
Somewhat The authors briefly mention constructivist approach. However, this is in the section on data analysis, and is not sufficiently explained.

iscrimination, harassment and non-reporting in UK medical education (Broad et al., 2018)

Quality assessment grade: high

1. Was there a clear statement of the aims of the research?
Yes, aims are stated clearly. “Discrimination and harassment create a hostile environment with deleterious effects on student well-being and education. In this study, we aimed to: (i) measure prevalences and types of discrimination and harassment in one UK medical school, and (ii) understand how and why students report them.”
2. Is a qualitative methodology appropriate?
Yes A mixed methods approach is used, but sufficient rationale and consideration is given to the qualitative component (i.e., to understand students’ direct and indirect experiences of discrimination/harassment in medical education). “In this study, we aimed to: (i) measure prevalences and types of discrimination and harassment in one UK medical school, and (ii) understand how and why students report them. METHODS The study used a mixed-methods design. A medical school population survey of 1318 students was carried out in March 2014. Students were asked whether they had experienced, witnessed or reported discrimination or harassment and were given space for free-text comments. Two focus group sessions were conducted to elicit information on types of harassment and the factors that influenced reporting. Proportions were analysed using the Wilson score method and associations tested using chi-squared and regression analyses. Qualitative data were subjected to framework analysis. Degrees of convergence between data were analysed.” “This enabled us to capture the types and prevalences of events and to obtain richer data to explore the student experience in more depth.”
3. Was the research design appropriate to address the aims of the research?
if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)... Yes The authors have discussed the design and why they chose this. They demonstrated careful consideration of how focus groups were set up (e.g., in terms of gender), to increase participation. However, the authors did not indicate why they chose focus groups, over, for example, interviews. They do however reflect on this in the limitations: “By using a survey and focus groups, we were able to identify common experiences, but the focus groups were not private and interviews may have been more sensitive to the disclosure of harsher experiences of harassment and abuse.” Design “A mixed-methods approach was adopted, utilising quantitative survey items, qualitative free-text reporting and two focus groups. This enabled us to capture the types and prevalences of events and to obtain richer data to explore the student experience in more depth. One male and one female focus group of five to eight participants were each facilitated for an hour by an experienced and trained female professor, Harriet Bradley (HB), from a different faculty who had no relationship with participants. Single-gender focus groups were used to increase the likelihood of full participation because previous experience suggested that mixed-gender groups sometimes led to the domination of discussion by one gender. Focus groups addressed questions based on real scenarios to explore issues that had emerged from analysis of the surveys. HB is a feminist with prior experience in anti-harassment work. Participants received information about the research goals prior to the focus groups.”
4. Was the recruitment strategy appropriate to the aims of the research?
Yes The recruitment strategy was appropriate for the qualitative component of the study. However, the authors had a small sample size/low response rate for the quantitative component. Convenience sampling was used to recruit eight male and eight female focus group participants for two focus groups. The 16 students who responded first to the recruitment e-mail or social media were included in the focus groups. The small sample size and the self-selected nature of the sample limit the conclusions presented here. As the authors recruited from one university, the findings may be subject to systemic bias.

5. Was the data collected in a way that addressed the research issue? Clear how data collected: YES Has researcher made methods explicit: (YES); "There was no validated questionnaire measuring discrimination and harassment at the time of the study. The present survey asked whether students had experienced specified examples of discrimination and harassment, was informed by a literature review and real scenarios, and included free-text space. The survey also included a free-text question asking whether students had reported their experience and what factors had influenced this. The survey items were sent to experts in abuse and harassment to find out whether they met key constructs and were piloted with five students from different backgrounds to improve face validity. Survey data were collected anonymously using the Bristol Online Survey tool and participants were able to respond from any device that accessed the Internet in a setting of their choice. Focus groups addressed questions based on real scenarios to explore issues that had emerged from analysis of the surveys. Setting for data collection: NOT JUSTIFIED? Form of data, clear: YES Discussion of Saturation: YES "The focus groups were audiorecorded. Transcripts and field notes were written in Microsoft Word. Two lead researchers discussed data saturation and felt that sufficient data had been gathered for the analysis. Transcripts were returned to most participants for comment; however, this was not possible in some cases because several participants graduated and changed their contact details. All transcripts were used in the qualitative analysis." Good consideration given to how the focus groups were set up/facilitated: One male and one female focus group of five to eight participants were each facilitated for an hour by an experienced and trained female professor, Harriet Bradley (HB), from a different faculty who had no relationship with participants. Single-gender focus groups were used to increase the likelihood of full participation because previous experience suggested that mixed-gender groups sometimes led to the domination of discussion by one gender. Focus groups addressed questions based on real scenarios to explore issues that had emerged from analysis of the surveys. HB is a feminist with prior experience in anti-harassment work. Participants received information about the research goals prior to the focus groups. The authors acknowledged the strengths and limitations of focus groups: "By using a survey and focus groups, we were able to identify common experiences, but the focus groups were not private and interviews may have been more sensitive to the disclosure of harsher experiences of harassment and abuse. We were compelled to group demographic categories into binaries to increase statistical power, which unintentionally perpetuates the gaze of the White male versus the 'other'."
6. Has the relationship between researcher and participants been adequately considered? Yes: research also benefited from the fact that it was conducted by an independent group of researchers, which may have allowed our respondents to be more honest than they might have if the project had come from the institution itself." Focus groups were "facilitated for an hour by an experienced and trained female professor, Harriet Bradley (HB), from a different faculty who had no relationship with participants. Single-gender focus groups were used to increase the likelihood of full participation because previous experience suggested that mixed-gender groups sometimes led to the domination of discussion by one gender.,,HB is a feminist with prior experience in anti-harassment work." "The principle investigator identifies as White, heterosexual and male, and the team includes a mix of genders, ethnicities, nationalities and sexual orientations. We adopt a pro-feminist and anti-discriminatory stance."
7. Have ethical issues been taken into consideration? Yes but limited information. Ethical approval: this study was approved by the University of Bristol and supported by Plymouth University Ethics Committee chair." Limited discussion of specific ethical considerations - e.g., how participants were handled during and after study, de-briefs etc.
8. Was the data analysis sufficiently rigorous? Yes

Description of analysis process: "For the qualitative data, we used a framework analysis approach. Two researchers independently familiarised themselves with the data and developed a thematic framework. They then agreed on the final framework by consensus with the option of an independent adjudication from a supervisor in the event of disagreement. Following this, two researchers independently indexed the data and populated the framework. The principal investigator mapped and interpreted the data. Transcripts were sent to 25 participants who had opted to provide their e-mail addresses and to be contacted; the remaining data were subsequently included as no concerns were raised about validation."

Table of themes, sub-themes, and data extracts provided.

Sufficient data presented to support findings.

Lack of evidence of critical analysis of own role, potential influence and bias during analysis and selection of data for presentation.

Some contradictory findings between qual and quant reported.

9. Is there a clear statement of findings?

Findings are presented clearly as themes, with participant quotations. The findings are discussed clearly in relation to the research question, and the credibility of findings are discussed, as well as strengths and limitations.

10. How valuable is the research?

The researcher discusses the contribution the study makes to existing knowledge or understanding: (for example: "This study develops understanding of the broad range of discrimination, harassment and reporting obstacles experienced by UK medical students and its findings may be useful to medical educators elsewhere. It uniquely describes everyday experiences that contribute to a culture of exclusion in several domains, including that of disability, a previously under-researched area. Comparisons with other studies show that our institution is not an exception. A global systematic review found similar prevalences in medical schools in many countries...")

The researcher discusses clinical implications in detail (e.g., "This study suggests an urgent need to address discrimination and harassment in medical schools, particularly in clinical settings."

The researcher discusses research, clinical, and policy implications: "We support the argument of critical race theorists that inequalities will not be overcome without increasing the diversity of representation in academic medicine and leadership. Our study emphasises the predominance of behaviours that involve subtle differences in treatment based on demographic factors. This unconscious bias has been reported by the Royal Society and recommendations to reduce its impact on discrimination have been made. Our findings suggest the need to increase staff awareness and challenge decisions that may be based on bias and stereotyping, and to build policy that evolves and adapts to current findings and trends. ...

Given that students in the clinical years and female students report the greatest experience of discrimination and harassment, the focusing of attention on clinical staff responsible for education should be a priority, particularly in the surgical specialties. Staff should be made aware of gendered behaviour and microaggression and their impact on students. Moreover, our study findings suggest that current reporting systems are not suitable for addressing these issues and must be updated according to best practice and evidence from medical education and higher education in general.

These findings have informed an initiative that will encourage prevention locally and set standards for medical education institutions in the effective reporting and monitoring of discrimination and harassment; it also clarifies the unacceptable and serious nature of these offences."

The researchers discuss future research: "Future research should seek out good practice on the prevention and effective monitoring of harassment and discrimination across specialties and educational institutions. Research should prioritise the standardisation of definitions and tools with which to measure harassment and discrimination. It should use representative sampling techniques and aim to increase response.' rates and therefore the generalisability of the sample measured. One particular area of research that requires quantitative analysis refers to barriers to reporting; such research may inform future interventions and reporting systems.

Appendix D

GRADE CERQual

Summary of Review Finding	Example Quote	Studies contributing to review finding.	Explanation of CERQual assessment	CERQual assessment of confidence in the evidence
Theme 1: The shadow side of healthcare This synthesis highlighted an epidemic of WPB in healthcare at present, with early career healthcare professionals (ECHCPs) seeming to be among the most victimised groups. Participants described this as a darker, ‘shadow’ side to healthcare that is at-odds with public perception and media portrayal of HCPs, which is often idealistic and sensationalised (e.g., ‘healthcare heroes’) (Cox, 2020). The researcher applied the Jungian theory of ‘the shadow’ (Jung, 1971 [original work published in 1921]) to make sense of the phenomenon of WPB in healthcare and the conditions that have engendered this over time. The ‘shadow’ is a Jungian psychoanalytic term, referring to the darker side of a person	Covert and insidious: <i>‘sometimes subtle nature of the bullying behaviours, as well as the element of personal interpretation, could prove challenging to identifying behaviours as bullying: In the beginning I did not realise she was bullying me. I guess it was always that like when does bullying become bullying? Because it was quite insidious.’</i> (Brown et al., 2021). Neglectful and abandoning: <i>‘At times this risk was not incidental, but deliberate. For example, students reported being left to practise unsupervised as a way of being put “through their paces” and literally ‘testing’ their competency.’</i> (Capper et al., 2021c)	1. Brown et al., 2021 2. Talash et al., 2022 3. Capper et al., 2021a 4. Capper et al., 2021b 5. Capper et al., 2021c 6. Capper et al., 2021d 7. Smith et al., 2018 8. Johnson et al., 2018 9. Gafson et al., 2017 10. Broad et al., 2018 11. Riley et al., 2021 12. Thomson et al., 2017	Methodological limitations: Minor concerns in two studies (2, 9). However, in some cases, it was unclear if the issues identified were of a methodological or reporting nature. Generally speaking, the findings were all of a high, publishable standard, in peer-reviewed journals. The findings of all the studies represented an important contribution to the evidence base. More detailed discussion of the strengths and limitations of each study can be found in the CASP table. Coherence: No or very minor concerns. ‘The shadow side of healthcare’ is more of an interpretative/analytical explanation. However, the two descriptive (or sub-themes) it is broken down into are ‘more descriptive findings, less transformed’. The subthemes are clearly and well-supported by the data. The over-arching theme is also well-supported by the data and the author provides a clear and detailed explanation of the underlying theory, and its application to WPB, to further illuminate this transformation (Colvin et al., 2018)	High confidence.

or thing; a part dystonic with someone's values, beliefs, and identity (Batemen et al., 2021; Bolea, 2016; Casement, 2012; Papadopoulos, 2006). It is often unacknowledged and exists outside of conscious awareness. Participants described WPB in healthcare as a dark phenomenon that can take many different forms, ranging from 'covert and insidious', to, 'neglectful and absent', 'discriminatory and harassing', and 'overt and brazen'. One striking, but unforeseen finding was the extreme nature and severity of bullying described, as participants provided sobering accounts of misconduct and abuse.	Discrimination and Harassment: 'Persistent sexual jokes... that made me uncomfortable... [The gynaecologist] would be <i>touchy-feely with all the females... [But] I didn't see him doing it with any of his male students.</i>' (FG5) (Broad et al., 2018) Overt and aggressive (in plain sight): <i>'There were about 15 of us in the room; the doctor consistently picked on this one boy the entire session, for an hour and a half, two hours, and didn't ask anyone else any questions, just constantly put him on the spot and was quite intimidating.'</i> (Johnson et al., 2018).		However, to the author's knowledge this is the first study to apply the Jungian shadow theory to the area of WBP in healthcare. The author did not find contradictory cases that challenged this model. However, the model needs to be more explicitly tested by future research. Adequacy: No or very minor concerns. This theme is made up of participant quotes across all the studies. Despite some concerns about the use of survey designs in some studies, the findings overall were rich and informative. Relevance: No or very minor concerns because all studies were in keeping with the inclusion criteria/RQ: • Exploring trainee/early career healthcare professionals' experiences of WPB. • In the UK • Between 2015 and now. Findings also discussed in relation to the RQ.
Theme 2: Power without impunity – facilitators of WPB The second analytical theme describes how WPB has become a hidden epidemic in healthcare, which has been maintained by problematic power dynamics, fear, and silence.	Power: <i>Hierarchy and power 'We [are]... at the bottom of the tree... there's a clear pecking order'..... 'I thought I would have been thrown out of medical school [if I reported]'</i> (Broad et al., 2018)	1. Brown et al., 2021 2. Talash et al., 2022 3. Capper et al., 2021a 4. Capper et al., 2021b 5. Capper et al., 2021c 6. Capper et al., 2021d 7. Smith et al., 2018 8. Johnson et al., 2018 9. Gafson et al., 2017	Methodological limitations: Minor concerns in two studies (2, 9). However, in some cases, it was unclear if the issues identified were of a methodological or reporting nature. Generally speaking, the findings were all of a high, publishable standard, in peer-reviewed journals. The findings of all the studies represented an important contribution to the evidence base. High Confidence

Subthemes: • Misuse of power • Fear • Silence Fear: <i>'Participants emphasised ...fear of potential consequences on their career should they speak up.... The person made me feel like they could ruin my career if I spoke out about it.'</i> (Brown et al., 2021) Silence/silencing: <i>'...A culture where medical 'banter' was a 'rite of passage' was a reason students gave for not raising concerns. (Johnson et al., 2018).</i> <i>....'minimised bullying as being nothing more than harmless 'banter'. (Broad et al., 2018).</i>	10. Broad et al., 2018 11. Riley et al., 2021 12. Thomson et al., 2017	More detailed discussion of the strengths and limitations of each study can be found in the CASP tables. Coherence: No or very minor concerns. 'Bullying in healthcare: A hidden epidemic' was the more analytical theme. The three subthemes, or more descriptive themes were: • Misuse of Power • Fear • Silence The sub-themes were clearly and adequately supported by the data. The over-arching theme is well supported and well-explained. The author did not find contradictory cases in the original studies that challenged these findings. Adequacy: No or very minor concerns. This theme is made up of participant quotes across all the studies. Despite some concerns about the use of survey designs in some studies, the findings produced were rich and informative. Relevance: No or very minor concerns because all studies were in keeping with the inclusion criteria/RQ: • Exploring trainee/early career healthcare professionals' experiences of WPB. • In the UK • Between 2015 and now. Findings also discussed in relation to the
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RQ.			
Theme 3: Time for Change • Cultural overhaul is needed. • Moving towards a brighter future: TIC.	Cultural overhaul: ‘...organisations should encourage and protect whistleblowers (Vivekananda-Schmidt and Vernon 2014)...and provide an environment where FDs feel valued by senior members of the hierarchy and able to voice their opinion... to have a long lasting impact changes should be implemented at <i>all levels, in particular organisation leaders</i> (Talash et al., 2022)’	1. Brown et al., 2021 2. Talash et al., 2022 3. Capper et al., 2021a 4. Capper et al., 2021b 5. Capper et al., 2021c 6. Capper et al., 2021d 7. Smith et al., 2018 8. Johnson et al., 2018 9. Gafson et al., 2017 10. Broad et al., 2018 11. Riley et al., 2021 12. Thomson et al., 2017	Methodological limitations: Minor concerns in two studies (2, 9). However, in some cases, it was unclear if the issues identified were of a methodological or reporting nature. Generally speaking, the findings were all of a high, publishable standard, in peer-reviewed journals. The findings of all the studies represented an important contribution to the evidence base. More detailed discussion of the strengths and limitations of each study can be found in the CASP tables
	Moving towards a brighter future: TIC <i>‘Participants referred to the positive regard by others in new work environments and the support from others when reporting workplace bullying, eliciting a sense of safeness....a more compassionate sense of self, which challenged self-criticism associated with bullying’</i> (Brown et al., 2021).		Coherence: No or very minor concerns. Time for change was the over-arching analytical theory, which consisted of two sub-themes. The first sub-theme was somewhat between descriptive and analytical: ‘A cultural overhaul is needed’, as there was some level of analysis and ‘abstracting up’ from the findings to make this interpretation. Participants across the studies clearly described the need for widespread, systemic changes, in various ways. However, the author brought these together and conceptualised it as a ‘Cultural Overhaul’ – as well as making the point that this needs to be rolled-out at all levels, and backed by those in leadership roles. There data supporting this is clear and sufficient.
	Hope and resolve to make positive changes. <i>‘their response escalated to outright defiance, with</i>		Moving towards a brighter future: TIC

students resolving to push on in the profession despite the obstacles placed in their path...students were plotting revenge of sorts: intent to reform the profession.' (Capper et al., 2021d).

This theme was somewhat analytical as it captured the ways in which participants across the studies expressed hope for a brighter future, as well as an increasing momentum for change.

Although not explicitly stated in the primary studies, the suggestions and recommendations outlined are in keeping with those of TIC. This theme was analytical as the author brought these ideas together, incorporating the TIC framework.

There is clear, sufficient data supporting this theme. The more analytical elements of the theme are clearly explained.

Adequacy:

No or very minor concerns.

This theme is made up of participant quotes across all the studies. Despite some concerns about the use of survey designs in some studies, the findings produced were rich and informative.

Relevance:

No or very minor concerns because all studies were in keeping with the inclusion criteria/RQ:

- Exploring trainee/early career healthcare professionals' experiences of WPB.
- In the UK
- Between 2015 and now.

Findings also discussed in relation to the RQ.

Appendix E

Thematic Synthesis: Line-by-line coding and theme development (NVIVO)

NVIVO
Systematic Review ...3.1).nvp (Edited)

Quick Access

- Codes
 - Coding 10 Capper et al Social Cultur...
 - Coding 11 Capper et al Organisation...
 - Coding 12 Capper et al. does age ma...
 - Coding 5 - Broad
 - Coding 6 - Smith et al. 2017
 - Coding 8 - Thomson
 - Coding 9 - Capper - The parents are...
 - Developing Themes
 - Study 1 - Brown et al**
 - Study 2 Coding -Riley
 - Study 3 coding Talash
 - Study 4 coding Johnson
 - Study Coding 7 - Gafson
 - Thematic Framework
- Sentiment
- Relationships

Study 1 - Brown et al

Name	Files	Refere
Blaming the trainee.	1	1
Blatant acts of discrimination.	1	1
Blocks to acknowledging and labelling the experience as b	1	1
Blocks to the idea of victimhood. Not wanting to see ones	1	1
CFT and trauma informed framework and model - to unde	1	1
Competitive culture is at odds with compassion, collaborat	0	0
Constant evaluation makes it difficult to open up fully.	1	1
Contradiction of caring role - irony, paradox, hypocrisy.	1	1
Covert bullying. More insidious	0	0
Clever and concealable	0	0
Leads to self-doubt, silencing, crazy making.	0	0
Unable to prove.	1	1
Crazy making	1	1
Creating self-doubt and self-criticism.	1	1
Disillusioned and cynical.	1	1
Disillusioned. Lost faith	1	1

In Code to

Unable to prove.

<Files\\Brown et al. 2021\\Workplace bullying from the persp
reference coded [0.59% Coverage]

Reference 1 - 0.59% Coverage

Sub-theme 2.1: challenges to identifying bullying. Trainees hi
nature of the bullying behaviours, as well as the element of p
challenging to identifying behaviours as bullying: In the begi
me. I guess it was always that like when does bullying becom
(Fiona)
It felt like it started quite gradually. And it started as a kind o
have been quite difficult to evidence. (Sara)

GK 163 Items

Thematic Synthesis: Analytical and Descriptive Themes (NVIVO)

Developing Themes						Search Project
	Name	Files	References	Created on	Created	
[-]	○ The Shadow Side of Healthcare	0	0	02/06/2023 10:37	GK	
+	○ The shadow side quotes	0	0	27/09/2023 22:30	GK	
+	○ Bullying occurs in many different forms.	0	0	25/05/2023 16:40	GK	
+	○ The effects of bullying are significant and pervasive - 'bullying is everyone's busi	0	0	25/05/2023 16:44	GK	
[-]	○ What is giving rise to and keeping the problem going - power, fear, silence.	0	0	27/05/2023 10:49	GK	
+	○ Silence and being silenced	0	0	28/09/2023 09:31	GK	
+	○ Abuse of power and hierarchy	0	0	28/09/2023 09:32	GK	
+	○ Fear of reporting	0	0	28/09/2023 09:33	GK	
+	○ Poor working conditions and pressurised environment	0	0	28/09/2023 10:21	GK	
[-]	○ Time for change - a cultural overhaul is needed - hope for the future	0	0	27/05/2023 10:52	GK	
+	○ Cultural, organisational, and systemic overhaul - towards TIC.	0	0	28/09/2023 10:26	GK	
+	○ Clearer, more accessible, anonymous, independent, and supportive reporting syst	0	0	28/09/2023 10:48	GK	
+	○ A more safe, supportive, and nurturing learning and clinical environment.	0	0	28/09/2023 10:56	GK	
+	○ Implications for research	0	0	28/09/2023 11:24	GK	

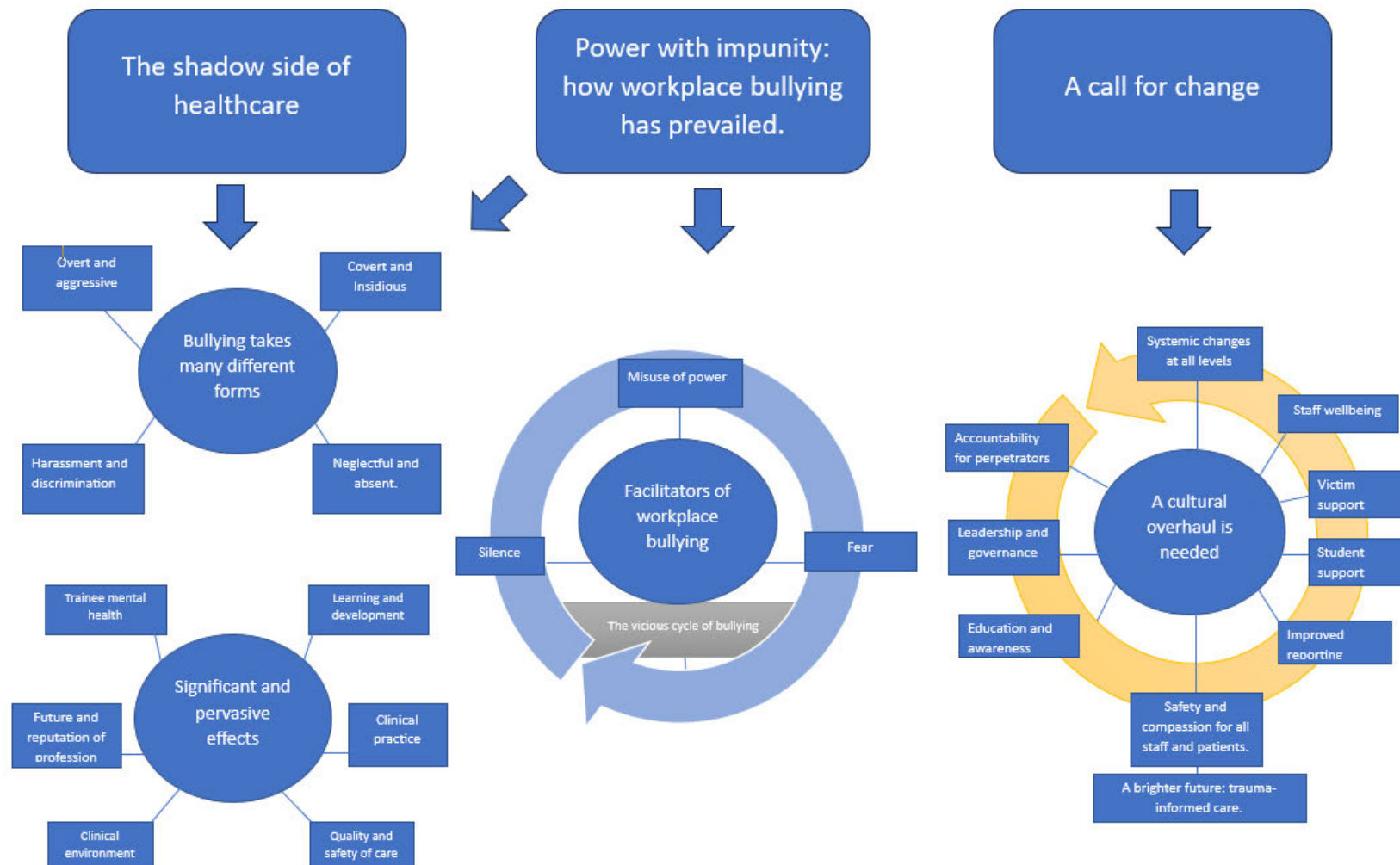
Appendix F

Systematic Review: Mapping Codes and Themes (Development Phase)

Initial Thematic Map (Rough Draft)

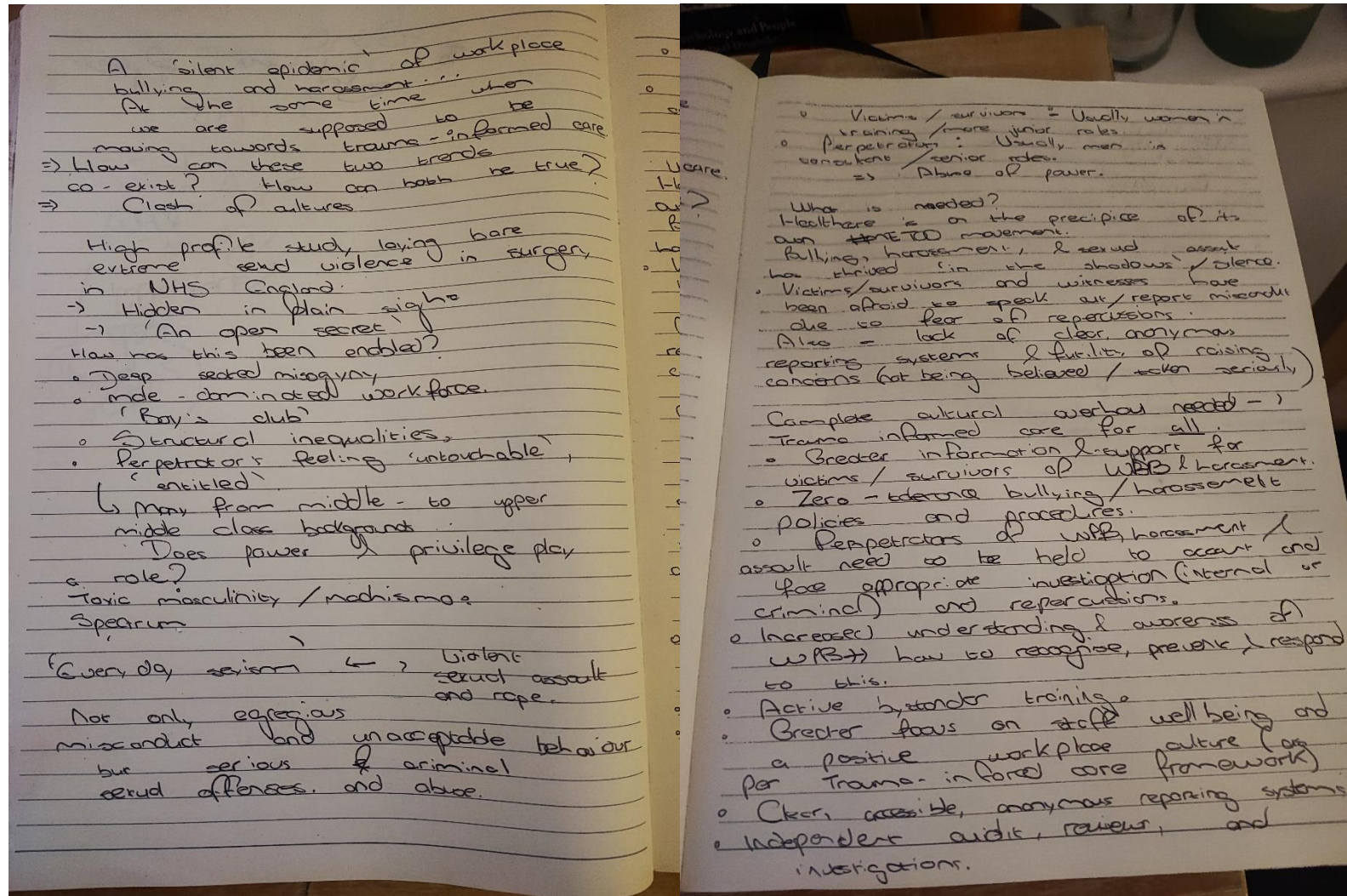


Thematic Map for Systematic Review (Development Phase)



Appendix G

Sample of Reflexive and Reflective Journal



Appendix H

University of Edinburgh Ethical Approval

FW: CLPS237 - RE: Application for University Ethics (DClinPsy Thesis)



Grace Kealy

To: HiSS Research Ethics



CLPS237_hiss_research_ethics_application_28.07.22KGS_Provisional approval.docx
131 KB



Mon 21/11/2022 22:06

To: Grace Kealy <

>

Cc: Charlene Plunkett <

>

Subject: Re: CLPS237 - RE: Application for University Ethics (DClinPsy Thesis)

Dear Grace and team

Thank you for your revised application. Based on your responses the application meets the standards for favourable opinion from the Clinical Psychology, University of Edinburgh Ethics Committee. The signed ethical response sheet/application is attached – please note that this is fine to attach to your dissertation etc. If you require a formal letter of ethics approval (this is only required if you are approaching third parties, NGOs etc) then please contact the new ethics mailbox (ethics.hiss@ed.ac.uk) requesting this and a formal letter of approval will follow in due course. If you need to make any changes to the study, you should return your amendment to the new ethics email - ethics.hiss@ed.ac.uk, cc'd above with the changes clearly noted in the relevant section of the form.

Please note that this favourable opinion is provisional until R&D approval has been granted. When you have this please respond to this email trail with proof of your R&D approval so that ethics have a note of this. We need sight of your R&D approval before you can begin your data collection.

Thank you.

Best wishes,
Karri

Appendix I

NHS Lothian Management Approval

Lothian NHS Board



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

FM/NL/approval

20th December 2022

Ms Grace Kealy
NHS Lothian/University of Edinburgh
Newington
Edinburgh
EH16 5XW

Research & Development
Room E1.16
Tel: 0131 242 3330

Email:
accord@nhslothian.scot.nhs.uk

Director: Professor Alasdair Gray

Dear Ms Kealy

Lothian R&D Project No: 2022/0175

REC No: N/A

Title of Research: Staff experiences of trauma-informed care in complex mental health services: an interpretative phenomenological analysis

Sponsor Reference: CAHSS 2112/06

Participant Information Sheet & Consent Form:

Version 2.0, dated 8 December 2022

Protocol: Version 2.0, dated 8 December 2022

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.

We note that this study has obtained approval from NHS Lothian Information Governance/IT Security for those aspects of the study that involve collection and transfer of identifiable information. Please note that Qualtrics must be registered with ICO if processing personal identifiable information (e.g., participant's name on consent form). NHS Lothian IG/IT Security must be provided with a copy of the ICO registration certificate. 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.

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>*

Appendix J

Thesis Protocol

STUDY PROTOCOL

Staff experiences of trauma-informed care in complex mental health services: an interpretative phenomenological analysis.

	The University of Edinburgh and Lothian Health Board ACCORD The Queen's Medical Research Institute 47 Little France Crescent Edinburgh EH16 4TJ
Protocol authors	Grace Kealy
Chief Investigator	Grace Kealy, Trainee Clinical Psychologist
Sponsor number	CAHSS 2112/06
REC Number	N/A
Version Number and Date	Version 1 28/07/22

To update the table of contents, highlight the existing table of contents; right click “update fields” and OK

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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. 15

15.	GOOD CLINICAL PRACTICE	15
15.1.	ETHICAL CONDUCT	15

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 approval will be met. 15

15.2.	INVESTIGATOR RESPONSIBILITIES	15
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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. 15

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LIST OF ABBREVIATIONS

This is not an exhaustive list.

Any additional abbreviations used within the protocol must also be added here.

ACCORD	Academic and Clinical Central Office for Research & Development - Joint office for The University of Edinburgh and Lothian Health Board
CI	Chief Investigator
CRF	Case Report Form
GCP	Good Clinical Practice
ICH	International Conference on Harmonisation
PI	Principal Investigator
QA	Quality Assurance
REC	Research Ethics Committee
SOP	Standard Operating Procedure
TIC	Trauma-Informed Care
CPD	Continued Professional Development
SIG	Special Interest Groups

1. INTRODUCTION

1.1. BACKGROUND

Over the past thirty years, there have been improvements in understanding the impact and treatment implications for individuals who have experienced trauma. It is now well-established that traumatic and adverse life experiences can lead to poorer mental and physical health outcomes in adult, including reduced quality of life, functioning, and life expectancy (Felitti et al., 1998; Sweeney et al., 2018). In accordance with the DSM-V, trauma can be defined as anything that causes serious injury, threats of and/or actual violence, and sexual assault American Psychiatric Association [APA, 2013], as well as childhood abuse, war, conflict, torture, and exposure to traumatic events/experiences through work (NICE, 2020). The 2014 Adult Psychiatric Morbidity Survey (APMS) in England reported a prevalence rate of 5.1% of women and 3.7% of men who screened positive for PTSD (McManus et al., 2016). Global prevalence studies have reported significant variability (ranging from 1% - 12%) in PTSD prevalence, which may be due to different socio-cultural factors, as well as methodological differences, and methods of assessment for PTSD (NICE, 2020). Individuals with PTSD can experience a range of symptoms, such as flashbacks, avoidance, hyperarousal, and dissociation. In more recent years, the construct of PTSD has been expanded on in recognition of the

impact of complex traumatic experiences, particularly those that are interpersonal in nature, experienced during childhood, and prolonged (Giourou et al., 2018). This is known as complex-post-traumatic stress disorder (ICD-11), and it includes the symptoms commonly associated with PTSD, along with greater difficulties with negative self-concept, emotional dysregulation, and interpersonal difficulties (Giourou et al., 2018; World Health Organisation [WHO], 2018). However, there is debate in the field with some researchers arguing that what constitutes trauma is individual and subjective, and therefore may not be something listed as part of diagnostic criteria (Johnstone et al., 2018; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014; Sweeney 2018). There is also a movement towards recognising that a person's responses to a traumatic event/experience are "normal responses to an abnormal environment", and away from diagnoses that are seen to be overly pathologising (Sweeney, 2018). This, combined with the inadvertent harm caused to service users through practices that are not trauma-sensitive has led to a paradigm shift in health service design and delivery towards trauma-informed care (TIC) (Harris & Fallot, 2001). The underpinning principles of TIC, as described by Harris & Fallot (2001) are: safety, trustworthiness, collaboration, choice and empowerment. There is also a strong focus on staff well-being, supervision, and reflective practice.

In response to increasing recognition of the harmful impact of trauma, abuse, and adversity, and potential for re-traumatisation through insensitive care practices, there has been a paradigm shift towards trauma-informed care (TIC) and widespread implementation of this approach (NHS Education for Scotland [NES] 2021; Sweeney et al., 2018). TIC aims to promote patient safety, choice, collaboration, trust, and empowerment, while preventing re-traumatisation and iatrogenic harm through health and social care services.

Although TIC has received widespread interest and its principles have been described extensively, there is a lack of empirical research on the efficacy, effectiveness, feasibility, acceptability, or experience of this approach among key stakeholders (Champine et al., 2019; Dawson et al., 2021; Sweeney et al., 2018). Furthermore, there is research to suggest that individuals with complex mental health difficulties often associated with complex trauma continue to experience iatrogenic harm in healthcare services, including practitioner stigma, hostility, and negative attitudes, as well as other potentially re-traumatising experiences, such as lack of choice, or sense of control in diagnosis and treatment, power imbalance, seclusion, restraint, and other forms of paternalistic, coercive, and/or restrictive forms of care (Sweeney, 2018). For example, individuals with complex mental health difficulties (e.g., 'borderline personality disorder'; 'substance misuse') continue to be subjected to high levels of stigma, hostility, and harmful attitudes in services to this day (Fried, 2020; Mendiola et al., 2018; Ring & Lawn, 2019; Sweeney et al., 2018; van Boekel et al, 2013). This is a concern, particularly as these are among the most highly traumatised groups in society. Therefore, this study aims to explore staff perceptions of the implementation of TIC in complex mental health services. This will involve seeking to understand staff views on the implementation of TIC, including facilitators and barriers to TIC, as well as all relevant client, staff, and systems/organisational based factors.

1.2 RATIONALE FOR STUDY

Although the implementation of TIC is widespread, empirical research on how staff are experiencing this is lacking. This study aims to address gaps in the literature by conducting a qualitative analysis of

how staff are experiencing the roll-out of TIC. Understanding how the implementation of TIC is going from multiple perspectives is essential to ensuring it is achieving the desired outcomes, in terms of improvements in staff and service user outcomes and experiences of care. It is hoped that a qualitative approach will allow for a rich, in-depth exploration of staff experiences of TIC.

2. STUDY OBJECTIVES

2.1. OBJECTIVES

Primary Objective

This study aims to explore staff perceptions of the implementation of Trauma-Informed Care in complex mental health services.

2.2. Secondary Objectives

N/A

2.3. ENDPOINTS

Primary Endpoint: Qualitative data on staff experiences of TIC

Detail primary endpoint(s)

Secondary Endpoints

N/A

3. STUDY DESIGN

This study will employ a qualitative research design. Data will be collected by way of semi-structured interviews conducted either in person, via MS teams, or telephone call – participants will be given a choice regarding this. This has been made optional to promote ease of participation through choice and flexibility, while also reducing the likelihood of social desirability biases, and barriers to engagement associated with costs (e.g., travel, time costs). However, it is recognised that in doing so, this standardisation and homogeneity of the interview process may be reduced. It is estimated that interviews will last approximately 60 – 90 minutes. It is expected that each participant will be in the study for one year. Depending on whether participants opt to receive research summaries, they will be contacted once or twice over a one-year period

4. STUDY POPULATION

4.1. NUMBER OF PARTICIPANTS

Staff (clinical and non-clinical) working in complex adult mental health services, and/or with individuals and groups who have complex mental health difficulties, will be invited to take part in this study by way of advertisement sent via email. The term ‘complex mental health difficulty’ can be subject to variability and determined on an individual basis in clinical practice. Complex mental health difficulties, as they are referred to here, and in keeping with policy guidelines (NICE Guidelines, 2011; The Matrix [Schwannauer, & Taylor, E, 2015]), will be used to describe mental health difficulties that are pronounced in terms of severity, risk, chronicity, and co-morbidity, as well

as those that require a high level/intensity of treatment, and/or provider specialisation. The British Psychological Society – Division of Clinical Psychology (BPS – DCP, 2022) describes complex mental health difficulties as those which impact one's interpersonal functioning, ability to regulate emotions, and function well in the world, and are often underpinned by traumatic experiences. The UK Centre for Mental Health suggests that people with complex needs often have complex, co-occurring disorders, and for that reason, are often considered 'hard-to-reach' and fall between the gaps of services (Centre for Mental Health, 2020). In Australia, The Women's Centre for Health Matters describe complex mental health needs as those that pose significant, enduring, co-morbid, and/or rare challenges and functional impairment for the individual affected across multiple domains. As well as this, people who have more complex difficulties often require more intensive MDT and multi-agency assessment and intervention (The Women's Centre for Health Matters, 2022).

Research suggests that small sample sizes allow for more in-depth analysis of an individual's experience in qualitative research (Smith et al, 2009). Clarke (2010) recommends 4-10 interviews for IPA at doctoral level research. However, as Sim et al. (2018) have identified, it is difficult to determine the sample size needed for qualitative studies prior to gathering and analysing the data. As such, we aim to gather enough individual viewpoints to allow for triangulation and saturation, while at the same time, maintaining feasibility through appropriate time frames for analysis etc.

This study will advertise and recruit across multiple sites, including community mental health, substance use, and psychological therapies services in NHS Lothian.

4.2. INCLUSION CRITERIA

- Staff (clinical and non-clinical) working with individuals and groups with complex mental health difficulties and needs.
- Some knowledge of what trauma-informed care is. However, participants are not required to have formal training or experience of working within this framework.
- Able to provide informed consent.
- Aged 18 and over (no age limit, but all participants will be of working age by default).

4.3. EXCLUSION CRITERIA

- Mental health professionals who do not have experience of working with clients with complex mental health difficulties and/or complex trauma will be excluded from this study.

5. PARTICIPANT SELECTION AND ENROLMENT

5.1. IDENTIFYING PARTICIPANTS

The researcher aims to recruit potential participants by way of email advertisement to staff working in complex adult mental health services in NHS Lothian. The project will also be discussed and advertised via the researcher and field supervisors at team meetings. This includes, for example, community mental health, substance use, and specialist psychological therapies services in NHS Lothian. These will be sent via email by the chief investigator, field supervisor, and/or a member of the clinical administration team. The researcher will also promote this research by attending team meetings in these services. I will also join any relevant CPD/SIG groups to promote this study. Staff working in NHS Lothian complex adult mental health services who are interested in taking part in this study can request (via email, telephone call, or in person) information sheets about the study, including how they can participate etc., as well as consent forms, which they can review and complete via Qualtrics online survey software.

5.2. CONSENTING PARTICIPANTS

To mitigate the risk of any harm, participants will be fully briefed and given an opportunity to give informed consent. Participation in this study is entirely voluntary, and participants will be free to opt-out or withdraw at any point. Contact details of the chief investigator will be made available so that interested persons can get in touch to find out more information, ask any questions, and/or take part in the study. Upon request via email, post, telephone call, or in person, Individuals interested in taking part in this study will be provided with an information sheet and consent form which can be completed via Qualtrics. Consent forms can be completed within two weeks to confirm participation.

5.3. Withdrawal of Study Participants

Participants are free to withdraw from the study at any point or a participant can be withdrawn by the Investigator. If withdrawal occurs, the primary reason for withdrawal will be documented in the participant's case report form, if possible. The participant will have the option of withdrawal from:

all aspects of the trial but continued use of data collected up to that point . To safeguard rights, the minimum personally identifiable information possible will be collected.

6. STUDY ASSESSMENTS

Assessment	Screening	Study data
Assessment of Eligibility Criteria	?	
Written informed consent	?	
Demographic data, contact details	?	
Semi-structured interview with staff	?	?

7. LONG TERM FOLLOW UP ASSESSMENTS

All participants will be fully de-briefed, which will involve checking-in with the participant to see how they are emotionally, asking how they found the interview, and signposting to relevant information and support services. Participants will be given the contact details of

the chief investigator, as well as the academic and field supervisors, should they wish to

get in touch regarding any questions or concerns about this study and/or their participation. It is expected that each participant will be in the study for one year. Depending on whether participants opt to receive research summaries, they will be contacted once or twice over a one year period.

8. DATA COLLECTION

Demographic questionnaires will be collected, and interviews will be recorded using an NHS encrypted recording device. Recordings will be transcribed manually by the researcher or a member of the research team. All identifiable information will be removed, and pseudonyms will be allocated to participants. Data will be stored securely and in accordance with University of Edinburgh, NHS Lothian, and GDPR policies. The procedures described in the MANTRA data management training

will be adhered to at all times. The chief investigator (Grace Kealy) will collect the data. It is estimated that interviews will last approximately 60 – 90 minutes. Participants offered a choice of face-to-face, MS teams, or telephone interview (to promote ease of participation and reduce barriers to open engagement in interviews, including the potential for social desirability bias).

9. Source Data Documentation

Demographic questionnaire will be collected and semi-structured interviews recorded via an NHS encrypted digital recorder.

10. DATA MANAGEMENT

10.1. Personal Data

The following personal data will be collected as part of the research:

Any identifiable information (e.g., names via consent forms) will be deleted when it is no longer needed for this research. Any such data will be stored securely on the University of Edinburgh secure database for up to 1 year after the study has finished. Each participant will also be given a unique identifying number so that names as data is anonymised. Consent forms will be stored separately from research data to reduce the risk of information becoming identifiable. Other identifiable and/or personal data (e.g., online identifiers, genetic, physical, economic, social etc.) will not be collected as part of this study.

10.2. Data Information Flow

Demographic data (e.g. age, gender, years of experience, and setting/service currently working in) as well as data from interviews will be anonymised. Research data will be stored separately from identifiable information, but also within the University of Edinburgh secure database. Interview recordings will be destroyed once data has been transcribed.

NHS codes of confidentiality will be strictly adhered to at all times, as will GDPR guidance on security and storage of data (e.g., data will be anonymised or pseudonymised). Paper copies of consent forms will be destroyed once the data has been uploaded to the secure server.

10.3. Data Controller

A data controller is an organisation that determines the purposes for which, and the manner in which, any personal data are processed.

The University of Edinburgh and NHS Lothian are joint data controllers along with any other entities involved in delivering the study that may be a data controller in accordance with applicable laws (e.g. the site)

10.4. 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.

11. SAMPLE SIZE CALCULATION

Research suggests that small sample sizes allow for more in-depth analysis of an individual's experience in qualitative research (Smith et al, 2009). Clarke (2010) recommends 4-10 interviews for IPA at doctoral level research. However, as Sim et al. (2018) have identified, it is difficult to determine the sample size needed for qualitative studies prior to gathering and analysing the data. As such, we aim to gather enough individual viewpoints to allow for triangulation and saturation, while at the same time, maintaining feasibility through appropriate time frames for analysis etc. This is an iterative process that becomes more evidence when the process of data collection and coding has started.

This study will advertise and recruit across multiple sites, including community mental health, substance use, and psychological therapies services in NHS Lothian. It is estimated that recruitment will take place between 1-3 months, depending on staff availability.

12. PROPOSED ANALYSES

Semi-structured qualitative interviews will be analysed by way of interpretative phenomenological analysis (IPA).

13. RISKS

We do not foresee any significant risks or disadvantages to participants taking part in this study. However, we are aware that all participants will be individuals with their own lived experiences, some of which may be challenging or distressing to talk about. As well, given that this research is exploratory, we cannot ascertain the exact content that will be discussed or the impact this will have on the individual. To mitigate this risk, this will be fully discussed, and participants will be given full information and an opportunity to provide informed consent before taking part in this study. Participants will also be reminded that their participation is voluntary, and they have a right to withdraw from the study at any point. The principles and policies of confidentiality, child protection, and duty of care will be discussed with participants and upheld throughout the interview. Participants will be informed at the outset and throughout the interview that if they feel in any way distressed or uncomfortable, they can take breaks, postpone, or discontinue the interview. The researcher conducting this study is also a clinician in training and as such has skills such as active listening, responding to distress, and risk assessment. Interview data will be anonymised, and participation is confidential. However, if there are concerns about the welfare of a participant and/or anyone else, this information would need to be shared with relevant persons/bodies to prevent the risk of harm. This is unlikely to happen but in the rare event that it does, it would be discussed with the relevant person(s) first. Taking part in research of any kind requires the time of the participant, and this is something that can be challenging for healthcare staff working in busy systems and services. It is hoped that this will not unduly disadvantage any participant and that the benefits of taking part will outweigh the potential of any such risks.

Participants will be signposted to additional supports, such as HR, employee assistance programmes, their G.P., as well as relevant information and support services, including emergency contact numbers.

14. OVERSIGHT ARRANGEMENTS

14.1. 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.

14.2. 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.

15. GOOD CLINICAL PRACTICE

15.1. 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 approval will be met.

15.2. 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.

15.3. 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).

15.4. 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.

15.5. Data Recording

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

15.6. Investigator Documentation

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

15.7. 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.

15.8. 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.

15.9. 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

16. STUDY CONDUCT RESPONSIBILITIES

16.1. 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.

16.2. 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.

17. 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.

18. 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.

19. 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.

20. REPORTING, PUBLICATIONS AND NOTIFICATION OF RESULTS

21. AUTHORSHIP POLICY

Ownership of the data arising from this study resides with the study team.

22. REFERENCES

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Consent Form

Researcher: Grace Kealy, Trainee Clinical Psychologist

Email: Tel: 079 298 18181

If you are happy to participate, please complete and sign the consent form below.

		Please Tick Box
1.	I confirm that I have read the participant information sheet (Version 1; 28/07/22) on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.	☐
2.	I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without my employment being affected.	☐
3.	I understand that following participation in the study, my data will be anonymised and analysed as part of this project. Therefore, once I take part in the study, it will not be possible to withdraw my data.	☐
4.	I understand that data will be anonymised. However, if there are concerns about the welfare of a participant and/or anyone else, confidentiality would need to be breached in line with duty of care and prevention of harm policies and ethical code of conduct.	☐
5.	I agree to my interview being recorded, transcribed, and anonymised by the researcher or a member of the research team.	☐
6.	I agree to the use of anonymous quotes in published reports and or in conference presentations.	☐

7.	I am aware that participating in this study at the current time may carry risks in relation to potential exposure to coronavirus, and I understand the steps that have been taken in relation to minimise the risks of exposure and transmission. You will be offered a choice in whether you would prefer to take part in interviews face-to-face, via Microsoft Teams, and/or telephone call.	☐
8.	I understand that data collected during the study, may be looked at by supervisors, markers, the research team and/or individuals from the Sponsors (University of Edinburgh and NHS Lothian), from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.	☐
9.	I understand that identifiable information (e.g., consent forms) will be deleted when it is no longer needed for this research. Prior to being deleted, identifiable data will be stored on the University of Edinburgh secure online database 'Datastore' for up to a year.	☐
10.	I understand that any email correspondence which takes place with participants will be deleted once it has been used for its intended purpose and is no longer needed for this research.	☐
11.	I understand my anonymised data may be retained for a minimum of 3 years and may be used in future ethically approved research.	☐
12.	I agree to being sent a copy of the final report upon completion (via email) (optional).	☐
13.	I agree to be contacted to take part in respondent validation checks (optional).	☐
14.	I agree to take part in the above project.	☐

Name of participant

Date

Signature/Tick box.

Tel:

Email:

Name of person taking consent

Date

Signature/Tick box.

Original (x1) to be retained in site file

Appendix L

Participant Information Sheet **Staff experiences of trauma-informed care in complex (adult) mental health services: an interpretative phenomenological analysis.**

You are being invited to take part in qualitative research exploring the implementation of trauma-informed care. This is being conducted by Ms. Grace Kealy, Trainee Clinical Psychologist (NHS Lothian/University of Edinburgh) and supervised by Dr Charlene Plunket (University of Edinburgh).

Background to the study

There is increasing recognition of the harmful impact of trauma and adversity on the mental health and well-being of those who survive these experiences. There is also growing awareness of the potentially harmful effects of healthcare when it is conducted in a way that is not sensitive towards individual experiences of trauma. This has brought about a movement towards 'trauma-informed care' and a largescale international roll-out of this approach. However, there is a lack of research evaluating the overall acceptability, experience, and effectiveness of trauma-informed care from the perspective of key stakeholders in clinical practice.

What is the purpose of this study?

The aim of this study is to explore staff perceptions and experiences of the implementation of trauma-informed care in complex mental health services and systems.

Why have I been invited to take part?

All staff (clinical and non-clinical) aged 18 and over working in complex adult mental health services in NHS Lothian are invited to take part in this study.

Other inclusion criteria:

- Some awareness of TIC.
- Experience working with individuals with complex mental health difficulties who have experienced trauma.

Do I have to take part?

No. Participation is voluntary, and you are under no obligation to take part in this study.

What happens if I initially agree to take part in the study but then change my mind?

You can take up to two weeks to consider if you would like to take part in this study. If you decide you do not wish to take part in the study or wish to withdraw from the study prior to participation, you are free to do so. Similarly, you can choose to stop, take a break, and/or discontinue the interview at any point. Deciding not to take part or withdrawing from the study will not affect your employment in any way. Once data has been collected, it will not be possible to redact information. However, all collected data will be uploaded to the University of Edinburgh Datastore, a secure online database and anonymised at the point of transcription.

What will happen if I decide to take part?

If you are eligible and interested in taking part in this study, please contact the researcher on the contact details provided below to request a copy of the consent forms. You will then be sent a link via email to Qualtrics (an online survey platform) where you can review and, if you are happy to do so, complete consent forms. This information will then be uploaded and stored securely on the University of Edinburgh secure online database 'Datastore'.

Once your consent form has been received and you are eligible to take part in this study, the researcher will be in touch with you to arrange a time and date that is convenient for you to attend for interview. It is estimated that interviews will last for approximately 60 – 90 minutes. You will be given the choice to take part in interviews face-to-face, over the phone, or MS teams.

When we meet, I will go through the consent and information forms again verbally to ensure that you are fully briefed and happy to proceed with the interview. With your consent, interviews will be recorded via an NHS encrypted recording device for the purpose of accurate data collection, transcribing, and analysis.

The first stage of the interview will involve demographic questions about your role, discipline, experience, and current level of understanding of/training in TIC, as well as age, and gender identity. You will be given space to add in any other demographics that you feel are important to note. The next stage will involve questions about your experiences of the implementation of TIC, and how you feel this has impacted staff practices and client experiences of care. We would ask you not to enter any personal identifiable information when completing these questionnaires. The final stage will involve de-briefing and signposting to relevant information and support services.

Following participation in the interview, you may be contacted once or twice over a one-year period for (i) data validation checks and/or (ii) if you wish to receive a copy of the research summary. Validation checks would involve reviewing an excerpt of data analysis and providing feedback on the researcher's interpretation. However, validation checks are completely voluntary, and you are not required to do these as part of your participation in this study. If you indicate (via consent forms) that you are happy to be contacted for validation checks, you may be invited via email to take part in these. Similarly, you can indicate whether you would like to receive a copy of the research summaries via the consent form.

Any email correspondence which takes place with potential or actual participants will be deleted once it has been used for its intended purpose and is no longer needed for this research.

Are there possible disadvantages and risks of taking part?

We believe that this study is unlikely to pose significant risks to or disadvantage you in any way. However, we are aware that all participants are individuals with their own lived experiences, some of which may be challenging or distressing to talk about. As well, given that this research is exploratory, we cannot ascertain the exact content that will be arise during interviews or the impact this will have on the individual. As such, it is possible that participants may become distressed and/or emotional as part of their participation in this study. To mitigate the risk of any harm, you will be interviewed by the researcher, who is also a clinician in training supervised by qualified clinical psychologists, with experience of active listening, risk assessment, and responding to distress. You will also be checked-in with regularly throughout the interview process and given opportunities to take breaks, postpone, and/or discontinue the interview.

To ensure participants are not disadvantaged in any way and to preserve anonymity, data will be anonymised, and participation treated with the strictest confidentiality. However, in keeping with duty of care policies and ethical codes of conduct, if there are concerns about yours or another person's safety and/or welfare, I would be obliged to share this information with my supervisor and relevant safeguarding personnel/agencies. This would be discussed with you and handled with sensitivity at all times.

Are there any benefits to taking part in the research?

There are no direct benefits, but it is hoped that the information gathered as part of this study will help to inform and improve service delivery, staff well-being, and client outcomes.

Risks of Participation (Covid-19)

We have taken specific steps to minimise the risk of exposure to the Coronavirus during the study by adhering to the Scottish Government guidance (<https://www.gov.scot/coronavirus-covid-19/>). Further, you will only interact with researchers who are well, and have had no known contact with COVID-19 positive individuals for the past 14 days. However, even with these control measures, there remains some additional risk of exposure from participating in this study.

What if I am unwell?

If you feel unwell or have been in contact with a COVID-19 positive individual in the past 14 days, then please contact the researcher, Ms. Grace Kealy () and we will postpone or cancel the research interaction.

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 initials, name, and contact details. The research team will use this information to check that the research is being done properly. It will also be used to obtain informed consent and adhere to duty of care policies and procedures.

People who do not need to know who you are 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. Unless they are anonymised in our records, your data will be referred to by a unique participant number and/or a pseudonym rather than by name. Consent forms will be collected via Qualtrics and uploaded directly to the University of Edinburgh secure online database 'Datastore'. Any email correspondence which takes place with participants (interested or actual) will be deleted once it has been used for its intended purpose and is no longer needed for this research. Interviews will be recorded and transcribed by the researcher or a member of the research team. Recordings will be uploaded directly to the University of Edinburgh secure online database 'Datastore' and deleted from recording devices/systems. Transcribed data will be anonymised. Once recordings have been transcribed, they will be deleted, and transcribed data will be uploaded to Datastore.

Anonymised data will only be viewed by the researcher/research team. A small section of anonymised data may be viewed by participants who take part in validation checks. Supervisors and/or markers may need to review a small number of anonymised transcripts. Personal or identifiable information (e.g., consent forms) will be stored separately from research data/responses to minimise the risk of identification. Identifiable data (i.e., consent forms) will be deleted once it is no longer needed for this research. Identifiable data may be stored securely for up to a year after the study has finished and anonymised data is retained for a minimum of 3 years. Participants will be asked to give consent for anonymised data to be used in future ethically approved research. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that once data has been collected and validation checks are complete, we will not 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>

- our leaflet which has been circulated across relevant services and is available upon request to one of the researchers.
- by asking one of the research team.
- by sending an email to _____ or _____

The University of Edinburgh is the sponsor for this study based in Scotland, United Kingdom. We will be using information from you 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.

What happens when the research study has been completed?

Personal data will be retained securely in an online database for approximately 6 months – 1 year after the study has finished, at which point they will be destroyed. Following completion of data collection and analysis, the final project will be written up and submitted, along with a systematic review, to The University of Edinburgh for review and evaluation in the form of Viva. This project will be written up in line with peer reviewed journal guidelines to promote dissemination of findings. A poster presentation will be prepared and presented at relevant conferences, and possibly within relevant services (e.g., where recruitment took place, for which the results are relevant). All data will be anonymised in the published results. Following the completion, review, and evaluation of the project, a summary of the findings will be shared with participants, relevant staff teams, and individuals with lived experiences who took part in the design and development of the study, should they wish to receive a copy.

Who can I contact?

If you have any further questions about the study, please contact the lead researcher, Ms. Grace Kealy, Trainee Clinical Psychologist on , or [Tel.](tel:07929818181) 079 298 18181. Alternatively, you can contact Dr Charlene Plunkett, Academic Supervisor on or Tel. 0131 650 4027

If you would like to discuss this study with someone independent of the study, please contact Dr. Tim Bird, Research Director for the Doctorate in Clinical Psychology at:

If you wish to make a complaint about the study, please contact:

Head of the School at headofschool.health@ed.ac.uk

13. Who is involved with organising the research?

The research has been organised by Ms. Grace Kealy, under the academic supervision of Dr. Charlene Plunkett and sponsored by the University of Edinburgh.

14. Who has reviewed the study?

A favourable ethical opinion has been obtained from the School of Health in Social Science at the University of Edinburgh. NHS Management Approval has also been obtained.

Thank you for taking interest in this research. If you would like to discuss this study further or have any questions about participation, please do not hesitate to contact either of the researchers, whose contact details are provided below.

Appendix M

Interview Schedule

Staff experiences of trauma-informed care in complex (adult) mental health services: an interpretative phenomenological analysis.

In keeping with the philosophy, ethos, and aims of Interpretive Phenomenological Analysis (IPA), this interview schedule has been developed to help facilitate participants in reflecting on and making sense of their individual experiences. The questions are open-ended, and the style of interview is intended to be non-directive, placing the participant as the expert of their own narrative. As such, the researcher will use the schedule flexibly and in a way that is sensitive, and responsive to the participants' account and experiences. It is estimated that interviews will last approximately 60 – 90 minutes.

Introduction and rapport building

This stage will involve the researcher introducing themselves, explaining again the purpose of the project, and confirming informed consent. The researcher will remind the participant of confidentiality, recording, and data management protocols and procedures (e.g., anonymising, pseudonymising, security and storage of data, and length of time data will be retained, who will have access to transcripts [i.e., the researcher, academic supervisor]).

The researcher will remind the participant of the core principles of trauma-informed care so that this can be held in mind throughout the interview. The researcher will also explain the style of interview (e.g., open-ended, exploratory) and remind the participant that the aim is to gain staff perspectives on the implementation of trauma-informed care.

Participants will be asked for demographic information, as well as more information about their profession, type of service they work in, client group, and experience of trauma-informed care, including training, utilisation, and if this has been formally/informally implemented in the service they work in.

1. Explore participant's experiences of trauma-formed care?

Tell me about your experience of the implementation of TIC?

- Prompt/reminder of key principles of TIC if needed:
 - Safety
 - Trustworthiness and Transparency
 - Peer Support
 - Collaboration and Mutuality
 - Empowerment, Voice and Choice
 - Cultural, Historical, and Gender Issues

In what ways has this influenced your practice and that of your colleagues, if at all?

How has this paradigm shift changed client experience of services and outcomes, if at all?

2. Barriers to TIC

In your view, what are the main barriers to the implementation of TIC?

- Prompt individual, staff, systemic, organisational cultures.
- Prompt: dominant models, resistance.

3. Facilitators of TIC

In your view, what factors can help to promote TIC implementation?

- Prompt: leadership, staff support, funding, training.

4. Staff wellbeing

TIC recognises the importance of staff well-being and the prevention of secondary trauma, staff burnout, and compassion fatigue.

What are your views on how this is in practice?

What factors, if any, do you believe act as barriers to staff well-being in practice?

What, in your views, would help to promote staff well-being?

- Prompt: training, support, supervision, reflective practice, peer support
- Prompt: Counter-transference, parallel processes, mirroring

5. Power

Power is an important factor highlighted as part of the implementation of TIC. Tell me about your experiences of power in the systems and services you work in.

- (Prompt: power-over relationships/power imbalance, power and powerlessness, misuse of power, empowerment)

6. Re-traumatising/Iatrogenic harm

Can you tell me what, in your view, are ways in which MH services, systems, and practices may continue to be potentially re-traumatising (if at all)?

- (Prompt: discipline specific practices, stigma, hostile attitudes, policies)

7. Diversity and Cultural Sensitivity

Another key principle in TIC is the adoption of culturally sensitive practices that promote equality, and respect for all individuals and groups, and awareness of ways in which people can be discriminated against based on culture, identity, race, ethnicity, sexual orientation, age, religion, gender identity, class, geography, and so on.

What are your experiences and views on current policies, practices, and procedures when it comes to being culturally sensitive and responsive?

8. Any further questions, thoughts, reflections?

Possible prompts:

- What was it like to reflect on your experiences of TIC?
- How has this made you feel?
- Have you any new insights following our discussion today

- Any wishes for the future in terms of trauma-informed ways of working?

9. De-brief

- Provide written and verbal de-brief.
- Signpost to supports available.
- Discuss/offer to share final report with participant, if they would like a copy.
- Provide contact details if need to get in touch or have any questions.
- Any final comments or questions?

Appendix N

Advertisement

Title: Staff experiences of trauma-informed care in complex adult mental health services: an interpretative phenomenological analysis. Version 1. 28/07/22

A qualitative analysis of trauma-informed care

We are inviting NHS Lothian staff working in complex adult mental health services to take part in this study.

If you wish to participate or enquire about this study, please contact Grace Kealy on G.Kealy@sms.ed.ac.uk

Staff experiences of trauma-informed care in complex adult mental health services

Calling on staff working with individuals with complex mental health difficulties and trauma to take part in this study. We are interested in hearing the views and experiences of staff (clinical and non-clinical) on the implementation of trauma-informed care (TIC) in these services. As part of this, we hope to gain insight into the barriers and facilitators of TIC, as well as issues related to staff well-being, power, diversity, and cultural sensitivity in the context of TIC.

What will participation involve:

- Attending an interview with the researcher lasting approximately 60 – 90 minutes.
- Possible validation checks to promote reliability of analysis.
- Contributing to an important area of psychological research.

Location

- Participants will be given an opportunity to attend for interview in person (at an NHS Lothian location), over MS teams, or telephone.

Are you eligible?

- Staff (clinical and non-clinical) working in complex adult mental health services in NHS Lothian.
- Some awareness of TIC
- Experiences of working with individuals who have complex mental health difficulties.
- Complexity in this context can be defined by clinical severity, co-morbidity, risk, presence of trauma, adverse childhood experiences, social disadvantage, and/or other socio-cultural factors that can make engagement or treatment more challenging. Complexity may also be related to the level of professional training/competencies required.

If you wish to ask any questions or discuss eligibility, please email:

- Grace Kealy, Trainee Clinical Psychologist
- G.Kealy@sms.ed.ac.uk



THE UNIVERSITY of EDINBURGH



Appendix O

Exploratory Notes and Experiential Statements

Table 1

Sample of exploratory notes and experiential statements for 'Jean' (pseudonym)

Experiential Statements	Original Transcript	Exploratory Notes
Different responses to the implementation of TIC: Psychologists are naturally aligned with this way of working.	would say that about self-efficacy, self-agency, empowering an individual that the person is always at the centre of everything that you do, and collaboration, again that is something that comes from your training but without that collaboration, really there is no therapeutic alliance, it is the rock of therapy in the relational context of therapy..... So I would say that....being able to recognise the impact of a person's history has on how they think, how they feel, how they behave, you know, we are just, we are constantly going back to that in in our sessions with people, the impact the trauma has had on them, their relationships with themselves, that's obviously the longest relationship that anyone is ever going to have is the one with themselves, so that is constantly raised in therapy, it comes back to the how do you feel about you, what is your relationship like with you, I do think that we speak about safety as well, can people at a basic level keep them safe, that internal safeness, not just physical safety. Researcher (R): yea, yea, can you speak a bit more about that – the internal safeness, not just the physical safe.	Person-centred care. The importance of the therapeutic relationship – it is at the heart of what we do. Working collaboratively (not doing to, but working with the person). Empowerment. Contextualising a person's difficulties in terms of their life experiences, traumatic events, ACEs. Always holding in mind and re-visiting what has happened to a person, when making sense of current difficulties. - This is a shift from earlier and other models (e.g., the medical model, other therapeutic modalities, such as CBT). More aware of the impact of trauma on a person's current difficulties, relationship with one's self and others. Self-concept. Safety is not just physical, but internal safeness. This is essential to TIC. Brings to mind the CFT concept of safety versus 'safeness'. The importance of feeling safe in your own body – internalised safeness within.

Other disciplines have not embraced or adopted the TIC framework as readily, The challenges of trying to integrate TIC with the medical model.	Jean: yea a lot of people don't feel safe in their own bodies, they're maybe in a safer environment than they perhaps grew up in ...but within themselves even within an environment that they are safe, doors locked, internally we see so much that people do not feel like there is hypervigilance, hyper arousal, even in our minds , there is self-critical thoughts that just constant state of fear...of foreboding...and helplessness and trying to support them through that so that they can have a more comfortable relationship internally with themselves Researcher: yea that makes sense Jean: Does it make senses? Researcher: yea it does, yea yea, and just so that is held in mind and the way you work is very trauma informed and I guess I'm thinking about that of your colleagues beyond your psychology Jean: think there is long way to go for that personally, you know, the ripples effect has maybe reached some areas, some wider areas but even with within adult mental health I do think that people are more cognisant of trauma of informed care. However the specifics, especially within <i>psychiatry</i> for examples there is that push-pull between psychology and psychiatry we are looking at the same thing from two different perspectives, you know, its not the medical model, it's not the bad psycho-social model, its very much a holistic approach and even diagnostic criteria – personality disorders, EUPD, my feeling is that we look at that diagnosis very differently, we look at that going ummm that person has a history of complex trauma Psychiatry, my sense of it is that it is very black and white, I appreciate that is maybe how they need to work, maybe that is the parameters that they have to work, but my own experience	The lingering effects of trauma (even when the threat is gone), people can feel unsafe internally. Psychologists are working more in a somatic and body level. This is a shift from previous ways of working that might have been more focused on risk assessment (and possibly defensive practice). Increasing attention given to developing internal safeness, soothing, and self-care. Seems to be some improved awareness of 'trauma-informed care' more generally within AMH teams. People might have more awareness of the idea and general movement towards TIC, however it is less clear how this has translated into practice for other disciplines. However, other disciplines have a long way to go with this. Acknowledgement of ongoing tension between psychiatry and psychology/different models/approaches to this work. The medical model can be at-odds with TIC. One of the most salient examples of this difference in approach can be seen in diagnosis versus trauma-informed formulation.
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	is that the fields I have worked in the past is that I liked to look at the bigger picture, more of a holistic approach to people, considering the past, the links to the past is forever there. G: yea, absolutely these are really valuable reflections, and important things we talk about and I wonder I am interested to hear a bit more, you have hit on something so crucial the personality disorder diagnosis and all the baggage that comes along with that vs seeing something different and complex obviously, what way do you think the black and whiteness might play out, I am thinking about how psychiatry might make sense of that person, what is it that is black and white? If you could peak more around that? Jean: I can only speak from personal experience with psychiatry Researcher: Yeah, absolutely....	EUPD, and the term 'personality disorder' in general can be a loaded term. Highly stigmatised and misunderstood condition. Contentious and fervently debated Psychiatry very 'black and white' – reductionist, diagnostic model overly simplistic – does not view a person's difficulties in the context of their life experiences and trauma. Psychology tends to view the person in the context of who they are, their experiences and so on. Seeing them as a human, and not just a diagnosis. Some acknowledgement that this 'black-and-whiteness' of psychiatry may be a product of their training, pressures they are under, parameters they work under, and how they practice. - Usually have higher caseloads, shorter consultation times, need to more economical with their time and made clear-cut decisions in an efficient manner. Jean's tone and demeanour suggests some frustrations/difficulties with this approach to mental health care – as this fails to consider the wholeness of the human being, in the context of 'what has happened to them'.
Longstanding tension between psychiatry and psychology.	Jean: There sometimes from my clinical perspective, as a professional that your not necessarily valued and on that same level that there seems to be the stance that 'I am the psychiatrist, so this is how its going to be' or if you are thinking this person has more complex PTSD rather than just PTSD it's that I experience this a couple of years ago, there is no indication that they do have that, well actually this, this, this and this, is the reason.....ehm, based on what they're presenting and the information that has been gleaned from weeks and weeks and weeks of spending time with this person compared to periodic appointments....You know, I have built up a relationship with this person; I have insights into their life and what they're struggling with, you know. I have undertaken outcome measures that keep on highlighting complex PTSD is a factor here.	Not feeling valued or treated as an equal when working with psychiatry colleagues. They often adopt an independent, autonomous style of working and decision making – less collaborative and democratic. Problematic power dynamics. Can feel disrespected, and condescended to.
Professional discord/disharmony.		
Not working in a collaborative manner within the MDT.		Psychological practitioner trying to advocate for patients and having to justify/provide evidence for decisions (e.g., complex PTSD vs. PD). Fundamentally different ways of working. Psychologists spend a lot of time with patients and hearing their stories. - Psychologists prepared to 'go there', 'to the dark place' – to listen to and sit with someone inn their suffering.

Not feeling respected/valued by psychiatry colleagues.	So that can be quite difficult when maybe you're professional courtesy is not given. And my sense was that you should have professional courtesy for whatever professional – within the NHS, social work, whatever; that – that is my values, that is my professional values.	- Psychiatrists have more patients, and less time in consultations – often not enough time to hear people. - Do not spend as much time or place as much focus on building a therapeutic relationships with patients. - Stands to reason then that patients may be not feel safe enough, or that they can trust this person enough to discuss the extent of their difficulties or disclose traumatic experiences (s). (so how could a patient disclose this information). - Feeling you have to fight to get your voice heard and to advocate for the patient. Hard work, huge effort. Feeling dismissed and not listened to by psychiatry. An absence of professional courtesy and respect. Psychiatry has 'self-appointed' themselves to leadership status ('doctor knows best' mentality) We should all have professional courtesy for one another (respect, listening to, treated as equals) – and that is not happening. How can we be trauma-informed to others, if internally within the system there is no professional courtesy. If they are treating psychological practitioners like this, how must patient feel?
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Appendix P

Sample of Group Experiential Themes

Table 2

Sample of Group Experiential Themes for the Empirical Project (a table of all Group Experiential Themes and data extracts is available upon request)

Theme 1: The Paradoxical Implementation of Trauma-Informed Care (TIC)

1a. The implementation of trauma-informed care has not been trauma-informed.

For many participants, they felt that the implementation of trauma-informed care has, ironically, not been 'trauma-informed', in the sense that it has been insensitive to the current climate in healthcare, and that many staff teams are still recovering from the traumatisation of the global pandemic, and are overwhelmed and under-resourced. Participants also highlighted that the TIC implementation has not upheld the very principles upon which it is based (e.g., safety, trust, choice, empowerment, collaboration).

Sarah:

"and I think especially in the culture of the NHS just now, what we see is under-staffed, under-trained, burnt out..its really hard to maintain a really healthy positive culture of care...and that makes introducing things like trauma informed or any other systemic changes in the way people are practicing really really tricky...people don't have those resources."

"what is the function of that resistance, like what's driving that, because that will maybe be really different for each team...I think for some people it may be fear, like for some people it could be fear of getting it wrong, for some people it might be like you are asking too much of me, I am burnt out, and I can't do anymore...."

"That will - the resistance will exist at all levels and I guess like for me I've kind of definitely the way I've noticed I'm talking about this and thinking about this is more at that level of each individual team with input and I do think I think all change in the NHS is hard and I think trying to implement change just now in the current state of stress and burnout and staffing and resources and people really, yeah people really just crashing."

...and I think probably to come along and be like 'hey let's be nicer to everyone'.

"...we don't understand what it's like to be in their shoes and then we're delivering training and they're going this is all great but how are we going to do this...and when we try to put the onus back on them that was really tricky..."

Participant 2 (Jean): *"but even when it comes to, you know, understanding other professionals, or ehm, the lack of resources that are available within MH, you know, how we're supposed to work with limited ehm funding at times, you know, resources, you know, community, organisations...you know, there's so much that people do need that just isn't available and you do feel that pull of...you know, you want to fill the gaps for people but you're just...you're just one service."*

"I suppose in the wider context, you know, of mental health and psychological services, that's maybe less of a case; that you feel more disempowered, that you're maybe not heard...or fully appreciated on a day-to-day basis. Appreciate as in understand your role and how it affects you. Again, the restrictions that you're working under. Especially on your time – there is not enough time in your week, even to be able to really spend some time on reflecting on your patients. You know, it does feel like you see your patients, you do their notes, and then you see them again the following week, for example...you know...that's not helpful for anyone."

Participant 3 (Anita): *"and I suppose it creates...it adds to that pressure. I think there is a bit of...I think because you could ALWAYS be more trauma-informed, eh, so there's this idea of, like....adds to that, is this good enough? Or, in the way it can make you think about things more and pay more attention to the kind-of subtle interactions. It could also go the other way – you know, in being kind of hypercritical of yourself, and that's not trauma-informed...because you're a human being yourself. Like, we can't be perfect. And not that we're looking for that but sometimes you can feel like that."*

GK: that makes sense actually and it's not something I have actively thought about...how it can make us critical of ourselves."

"Like we're not doing enough or ehm, yeah, yeah, just not doing good enough."

Participant 4: (Isabelle): *"It's nurse led team. So I know that they have very big caseloads and they see a lot of people and because its nursing, so it's all about medication mainly....but ehm, I think it must be more difficult for them to be trauma-informed enough because they have less time to see the patients and they have bigger caseloads."*

Participant 5 (Samantha): *"Yeah, I think that with time, the frustrations return – sort of. Ehm, this whole idea of becoming trauma informed, I think staff have very sort of mixed responses to that because to some degree we feel like we're doing what we can within a an environment or a setting that inherently isn't from informed... and that is you know...ehm....out-with our control."*

Participant 6 (Vicky): *"But I can imagine from what I know of working alongside others, most people would love to go and do half day training on something like that ...but whether they have the time and space..."*

So, it's a bit of a short sighted view of 'we don't have time to invest in this because we're so busy fire fighting...or were so busy doing the immediate stuff... and we don't have enough staff and whatever the demands may be'....whereas actually if there was more of that culture of trauma-informed care there would be less ...there be less complaints ...there would be less difficult working dynamics there would be less people trying to elicit care in unhelpful ways... you would hope.

"I think people are are generally, I think the - and that's just an observ - I think it's there's an element of it being true over a longer period but I think in recent times, I think the idea, if you were to say to a CPN, 'would you like to come on 1/2 day trauma informed course' or 'would you like to read this book?', I think they would love to but I think they really struggle to be able to justify the time...ehm to be maybe necessarily be supported by that by their management...and I mean more kind of maybe upper management with that...because again it's less measurable in terms of use of time...ehm... and cause they're carrying such heavy caseloads, if you take time to go and do something like that then you know the work has to be picked up somehow. So, I think it's you know that prioritisation in the NHS, of immediate needs are unfortunately that is seen as - well not unfortunately, it's what it is."

Needs to be individualised/not a one-size fits all model/approach. Implementing it in rigid or 'standardised' might backfire. Requires nuanced thinking and consideration (unintentional trauma un-informed care; iatrogenic harm; not perfect, will not always get it right)

Participant 1 (Sarah): *"ehm, but in other services I can imagine that's going to feel really really tricky in lots of ways and actually just sometimes and I wonder if that will impact the buy- in as well...s like, if you're following your kind-of like your company or your workplace's standard trauma-informed protocol...and then every now and then it backfired, you're like, 'well this is rubbish, like.'*

"like, if you're following your kind-of like your company or your workplace's standard trauma-informed protocol...and then every now and then ibackfired, you're like, 'well this is rubbish, like....

yeah... and like for example.... a really interesting thing is that like so people who have really abusive backgrounds for example where, and who have never experienced compassion or have only experienced compassion by like the perpetrators of their trauma and abuse... then compassion can be really threatening. So, you're being a compassionate person and they're going "fuck off, you're about to rape me. I'm not touching you like...why are you doing this?"...our response is to be more compassionate.It was brought up in recent webinar by Dr Chris irons around compassion focused therapy, and he described it really beautifully and it is, and I think you know in the therapy room one-on-one, we can navigate that with this skills we've got and our experience... ...but the receptionist or the kind-of someone else who's kind of just being told to be caring, compassionate and kind-of trauma-informed..."

Participant 3 (Anita): *"So, just depending on the style and the way I like to work, that could be trauma un-informed for that person. And, yeah that kind of collaborative nature...it's difficult and because of - with complex trauma symptoms if you like, it's hard for them, an individual whose had these experiences, to even get into... buy into a notion of collaborativeness...and ehhh, even that in itself could take a lot of work. Or (they might) want you to take lead and to be the expert and to fix and to direct how they.... And that – all that is difficult to...so it's quite hard to achieve - sometimes trauma-informed principles, it could be a very long process in itself for that*

person to even hear or respond; hear your compassion, your understanding, your ideal; or wanting to give them aspects of control or choice ...ehm to even see that as is difficult thing. It's like really multi-layered isn't it. It's like there's so much that runs through everything actually."

Participant 5 (Samantha): ""...I think it's a tricky one though because reflective practise isn't for everyone and I think we can sort of say we can say to people 'oh reflective practise... you know ...you need to go and reflect on how difficult this work is'... but I think we have to acknowledge that not everybody wants to do that in that way with work colleagues. Yeah, I think sort of respecting peoples sort of boundaries and defences. You know, to do this sort of work requires a certain resilience and if someone's coping with this work in some way by vaguely detaching from how difficult the work is...if we then encourage them to sit in a room and reflect on how difficult the work is, that's not going to be for everyone.... coz some people will say this is actually...this is freaking me out.... being encouraged to reflect on this. So, as a psychologist, we see the value in it but I don't think every, ehm, you know, someone who's quite medically focused won't necessarily have that same ehm desire to do that."

Pressure:

Okay, and then I suppose what I was saying earlier, there is a bit about, it can influence you in terms of, well with the....I know we should be doing it this way but this kind of process is saying otherwise, and I suppose it creates...it adds to that pressure. I think there is a bit of...I think because you could ALWAYS be more TI, eh, so there's this idea of, like....adds to that, is this good enough? Or, in the way it can make you think about things more and pay more attention to the kind-of subtle interactions. It could also go the other way – you know, in being kind of hypercritical of yourself, and that's not TI...because you're a human being yourself. Like, we can't be perfect. And not that we're looking for that but sometimes you can feel like that.

(Anita)

Okay, and then I suppose what I was saying earlier, there is a bit about, it can influence you in terms of, well with the....I know we should be doing it this way but this kind of process is saying otherwise, and I suppose it creates...it adds to that pressure. I think there is a bit of...I think because you could ALWAYS be more TI, eh, so there's this idea of, like....adds to that, is this good enough? Or, in the way it can make you think about things more and pay more attention to the kind-of subtle interactions. It could also go the other way – you know, in being kind of hypercritical of yourself, and that's not TI...because you're a human being yourself. Like, we can't be perfect. And not that we're looking for that but sometimes you can feel like that

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1b. Trying to implement trauma-informed care in a service with contradictory policies/Trying to be trauma-informed in a system that is not.

Navigating contradictions within the system. The challenges of trying to be trauma-informed in a system that is internally at-odds with this in terms of policies, practices, and cultures.

Participant 1 (Sarah): *"ehm, like I guess lots of the key...so if we're thinking of like the kind of relationship dynamics that often play out in in trauma or interpersonal trauma there's usually something around control, power that might be something like criticism or kind of humiliation could be in there but yeah I think I lack of power and control is often a key bit there – and actually when you're being detained, when you're being kind of dictated to by strict ward policy when you have to behave in a certain way that can be really difficult and can be really triggering for for people..."*

"I do think in terms of like kind of TI. ..just thinking of like the kind of interactions with complex trauma patients I think power probably can often be something that does come up for people...beause when you are being traumatised you usually pretty powerless....yeah, but we've got kind of hard lined rules about access to services - sometimes that's an important boundary but I guess I'm thinking about say if you are in distress trying to seek help through a service and that service is being...is kind of saying 'no I'm not kind of offering you any kind of support that you feel you need' or being quite kind of not recognising the power that they hold that might put you back in that victimised place...ehm...of kind of being powerless."

Participant 2 (Jean):

"I think working also within your sphere of competence and confidence. So, while being assigned a Matrix 3 presentation, that is based on a one hour assessment apt that maybe had been done months previous to you seeing them for the first time. And then, once you start to scratch the surface, then you're like...mmm, this person is not 'matrix 3' and then it can be quite difficult you know, once you're building up that relationship, you've got to formulation, to say, this person is not appropriate for me at this current point; they should be seeing more of a matrix 4 presentation. So, there is that. I think it has improved. I think we have looked at the criteria for different matrix levels, you know, at assessment. I suppose it's just the nature of people; sometimes people do not share everything with the person at assessment; sometimes there's not enough time, but also they want to build up a trusting relationship before you have that conversation of that...'I haven't told this to anyone before...'. So, we need to think about, am I the best person to see you or do we then need to take this case and refer it upwards.... G: And it's interesting that even, thinking...is that the most trauma-informed way of doing things...you know, you've developed this rapport, trust, and because of our systems in place, they may go up another level..

Participant 3 (Anita): *"Put that trauma-informed thing into action if you like. Whereas, all that but we have to be informed by a not very trauma-informed system and make it trauma-informed – but at the ground level, and it's like...yeah."*

W just think that it's obviously coming from a set of...a certain set of money, we've got a certain set of things that we need to do, and there's pressures to meet that from above, which is fair enough but yeah at a practitioner level, when you're dealing with the human being and we're the ones that goes it we've got to like ...Put that trauma-informed thing into action if you like. Whereas, all that but we have to be informed by a not very trauma-informed system and make it trauma-informed – but at the ground level, and it's like...yeah...

Ach, it's frustrating and think it can obviously get in the way a wee bit of what we're actually trying to do so it does make it feel a bit counter intuitive at times... but it is a pressure....and it doesn't add up and it makes you a bit annoyed actually because you're a bit like "euuuughhh" – frustrated that this is the scenario we're in and there's big things about: 'oh, you have to be TI'...but it's like....ohhhh....It has to be – one thing about trauma-informed is that it has to be running throughout consistently/consistency and not mixed messages and a safe, secure unit, or there's this kind of, with these attachments, we're trying to re-create healthy attachments with people and that includes the system, like a family system....and like that but like any family system there's flaws and ehm...I suppose in another sense it's just another challenge... like we can't make somebody have the perfect scenario either, so there is that too yeah"

"I think there is a lot of contradiction....ehm.... in terms of the NHS as a system.....I often feel that the processes are quite punitive when actually.... yeah we're saying that we need to not cause harm, or re-triggering or re-traumatising. However, a lot of the processes that are embedded in a system such as the NHS, is actually – doesn't take attachment issues into consideration. It doesn't seem – well, informed by attachment and complex trauma theory if you like. However, a lot of the ways that it is rolled out kinda seems to contradict a lot of the kinda theory or knowledge that we have about complex trauma..Ehm....so that might look like, I don't know, I mean a certain number of sessions which can be a good thing in some respects....but also there's maybe kind of DNA policies or things like that that kind of it must feel quite punitive for patients, clients."

"Ehm like their almost – whereas, att – relationship issues is the crux of the issue, so we're like, in terms of from therapy perspective, forming a relationship, and obviously all the issues of trust and harm come up...and, you know, particularly in an addiction context, avoidance is a huge issue there so it's very hard to navigate or like deal with that....where you're trying to be trauma-informed so you know you're tryna take these issues into consideration when making decisions about the care yet our processes are kind of dictating that well - we have to, if you if you missed three sessions then technically that should be the end of therapy and then so you're dealing with a real human being and yet you also holding the fact that this is a massive organisation and we can't see everybody and....there's this huge waiting lists, and so there's that kind of side of it too.So, I think my initial reflection is about it being an incredibly complex and like almost impossible to get it right, like....and again that I suppose we're not looking for perfection of course but as a practitioner, it's hard to hold all those tensions."

"Yeah, just...or maybe just like discussions or just like about a space for practitioners to be able to...to...yeah to speak to people about how this fits with that or ehm, and yeah, I mean obviously, in terms of TI, there's this idea about flexibility as a focus or like adapting to the needs of people and I think we do do that but I think it is hard on practitioners because they're the ones that are kind-of having to deal with all the conflicting pressures. Like, whose needs are we meeting here? The NHS? Government figures? Are we meeting patient in it."

Participant 4 (isabelle):

"In terms of becoming more trauma informed I think it's difficult taking on board and probably from a policy level that there will be manager having to set the tone in terms of policies making allowances for keeping people on the caseload for longer even if they are not engaging well, making allowances by contacting people outside of appointment to check in making allowances for that to happen so staff are able to do that."

Participant 5 (Samantha):

"So although there are MAT standards around being trauma informed, there are also MAT standards about people having access to same day prescriptions, which means that the nurses are increasingly under pressure and busier – so, I guess I'm mindful of the trauma informed aspects of work perhaps needed - we need to keep an eye on that as well"

"Ehm.....(pause), I guess that idea that a person's treatment focus is the prescription and getting them onto a prescription ehm, and, I know a lot of the nurses are super busy. So, when their patients come in to see them - the 10 minute slot they have or the 20 minutes slot – it does generally get taken up with discussions around titration, about what prescription of methadone they're on, ehm, and I think at times then that there is generally less time for them to discuss the other things so a patient might start to disclose something that's happened to them or feel that they are in crisis and I think nurses genuinely feel that they're torn between obviously trying to contain that and help that person sort of regulate their emotion a bit... but also having to discuss things like a drug swab or what's happening with their prescription so ...ehm...I think that makes it really difficult for the nurses and it's a challenge, and it's a really challenging role for them."

"Also, endings, I think can be really challenging so with our work, it can take time to build up the rapport with people working with and then feeling under pressure to move them on or to complete therapy or ...ehm....you know, there's a waiting list, there's HEAT targets, and I think when people have complex trauma it's not just a case of: 'Oh, you can offer 6 sessions of therapy, 12 sessions, whatever'."

Participant 6 (Vicky):

"I mean again as the service we would deliver them kind of level 1, 2...I think I... if I'm right and I obviously didn't deliver it. The sort of early level training that NES provide, the framework for - we deliver that as a team to kind-of patient-facing staff but more that lower level need so you know reception staff ehm admin staff, that kind of thing. B I'm aware that's not happened for some time and again I think that's resourcing, I think that's you know, we're under such pressures for throughput, to reduce waiting lists, which is really important but it leaves less time...ehm for these things."

"So, I think clinical superv - I think supervision opportunities are really important in terms of that and again, you know, it speaks to some of the difficulties, I think as a discipline we are very aware of the necessity and the ethical nature of practising supervision. I guess that doesn't exist necessarily in other disciplines and I suppose that again is something that we can kind-of bring but again something that maybe... may be a challenge when there's kind of staff – staffing pressures, time pressures, and it maybe it's not felt to be a priority."

"And....ehm...from the role of psychology, there's an element of kind of almost like push through that just from the level of time you kind of spend doing it and stuff... "

Participant 7 (John):

I think if you have a - if you have a line manager, a supervisor whose very aware and very focused on trauma I think you're given quite a lot of encouragement to go down that route with a patient. I think sometimes there's a bit of a ceiling so, you might have people beneath a certain level within the structure of an organisation who are very trauma aware and to engage in trauma informed practice, and then take training but that might not then travel up through the pyramid of management structures, who may not be as aware of trauma practice or even trauma presentations, and that's very difficult if that management structure is setting the strategic direction of your team or your goals

I mean, sadly, we know don't we. Well we only, well I mean sometimes I suppose patients will tell you but I, you know, I I think you just, you just anecdotally you you see it, you know, as well as being NHS staff, we also use the NHS ourselves and we have our own experiences of going, thinking 'bloody hell', like, am I talking a foreign language here because it's like...or why am I getting so rushed to finish my presentation, or else, did you not read my notes before I came to this appointment?

I think I think I think where the the biggest change....whether it's a good model or not I don't know but the model that we operate to is that the people that are at the very very frontline of community contact with the general population are still GPs. So everything is still being filtered through GPs. If we - we would literally have to have every GP in Scotland really trauma aware but also very confident at being able to have trauma informed conversations ehm and so if they're seeing patients and they're not they're not seeing patients from that trauma perspective then a lot of opportunities I think get missed. I think people do try in various ways to tell their GP or to try and tell someone, and usually that ends up being the GP about about what's going on inside of them. I think that we're just not there yet. I just don't think we have that model, where I think people think the GPs need to know quite a lot of stuff - and they absolutely do - but I'm not sure anyone realises that on that list of really important stuff for GP should know, I think that trauma should be in the top three of that list. And until it is, I'm not sure that we will ever be ready to receive the members of the public that are trying to get some attention to their distress....

...I used to work in general practise before.....and I remember the GPs there saying they get six months training on mental health - that's everything, like, you know. So, even if you got - even if there was a day on trauma, it's an absolute drop in the ocean and they already are aware that they don't feel confident in dealing with presentations of mental health, no matter what that presentation may be. So, until they are given the knowledge, the skills, the tools, and guidance on how do you deal when a patient comes in and it's actually kinda trauma that's driving their symptoms, whether there physical or psychological symptoms.

Trauma doesn't fit neatly into diagnostic criteria/Matrix/Inconsistencies between TIC and the medical model.

TIC sees people in the context of their life experiences, early relationships, and trauma. The medical model views people in terms of their diagnosis and treatment plan.

Participant 7 (John): *“over the course of my career I've worked in places where it would it (trauma) wouldn't really be given any attention, their focus would be purely on an I suppose symptoms, you know depression, anxiety. No no, you know, sometimes I've seen someone in practice and be thinking they have depression, they do meet the criteria, but they also meet the criteria for general anxiety disorder, panic disorder, and OCD. Like, they have everything, and they're self-harming. And, you know, so if someone hasn't placed in that into a trauma context, it just looks like a very, very complex set of symptoms. When you place it in a trauma context, you're able to go well it's actually not - that's exactly how we would have we would expect this person to be feeling and behaving given the trauma history they've come in to this stage of their lives with. Ehm but if you work in a team they just want you to focus on depression or anxiety, you know, almost like as if you could just have people in in these silos and trauma patients just don't fit into silos. They crossover so many silos.”*

Invalidating/re-traumatising experiences /trauma un-informed care

Participant 7 (John):

“Well I think, I think it works, I think often works on quite a simple level, you know, if someone has been abused in their early life yeah they've tried to express that, they've tried to, try to get someone's attention towards that, and no one's listened, and no one's tuned into them, no one's, no one's picked up the signals that they've been trying to give, and then as an adult you come into service land and service land isn't really listening to you, it isn't really validating you, it isn't picking up your signal's....how could it be anything other than re traumatizing? You are literally confirming that patients worst fear -that I can't be heard, I can't be seen, I can't be understood, and the pain that I'm in – no one wants to know about it, no one wants to help me take that pain away. I mean, if you've been getting that message since you were 5 years old and you're still getting it at 65 year old from service land, then there's a fair chance you ain't gonna have a lot of hope the anythings ever going to get better for you.”

TIC needs to be matched with policy at government level.

...tend to focus on the traumatised survivors that are coming in the door and the trauma informed practitioners that are trying to do some kind of therapeutic intervention with them, and then – because your whole attention just gets sucked into that it is sometimes difficult to lift your head up and look slightly further afield. And, when I look further afield I just all I see is the numbers increasing. Like, I just I see this - what I see is an epidemic, Grace, of trauma. I see – I just see that so much of our society is harmed by it. And, I think it's some stage would love to see would be the government, the policy makers actually making this their central policy. I mean we can talk about a team of psychologists making it their central focus or a therapist or even a team of G.Ps. But at the end of the day, I would far rather that actually these conversations were actually not happening in health centres at all. I wish they were happening in meeting rooms at Holyrood or Westminster. I still find it staggering that with all the work that is being done at the cold face that there is still such a lack of policy... because, you know, as much as we will be imaginative and compassionate to try and help a survivor as best we can to try and, you know, that trauma is – it's in your very bones. You know, it gets right into – well, we know its in your DNA, because it gets passed down intergenerationally. You know, so realistically, what impact – how big an impact can we have, if there's not someone at a policy level that actually says, at the end of the day, the best way to treat trauma, the very best way is actually not to cause it in the first place.”

1c. How can we be trauma-informed to others if we are not to ourselves and each other?

Internal conflict and disharmony within the system. Staff wellbeing, MDT cohesiveness, and morale not given enough attention.

Participant 1 (Sarah): “within the NHS, places where it’s more difficult are the places where the like the relationships maybe are more strained, that staff are feeling more at risk and kind-of more threatened...and, yeah, I have seen a bit of resistance to that... but its resistance to... ‘we don’t have the capacity to change’ like we don’t have the capacity to make any kind of changes, regardless if it’s trauma-informed or if it’s behavioural support or if it’s something else...like we’re in the here and now. And yeah, you can argue that actually like things might be easier if we can make this change but if they’re not feeling resourced so yeah i’ve seen a bit of resistance in that sense.”

“And, I guess it comes back to what we were saying about earlier.... is if we are not being trauma informed to the staff, how are the staff meant to be TI, like I guess that kind-of... it almost brings us back to that doesn’t it, if we’re not looking after our own/each other, then how can we look after others??”

“...and if you have a compassionate and open minded and positive culture within your team, or profession or ward then the care of patients tends to be more trauma-informed and just generally better.”

“but thinking of complex trauma on the wards again what you oftentimes in mdt and psychiatry are usually the head of that because that’s everyone assumes psychiatry ahead of it. I don’t know if they’re actually officially the head of it but they are. Interestingly, in this very un-trauma-informed ward I was talking about, ehm, the psychiatrist who led the team was very trauma-informed and very compassionate and he would, when a decision was being made, he would ask everyone on mdt (like, cause you’d have the MDT meetings and that’s where decisions were made)... he’d ask everyone ‘what do you guys think? Do you agree with the plan? I think this. What do you think?’ and that was really really lovely...and that was the best MDT team in that environment. It was brilliant.... whereas the other ones ...and the other thing he did cause it’s three hour meeting another thing he did was have a 5 minute break and that was gorgeous...and every every ...all the other MDTs were jealous of our MDT because we got five minute break...and, you know, we still finished on time... but that’s a really good example, people enjoyed that meeting, people enjoyed being part of that team, and people enjoyed working with that psychiatrist. They felt safe to be reflective and more thoughtful about patients. The other psychiatrists were maybe less so it was maybe more of that kind of traditional medical model approach or a bit more kind of like: ‘this is what I’m going to do - does anyone have objections’ rather than ‘does anyone have a thought?’. I don’t want to sound negative about psychiatry but it’s that kind of yeah they tend to be the kind of allocated leaders. (some laughter and cynicism in tone of voice).”

Participant 2 (Jean): *“There sometimes from my clinical perspective, as a professional that you’re not necessarily valued and on that same level that there seems to be the stance that ‘I am the psychiatrist, so this is how its going to be’ or if you are thinking this person has more complex PTSD rather than just PTSD it’s that I experience this a couple of years ago, there is no indication that they do have that, well actually this, this, this and this, is the reason.....ehm, based on what they’re presenting and the information that has been gleaned from weeks and weeks and weeks of spending time with this person compared to periodic appointments....You know, I have built*

up a relationship with this person; I have insights into their life and what they're struggling with, you know. I have undertaken outcome measures that keep on highlighting complex PTSD is a factor here...

So that can be quite difficult when maybe you're professional courtesy is not given. And my sense was that you should have professional courtesy for whatever professional – within the NHS, social work, whatever; that – that is my values, that is my professional values."

"It's probably historical....that, the kind-of tension that I've witnessed across my career between psychology and psychiatry. That it's probably – one is probably equally as dismissive of the other. Ideally what we'd need is open lines of communication to be able to sit and not just listen but properly hear and maybe re-evaluate, re-think – well, is this the best way of working for our patients? Because that's what we're there for. So, what else can help? Can – are you allowed to get out of your professional bubble? And to consider other ways of working eh, you know, that – I think it becomes entrenched in all our behaviour; well this is how we've always done it. But you know, no change is ever gonna come from that viewpoint; that mindset is very fixed."

Participant 4 (Isabelle): "Yes, I remember that a very common issue at MDT meetings in psychiatric rehab that psychology would want to involve the patient, and the psychiatrist would say that the patient is not ready and it would be de-stabilising. So very often there was a conflict there, we felt that the person was ready and would benefit from input and the psychiatrist would say 'you don't understand, it wouldn't be good for them'....Definitely the psychiatrist would have final say, always."

"Definitely, I would say so, kind of almost like medical care has to take priority, and you can understand why if a person is genuinely so unwell that their health is at risk, absolutely it makes sense why this medical model must take the priority, but I don't think it means that the person cannot benefit from any psychological input, if it is an assessment of the clinician if they would, I think if they would we have to trust that judgement and I think if the person was genuinely not ready the psychologist would pick up on that in the assessment.... Yea, it's an interesting point I cannot say that I feel that my views been heard much in the past, you know as you go on through the adult mental health career, you do see things, notice things, you have your own reflections, I cannot say that I ever had an experience that I would voice some of it out and it was taken on board and something changes, not really... Um, yea however I do feel much more involved within my current team. It is a much better balance, and I do feel there is a space for voicing your opinions, and I do think that they will be taking these on board."

Participant 5 (Samantha): *"Yeah, I mean I think on the medical model definitely is open to issues around that I think. Less so the current team psychiatrists, but previous psychiatrists that have been in our team, at times I think I have felt uncomfortable with perhaps decision making around eh medication or access to appointments ...ehm yeah, I don't... yeah ...So I think I have seen it in a way that has felt quite eh uncomfortable at times. So, decisions that are made about people's treatment, you know 'discharge', for example, you know the idea that somebody is struggling to attend and perhaps not a lot thought gone into why they're struggling to attend. Just taking it as well, they're not attending so we'll just discharge them."*

"Eh, you know, I mean my feelings it's just more to do with sort of characters who are in that leadership role so the team psychiatrist is lead on the medical sort of model within our Hub, so there have been various psychiatrists over the years and the psychiatrist we have now, obviously you know, you know she's an I think she is more open

to giving people...ehm... giving people another chance, you know, not being reactive within that yeah. Whereas I think there's been times when psychiatry hasn't always been quite as reflective or interested in compassion, I suppose. Sometimes it's not, you know, a bit burnout."

"Yeah, just quite, you could interpret it or I felt were sort of punitive responses to people you know, you know, reduce them off the prescription, discharge them, they can go back to the waiting... back to the bottom of the waiting list. That's not acceptable behaviour. You know, these sort of ...so I think, the boundaries, we do need boundaries and we do need to obviously communicate our boundaries to patients yeah but at times I think people can veer towards becoming punitive perhaps as a way of managing the complexity of people, or ehm..."

Participant 6 (Vicky):*I think it is held in mind and I think that's about individual kind of approaches and it's but it's also about the culture in teams...and I think that tends to be traditionally hierarchical and laid by psychiatry so if your psychiatrist is psychologically minded then life ...those conversations are way easier than if you're fighting ehhehm a purely kinda medicalised view of the presentation of distress or difficulties.*

"I have one colleague; psychiatry colleague, who always, ehm....ehm...is not as warm to psychological perspectives, shall we say, and eh, you know, I...and...the other day in a meeting about ADHD, did actually say the word trauma and I felt that was like a real win! (laughing). You know, the idea that trauma could present in a similar way...I felt like I'd kinda been beating that drum for a couple years in their company and suddenly I felt a little (moment) – ahhhh...(I felt).

"I think it's just their training backgrounds. I just... I mean...and I don't know coz I've never asked the people who tend or the person who tends not to be so psychologically minded why they're not (laughing) yeah it's kind of a hard ...hard, tricky topic to approach. Yeah, I think... I think it must just be background, training....ehm, maybe experiences of working alongside other disciplines, or not, over the years and that shaping... forming a bit of an opinion.'

Appendix Q

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