A Systematic Review of Burnout in Trainee Mental Health Professionals and a Qualitative Exploration of Clinical Psychologists' Use of the Power Threat Meaning Framework

Thesis submitted in partial fulfilment of the requirement for the degree

of:

Doctorate of Clinical Psychology (DClinPsy)

South Wales Doctoral Programme in Clinical Psychology

Cardiff University

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23rd May 2022

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Acknowledgments

I would like to thank the clinicians who generously gave their time to participating in this research, without whom this thesis would not have been possible. I really enjoyed listening to your thoughtful and honest perspectives, and hope this research has done justice to your insights.

I would also like to thank my supervisors, Dr Chris Hobson and Dr Heledd Lewis, for your unwavering support and belief in me throughout this process. Thank you for sharing your expertise whilst encouraging me to seek out my own answers, and enabling me to grow and develop as a researcher. I would also like to thank Dr Lucy Johnstone, whose early input into this project was both invaluable and inspiring. I wish to thank the service user consultant who provided input into the design of the project for their thoughtful contributions.

I would like to thank my placement supervisors, for supporting me to balance the competing demands of training, and for showing me many examples of the kind of clinician I aspire to be. I have also benefitted from the support, inspiration, and friendship of my fellow trainees and would like to thank the 2019 South Wales DClinPsy cohort.

Thank you to my family and partner, Joe, for supporting me on this journey and keeping me in touch with life outside of clinical psychology. I could not have completed this thesis without your encouragement, understanding, and humour along the way, and I am hugely grateful.

Preface

This thesis consists of a systematic review and an empirical study which consider the experiences of those working in mental health services in order to address important topics relevant to the clinical psychology profession. Part one is a systematic review of the literature on factors associated with burnout in mental health professionals during their clinical training. Although academic interest in burnout has been growing within the last two decades, the literature regarding burnout during clinical training has yet to be rigorously investigated. The physical and mental health related consequences of burnout, along with associated clinical and financial implications are well documented, warranting further exploration of the individual and organisational correlates of burnout.

Seventeen studies were included in the literature review, which included participants training in professions including clinical and counselling psychology, counselling and psychotherapy, and psychiatry. The literature was of moderate-high quality and consisted of cross-sectional research designs.

Findings were explored within a framework of individual and situational variables associated with burnout. The more prominent factors explored in the literature included social support within personal and professional relationships, age, and psychological factors such as self-compassion and mindfulness. Findings were critically discussed and implications for further research and clinical practice explored.

Part two is an empirical study adopting qualitative methods. This study aimed to explore the experiences of clinical psychologists who had used the Power Threat Meaning Framework (PTMF) in their work. The PTMF presents a lens for understanding many forms of distress as an

understandable survival response to a range of adverse life experiences, shaped by the operation of power, at both the interpersonal and societal level.

The PTMF has gained traction as a model of formulation, and within the training of psychologists and other professionals; however, there has been a lack of research underpinning its use in mental health services. This study aimed to explore the experiences of clinical psychologists who have applied the PTMF to clinical practice within an adult mental health context, with a specific focus on the potential opportunities and impacts of using the framework, and associated challenges.

Eleven clinical psychologists participated in semi-structured interviews, and transcripts were analysed using Thematic Analysis. Analysis generated four themes which were critically discussed and situated within an empirical and theoretical landscape. Findings indicated that whilst the PTMF has offered a valued alternative to the 'medical model' of distress, there are ongoing challenges in negotiating its use within the current context of mental health services. Recommendations for clinical practice included an emphasis on multi-disciplinary and collaborative approaches to care.

The findings highlighted the potential utility of the PTMF as an approach to formulation, whilst also drawing awareness to avenues for further research to explore the possible impacts of applying the PTMF within mental health services. This thesis may therefore be of interest to multi-disciplinary clinicians, professional bodies, and researchers.

Part 1: Systematic Literature Review

Factors Associated with Burnout in Mental Health Professionals During Clinical Training: A Systematic Review

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Word count: 7398 (Main text)

207 (Abstract)

Prepared in accordance with author guidelines for the Journal of Mental Health Training, Education and Practice (Appendix A.) For the purposes of this submission, the DClinPsy 8000-word limit has been used to ensure all relevant information has been included for the examiner.

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Abstract

Purpose: The phenomenon of burnout has received growing interest in the helping professions; however, less attention has been paid to the specific job demands, resources, and protective factors that are relevant to burnout in trainee mental health professionals. This study aimed to systematically review the published literature regarding the presence of burnout and associated factors in mental health professionals in training.

Methodology: The current review was conducted in accordance with PRISMA guidelines. PsycInfo, Medline, CINAHL, SCOPUS, and Web of Science were searched for original research pertaining to burnout in trainee mental health professionals and associated individual and situational risk factors. Papers were screened for risk of bias.

Findings*:* Seventeen studies were included in the review. Participants included trainee psychologists, psychiatrists, social workers and counsellors. Findings indicated that trainee mental health professionals are at risk of experiencing burnout and individual and situation risk factors for burnout were identified. These include younger age, high workloads, and lack of supervision, whilst psychological and situational resources, including social support, were thought to reduce risk of burnout.

Originality: This study provided a unique insight into the demographic, psychological, and situational factors associated with burnout during clinical training. Implications for clinical practice and further research are discussed.

Keywords: Burnout, clinical training, systematic review

Introduction

Background

There is a growing research and policy interest in understanding workforce burnout and resilience within healthcare (Health and Social Care Committee, 2021; The King's Fund, 2021). The construct of burnout has been central to understanding work-related distress within the 'human services' since it was first introduced to the literature in 1974 (Freudenberger,1974). Although discussions around workforce wellbeing within the mental health sector may be increasing (e.g. American Psychological Association, 2018), ambiguity remains around the individual and organisational correlates of burnout during clinical mental health training.

Burnout

Maslach and Jackson (1981) define burnout as a psychological syndrome distinguished by physical depletion, detachment and cynicism, and negative attitudes towards work, life, and others. The Maslach Burnout Inventory (MBI; Maslach *et al.,* 1997) has been widely cited as a favoured approach to measuring burnout (Lee and Ashforth, 1990; Morse *et al.,* 2012). The MBI measures burnout across three dimensions: emotional exhaustion, depersonalisation, and personal accomplishment.

Emotional exhaustion is considered a state of emotional and physical depletion, characterised by a sense of feeling overextended, frustrated, and depleted by one's work (Maslach and Jackson, 1981). Depersonalisation is conceptualised as an impersonal and detached response to the recipients of care. The personal accomplishment domain reflects the reduction in sense of accomplishment and negative view of oneself and one's professional abilities (Maslach, 2003). Criticisms of the MBI have centred on its factor structure, in that the uni-directional

wording of the domains may cause an artificial clustering of the depersonalisation and emotional exhaustion factors which are both worded negatively (Bouman *et al*., 2002), and the concern that its domains do not map onto targets for intervention (Schaufeli and Taris, 2005). The MBI has also been adapted for student populations, whereby burnout is conceptualised within the domains of exhaustion from study demands, a cynical attitude towards study, and feelings of incompetence as a student (Schaufeli *et al*., 2002).

Other definitions of burnout have been suggested, including Bakker and Demerouti's (2007) conceptualisation of burnout through two core dimensions: Exhaustion, which can include affective, physical, and cognitive elements; and disengagement from work. Alternatively, Kristensen *et al*., (2005) proposed that only fatigue and exhaustion are the core domains of burnout, and that depersonalisation is better understood as a coping strategy. This definition also conceptualises personal accomplishment as a consequence of burnout rather than part of the construct itself (Kristensen *et al*., 2005).

Engagement has been conceptualised as the positive antithesis of burnout, characterised by high energy, involvement, and efficacy at work (Maslach and Leiter, 1999), whereas other researchers have defined engagement as a unique concept in its own right, characterised by vigour, absorption, and dedication at work (Bakker and Schaufeli, 2014).

Bakker and Demerouti's (2007) job demand-resource model can explain both burnout and engagement as a result of the interaction between the job demands, such as physical or psychological exertion, and job resources, such as opportunities for personal growth, supervision and feedback. High demands coupled with low resources are likely to produce burnout, disengagement, and high staff turnover (Bakker *et al*., 2003; Hu *et al*., 2011). Similarly, the

conservation of resources model (Hobfoll, 1989) suggests that unresolved chronic stress can result in burnout, yet personal or occupational resources can buffer this effect.

Burnout can be distinguished from other relevant work-related negative emotional and cognitive experiences, including compassion fatigue, defined as the reduced capacity for experiencing the distress of others (Adams *et al*., 2006), and vicarious trauma, the negative transformative process experienced by health professionals exposed to indirect trauma (McCan and Pearlman, 1990). Meadors *et al*., (2010) demonstrated that these can be considered correlated but ultimately distinct constructs which make a unique contribution to our understanding of the experiences of healthcare professionals.

Impact of burnout

Studies of healthcare professionals have shown that high levels of burnout are associated with increased levels of depression (Mutkins *et al*., 2011), anxiety (Zhou *et al*., 2016), suicidal ideation (IsHak *et al*., 2013), and substance use (Shanafelt *et al*., 2002), as well as reduced immune functioning (Nakamura *et al*., 1999) and a range of physical health difficulties (Salvagioni *et al*., 2017). At the organisational level, burnout is associated with reduced job satisfaction, absenteeism, and intention to quit (Kristensen *et al*., 2005).

The experience of burnout is inherently linked to a lack of engagement, purpose and hope (Maslach, 2003), which has implications for patient care. High levels of burnout have been shown to correlate with self-reported quality of care in hospital nurses (Van Bogaert *et al*., 2010) and physicians (Williams *et al*., 2007), as well as with poorer patient reported satisfaction with care (Panagioti *et al*., 2018). In therapeutic settings, staff experiencing burnout are at risk of experiencing lower levels of therapeutic optimism (Happell and Koehn, 2011) and poorer

therapeutic relationships (Zarzycka *et al*., 2021) which in turn is likely to fuel negative spirals of interactions with service users.

Mental health professionals

Mental health professionals have been identified to be at high risk of burnout (Morse *et al*., 2012; O'Connor *et al*., 2018). Staff working in mental health settings are likely to be both directly and indirectly exposed to highly emotive and traumatic information, which increases the likelihood of experiencing secondary traumatic stress (Newell and MacNeil, 2010) compassion fatigue (Newell and McNeil, 2010), and burnout (Cieslak *et al*., 2014). Clients with severe and enduring mental health difficulties may be perceived as difficult to treat, a perception which decreases staff sense of efficacy and may increase their susceptibility to burnout (Savicki and Cooley, 1987). Furthermore, the emotional intensity of their work is set against a backdrop of chronic funding and resource challenges, which have been found to contribute to the stress burden of community mental health nurses (Edwards *et al*., 2000).

Mental health professionals in training

Training as a mental health professional such as a psychologist, counsellor, or psychiatrist typically requires intensive academic study coupled with clinical placements. In addition to the pressures described above, trainees in the mental health professions must balance various roles including student, therapist, researcher, and supervisee (Schwartz-Mette, 2009). Indeed, early career mental health professionals have been found to report moderate to high levels of burnout, suggesting that further investigation into burnout at the beginning of a professionals' career is warranted (Volpe *et al*., 2014).

Previous research has identified various predictors of burnout within healthcare student populations, including anxieties regarding academic performance, expectations from staff, and pressure of full-time study (Tomaschewski-Barlem *et al*., 2014). The implications of experiencing burnout at this stage may include entering the profession already burnt out (Volpe *et al*., 2014), or dropping out of training altogether (Costa *et al*., 2012), with associated economic consequences.

The majority of clinical psychology trainees reported experiencing psychological distress during training (Cushway, 1992), and more recently, 70% of psychology graduate students reported stressors that impacted their ability to function to their highest potential, including academic responsibilities, finances, and poor work life balance (El-Ghoroury *et al*., 2012). Furthermore, it has been hypothesised that inexperience and limited coping skills put qualified social workers at risk of burnout, suggesting that trainees are also at higher risk (Acker, 1999).

Previous Reviews

Previous reviews have considered the prevalence and determinants of burnout amongst healthcare professionals (Bria *et al*., 2012), nurses (Khamisa *et al*., 2013; Monsalve-Reyes *et al*., 2018), and physicians (Rotenstein *et al*., 2018), and have explored the relationship between burnout and individual factors including empathy (Wilkinson *et al*., 2017) and emotional regulation skills (Jackson-Koku, and Grime, 2019). Whilst some factors such as workloads and lack of autonomy appear ubiquitous in the burnout literature, studying specific professional groups has allowed for unique insights, such as the finding that exposure to traumatic events is linked to burnout in emergency medicine (Adriaenssens *et al*., 2015).

In accordance with the job-demands resources model, previous reviews have also identified evidence for a moderate effect of organisation directed initiatives including reducing workload, enhancing teamwork, and providing mentorship (De Simone *et al*., 2021), and individual level interventions such as psychosocial and coping skills training (Aryankhesal *et al*., 2019).

Two recent reviews of burnout amongst mental health professionals identified that whilst high workloads were associated with increased levels of burnout, a sense of autonomy and capacity to influence decisions at work was associated with lower burnout (O'Connor *et al*., 2018; Yang and Hays, 2020). Similarly, a recent systematic review of burnout amongst psychologists also identified both high workloads and lack of autonomy as correlates of increased burnout (McCormack *et al,* 2018). A similar review investigated burnout amongst psychotherapists and psychologists (Simionato and Simpson, 2018). The authors identified younger age as a consistent predictor of risk of burnout, and hypothesised that due to less therapeutic experience, younger therapist may have few coping strategies and unrealistic expectations, resulting in hopelessness, disillusionment and burnout (Simionato and Simpson, 2018)

None of these reviews have specifically targeted trainee mental health professionals, and some researchers have explicitly excluded this population due to differing job demands (e.g. Wilkinson *et al*., 2017). Trainee mental health professionals may have smaller clinical caseloads than qualified professionals, however their workload consists of both clinical and academic tasks, conferring unique job demands for this population (El-Ghoroury *et al*., 2012). Furthermore, the resources available to trainees may differ from other staff, given that some training bodies stipulate requirements for levels of clinical supervision (e.g. British

Psychological Society, 2019). According to the job demands-resources model, the interaction between these factors will contribute to the unique experience of burnout in the trainee population (Bakker and Demerouti, 2007).

Rationale and aims

There are clear costs of burnout at the intrapersonal, interpersonal, and organisational level within healthcare. Given the unique job demands of this population, existing theoretical and empirical accounts of burnout might not lead to practical solutions for addressing burnout within the context of mental health clinical training. Although the literature in this area is growing, it has yet to be systematically synthesised. Generating a more rigorous understanding of the correlates of burnout may help to identify trainees at greater risk and may be used to inform preventative interventions and support systems within training programmes.

This review aimed to systematically appraise the empirical evidence regarding the factors associated with burnout in mental health professionals in training and address the following questions:

1. What literature exists in relation to burnout in trainee mental health professionals?
2. What is the methodological standard of the literature in this area?
3. Which individual and situational factors have been associated with burnout in mental health professionals in training?

Methods

The systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidance (Moher *et al*., 2009).

Initial scoping searches were conducted to refine the review question. A search of the Cochrane library and Prospero in April 2021 revealed that no similar reviews were registered as being in the process of being undertaken. The protocol for this systematic review was pre-registered on Prospero on the 13th May 2021 (Reference: CRD42021254432).

Search strategy

An electronic search of PsycINFO, MEDLINE, CINAHL, Scopus and Web of Science databases was conducted. The search was undertaken in May 2021, and re-run in January 2022 to include most up to date literature. Databases were searched from inception until 11th May 2021.

The search strategy included search sets relating to mental health professionals, terms relating to clinical training, and terms relating to burnout. Search terms within sets were combined with the Boolean operator "OR" and search sets were combined with "AND". Full details of the search strategy can be found in Appendix B. No limits were set on publication type or language at this stage to allow for comprehensive searching of articles that may include relevant reference lists.

Forward and backward searches were undertaken at the full text screening stage to identify further studies. For the backward search, reference lists of articles were manually examined for pertinent citations. Forward citation searches were undertaken of the same articles as well as of burnout measure manuals and validation studies.

Eligibility

The inclusion criteria were generated by the researcher through preliminary scoping searches of the literature and verified by supervisors.

The inclusion criteria were:

- Participants are undertaking training comprising academic and clinical elements which qualifies trainees for mental health related practice
- Empirical quantitative study reporting primary data
- Validated measure of burnout
- Measured at least one individual or situational variable in relation to burnout
- Studies of mixed groups where data are separated out
- Full text available in English
- Published in peer reviewed journal

The exclusion criteria were:

- Qualitative study
- Literature review
- Intervention study (unless baseline was available and met other inclusion criteria)
- Unpublished dissertation or thesis.

Studies that did not provide enough detail to ascertain whether they met the inclusion criteria were excluded.

Data extraction

After removing duplicates, titles and abstracts were screened for eligibility using EndNote software. Full text articles were then reviewed for inclusion. Comparable information regarding sample size, measure of burnout, and findings was extracted from included studies.

Quality appraisal

Included studies were assessed for quality using the AXIS tool (Downes *et al*., 2016), which is one of the recommended tools for assessing the quality of cross-sectional studies (Ma *et al*., 2020) and offers the benefits of clear guidance for completion. The tool comprises a 20-item checklist which appraises studies on areas including reliability of survey instruments, risk of non-response bias, and transparency of reporting. A second researcher independently rated 5 of the included papers, and disagreements were resolved through discussion to reach a consensus.

Analysis

Due to the heterogeneity within studies' measures and methods of analysis, a meta-analysis was deemed unsuitable. The findings were therefore narratively synthesised. Consistent with guidance on the process of narrative synthesis, a preliminary synthesis was undertaken in order organise and identify key findings of the included studies; following this, relationships within and between studies were investigated, with a focus on how factors such as methodology, context, and populations studied may account for different findings within the literature (Popay et al., 2006). The methodological quality of studies was critically discussed when comparing the findings of included studies, strengthening the robustness of the synthesis (Popay, 2006).

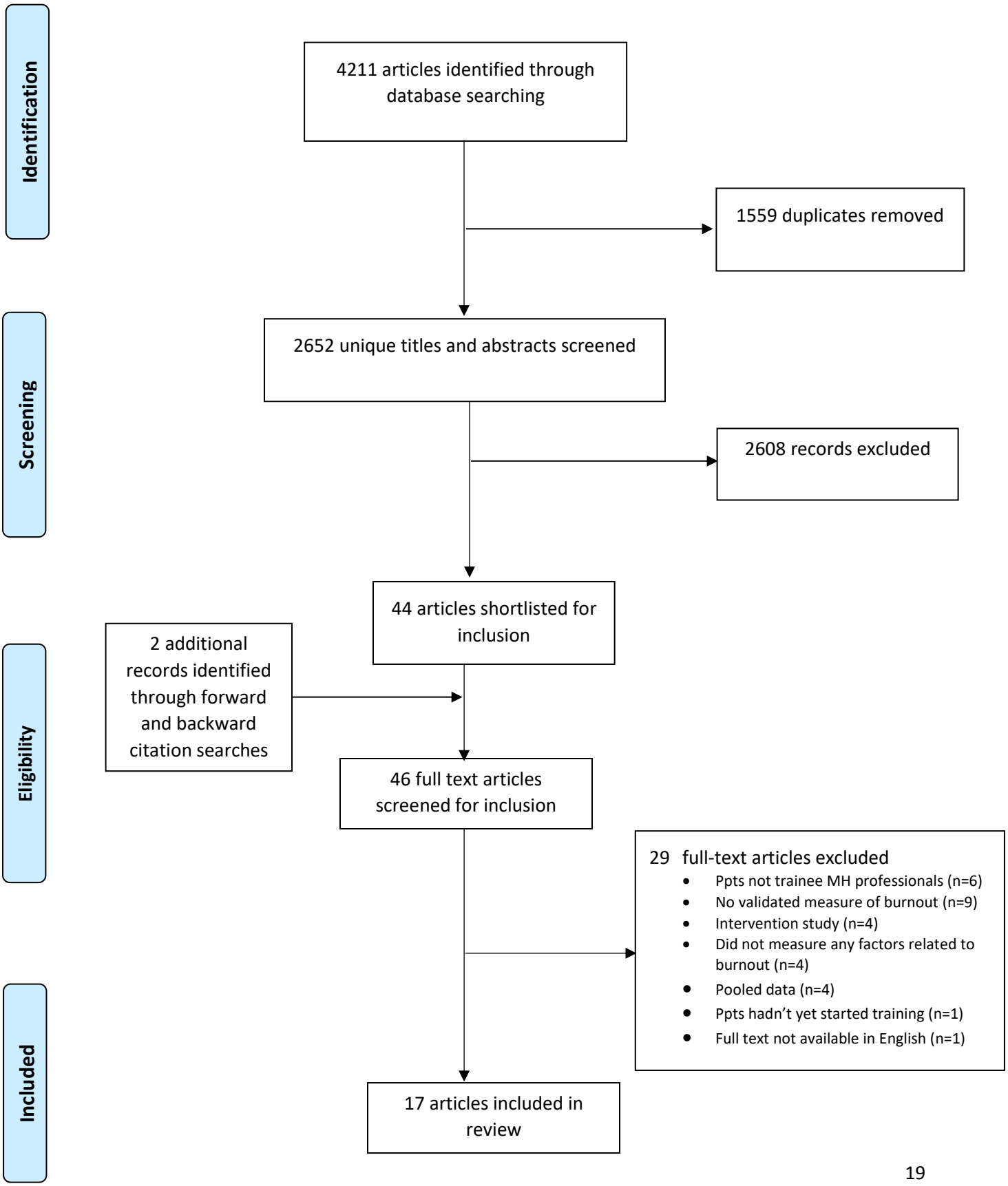
Results

Study selection

The search identified 4211 titles, leaving 2652 unique citations once duplicates were removed. Titles and abstracts were screened against inclusion criteria, leaving 44 full-text articles to be sourced. Forward and backward searches at this stage resulted in two additional records being identified. Forty-six papers were therefore retrieved and reviewed in full against eligibility criteria. Seventeen studies were deemed to meet inclusion criteria and were included in

the review. A PRISMA flowchart detailed the search process from identification to selection of final papers (Figure 1).

Figure 1. PRISMA diagram



Study characteristics

Table I summarises the key characteristics of the included studies. All studies adopted a cross-sectional design utilising self-report measures, and were published between 2001 and 2021. The number of respondents ranged from 28 (Ying, 2008) to 1980 (Jovanović *et al.*, 2016). All studies undertook statistical analysis including correlation and regressions.

Eleven studies took place in North America (Basma *et al*., 2021; Butler *et al*., 2017; Harr and Moore, 2011; Kovach Clark *et al*., 2009; Lee *et al* 2018; Newton *et al*., 2020; Richardson *et al*., 2018; Rico and Bunge, 2021; Swords and Ellis, 2017; Testa and Sangganjanavanich, 2016; Ying, 2008), two in the UK (Beaumont *et al*., 2016; Rose *et al*., 2019), one in South Africa (Le Roux *et al*., 2018), and three in multiple countries (Jovanović *et al*., 2016; Kaeding *et al*., 2017; Lushington and Luscri, 2001). Six studies involved trainee clinical or counselling psychologists (Kaeding *et al*., 2017; Kovach Clark *et al*., 2009; Richardson *et al*., 2018; Rico and Bunge, 2021; Rose *et al*., 2019; Swords and Ellis, 2017), six studies involved counselling or psychotherapy trainees (Basma *et al*., 2021; Beaumont *et al*., 2016; Lee *et al*., 2018; Lushington and Luscri, 2001; Newton *et al*., 2020; Testa and Sangganjanavanich, 2016), four studies involved social work trainees (Butler *et al*., 2017; Harr and Moore, 2011; Le Roux *et al*., 2018; Ying, 2008), and one involved psychiatry trainees (Jovanović *et al*., 2016).

Sixteen studies reported demographic data in relation to gender; in all of these studies the majority of participants were female. Fourteen studies reported their mean age, which ranged from 22.7 years (Le Roux, 2018) to 37.66 (Lushington and Luscri, 2001). Twelve studies reported on the ethnicity of their sample; in ten studies, the majority of participants were white.

Table I. Characteristics of included studies

Number	*Authors, Year, and Country*	*N (response rate)*	*Participants*	*Demographics*	*Study aim*	*Burnout measure*	*Design*	*Analysis*	*Key Findings*	*AXIS quality rating*
1	Basma *et al*., 2021 US	105	Counselling students	Gender: 86.6% female; 13.4% male. Race: Asian (15.2%), African American (29.5%), biracial (9.5%), multiracial (7.6%), other (20.0%), Indian (1.9%), multiple options (12.4%), and no report (3.8%) Most participants (n = 64, 60%) were 18 to 29 years of age.	To assess for wellness factors among counselling graduate students of colour, while also attempting to identify whether discrimination is a predictor variable of wellness, stress, and burnout	MBI	Cross sectional. Self-report online survey.	Regression	Discrimination predicted wellness and burnout among counselling students who identified as black, indigenous, or people of colour. Age and gender were also significant predictors of burnout.	16 – high
2	Beaumont *et al*., 2016 UK	54	Student cognitive behavioural psychotherapists and person-centred counsellors	Not reported	To measure associations between self-compassion, compassion fatigue, wellbeing and burnout in student counsellors and student cognitive behavioural psychotherapists	PROQOL	Cross sectional. Self-report	Correlation	Self-compassion was negatively correlated with burnout and compassion fatigue.	14 – moderate
3	Butler *et al*., 2017 US	95 (47.6%)	Graduate social work trainees	87.7% female. 81.7% non-Hispanic white. Median age between 25 and 29 (range 20-55).	To investigate relationships between trauma exposure, secondary traumatic stress, self-care, and burnout during clinical training	PROQOL	Cross sectional Self-report online survey.	Correlation and regression	Re-traumatization, field stress and decreased self-care effort were significant predictors of burnout. All students reported trauma exposure in their placements and/or coursework.	16 - high

4	Harr and Moore, 2011 US	285	Social work students	Mean age = 32 (SD 9.94, range 21-56). 11% male, 89% female. Race/Ethnicity: 62.4% Caucasian, 25.9% African American, 9.1% Hispanic, 2.6% Other.	To explore the psychological effect of compassion fatigue and compassion satisfaction on social work students in field placements.	PROQOL	Cross sectional. Self-report	Chi Squared and ANOVA	Social work students had higher risk of burnout than instrument average for helping professionals. Number of working hours was the only variable significantly associated with burnout.	15 - moderate
5	Jovanović *et al*., 2016 Multiple	1980 (26%)	Psychiatric trainees	Mean age = 31.9 (SD = 5.3) 59.4% female, 40.6% male.	To assess burnout among psychiatric trainees to explore associations with individual and work-related variables.	MBI-GS	Cross sectional. Self-report online survey	Regression	Risk of high burnout was associated with being younger, without children, and having not opted for psychiatry as a first career choice. After controlling for demographic factors, high burnout remained significantly predicted by long working hours, lack of supervision, and lack of rest.	18 - high

6	Kaeding *et al*., 2017 Multiple including Australia, US, Canada and the UK	1297	Trainee clinical (78.3% clinical) and counselling psychologists	Mean age 28.24 (SD = 6.29, Range = 21 – 64) 82.3% female.	To explore the role of early maladaptive schemas (EMS) in predicting vulnerability to burnout, as well as attendant effects on short-term physical health, in clinical and counselling postgraduate psychology trainees.	MBI EE subscale	Cross sectional. Self-report online survey	T-test	Trainees with high burnout also scored more highly on all early maladaptive schemas, however only the 'unrelenting standards' schema predicted high burnout among trainees. Trainees experiencing high burnout also reported higher physical health symptoms.	15 - moderate
7	Kovach Clark *et al*., 2009. US	284 (76%)	Counselling Psychology Graduate Students	Mean age = 29.42 years (SD = 5.77, range = 22 – 53) 209 female and 75 (26%) male. Ethnicity: 73 % Caucasian, 8% African American, 7% Asian or Pacific Islander, 6% Hispanic, 1% Native America.	To test hypotheses that social support would buffer the effects of stress on burnout and career choice satisfaction	MBA	Cross sectional. Self-report online survey	Correlation and regression	Global stress, advisor support, and sense of community were significant predictors of burnout in the regression analysis.	15 - moderate
8	Le Roux, *et al*., 2018 South Africa	43 (74.1%)	Social work students	Mean age: 22.7 years (SD=1.82 years). Gender: 95.3 % female, 4.7 % male. Race: Black (76.7%), White (20.9%), Coloured (2.3%).	To investigate burnout and engagement in fourth-year social work students, and describe their relation to background characteristics of students	MBI-SS	Cross sectional. Self-report	Bivariate analysis, Mann-Whitney U tests, Chi Squared tests	Respondents reported above average levels of exhaustion, professional efficacy, vigour, dedication and absorption, and below average levels of cynicism. Analysis showed that Black respondents experienced higher levels of	15 - moderate

									exhaustion compared to White respondents. Risk of burnout was higher for black students, those from lower-income households, and those from rural and township areas.	
9	Lee *et al*., 2018 US	201	Counsellors in training	Mean age = 31.07 (SD = 9.36, range = 21 to 64) 84.1% female, 13.4% male, and 2.5% did not respond. Ethnicity (could select more than one): 76.6% white, 10.9% Black, 9.0% Lantinx, 6.0% Asian, 3.0% other ethnicities.	To explain contributing variables of counsellor trainees' burnout, specifically focusing on their attributional styles.	MBI	Cross sectional. Self-report online survey	Correlation and regression analysis	Stability and globality of attributional style (e.g. a tendency to perceive causes of negative events as unchangeable and universal) collectively explained significant amounts of variance across burnout dimensions.	16 - high
10	Lushington and Luscri, 2001 Australia, Singapore and Hong Kong	306 (98%)	Counselling trainees	69% female. Mean age = 37.66	To compare burnout in counselling trainees in Australia, Singapore and Hong Kong	MBI	Cross sectional. Self-report	Correlation and regression	Trainees in Hong Kong reported higher levels of EE and DP compared with Australia and Singapore. Loneliness was a modest predictor of burnout, whilst younger age was a weak predictor of EE and reduced PA.	15 - moderate

11	Newton *et al*., 2020 US	136	Counsellors in training	Mean age = 27.8 years (range 21-66). Ethnicity: 18.4% African American, 72.8% White/non-Hispanic, 2.2% Asian/Pacific Islander, 2.9% Hispanic, and 3.7% other.	To investigate whether counsellors in trainings' mindfulness, emotion regulation, and perceived social support are predictive of their level of burnout.	MBI – HSS	Cross sectional. Self-report	canonical correlation analysis	Significant relationships were observed between mindfulness, emotion regulation, and burnout. Cognitive reappraisal explained greatest degree of variance in burnout.	16 - high
12	Richardson *et al*., 2018 US	119	Doctoral trainees in Clinical (74%) or counselling (26%) psychology	Gender: 86% female. Race/Ethnicity: 71% White, 12% Asian, 9% Hispanic, 5% African American, and 3% Multicultural Mixed Race. Mean age: 27.11 years (SD = 3.12)	To investigate relationships between self-compassion, self-critical perfectionism, depression and burnout	CBI	Cross sectional Self-report online survey.	Correlation and Regression	Burnout was negatively associated with self-compassion. Burnout was positively associated with self-critical perfectionism. Mediation analysis indicated that self-compassion mediated the relationship between perfectionism and burnout.	16 - high
13	Rico and Bunge, 2021 US	204	Psychology doctorate students	Mean age = 27.59 years (SD = 4.94; range = 22–50). Gender: 86.8% female. 11.3% male. 1% genderqueer; nonbinary, .5% prefer not to say, .5% missing. Ethnicity: 2.9% American Indian or Alaska native, 8.3% Asian, 2.5% Black or African American, 10.8% Latino or Hispanic, 3.9% Middle eastern or Northern	To compare burnout and stress between psychology trainees and the general population	MBI-HSS	Cross sectional. Self-report online survey.	ANOVA	Psychology doctorate students' stress levels were similar to that of the general population. Higher EE scores were found in trainees years three and four compared with years one and two.	15 - moderate

				African, 1.5% Native Hawaiian or other Pacific Islander, 79.4% White, 1% decline to respond.						
14	Rose *et al*., 2019 UK	214 (82%)	Trainee clinical psychologists	Mean age = 29.46 (SD = 4.64, range = 23-55). 88.5% female, 11.5% male.	To explore reciprocity in trainee relationships and self-efficacy beliefs and their associations with trainee burnout and psychological well-being	MBI-HSS	Cross sectional. Self-report online survey.	Correlational and regression	The degree of investment in certain relationships was significantly positively correlated with and was predictive of EE and lower PA. Self-efficacy across clinical, academic, and course related aspects of training also predicted levels of burnout.	15 - moderate
15	Swords and Ellis, 2017 US	203	Clinical (71.8%) and counselling psychology (28.2%) doctoral trainees	Mean age = 28.69 (SD = 5.71, range = 23 – 58). 86.% female, 12.8% male, 0.5% genderqueer. 76.4% non-Latino White, 7.9% Latino, 4.9% Asian or Pacific Islander, 4.9% Biracial or Multiracial, 3.4% African American, 2.0% Middle Eastern, and 0.5% Native American.	To identify predictors of burnout	SMBM	Cross sectional. Self-report online survey	Correlation and regression.	Levels of burnout were higher than normative samples. Supervisory working alliance and work-related stress uniquely predicted burnout and vigour.	16 - high

16	Testa and Sangganjan avanich, 2016 US	380	Counselling students	Age: M=34.07 (SD= 10.75, range = 22 – 68). Gender: 16.1% male, 82.9% female, 1.1% other. Ethnicity: Asian, Asian American, or Pacific Islander (0.5%); Native American, American Indian, or Alaska Native (0.3%); Black or African American (12.1%); Hispanic or Latin American (5.5%); Middle Eastern or Arabic American (0.5%); White or European American (71.8%); multiracial (8.4%); and other (n = 3, 0.8%).	To examine the contribution of mindfulness and emotional intelligence to burnout among counselling interns	MBI-HSS	Cross sectional. Self-report online survey.	Canonical correlation analysis	Emotional intelligence and mindfulness were both negatively correlated with burnout.	15 - moderate
17	Ying, 2008 US	28	Social work students	Mean age: 27.6 (SD53.4), Gender: 92.9% female. Race: 64.3% European American.	To examine the buffering effect of self-detachment against emotional exhaustion among second-year MSW students, controlling for social support	MBI – EE subscale	Cross sectional. Self-report	Regression	Self-detachment, an element of self-compassion, and social support emerged as significant negative predictors of EE.	14 - moderate

Abbreviations: CBI = Copenhagen Burnout inventory, MBI – Maslach Burnout Inventory, MBI-HSS = Maslach Burnout Inventory Human Services Survey, MBI-SS = Maslach Burnout Inventory Student Survey, MBI-GS = Maslach Burnout Inventory General Survey, PROQUL = Professional Quality of Life Scale, EE = Emotional Exhaustion, DP=Depersonalisation, PA= Personal Accomplishment, MBA = Meier Burnout Assessment, SMBM = Shirom-Melamed Burnout Measure.

Quality assessment

The appraisal of quality for included studies is presented in Table I. In line with the interpretations reported elsewhere in the literature (e.g. Bull *et al*., 2019; Moor and Anderson, 2019), scores above 15 were interpreted as reflecting studies with a low risk of bias, conferring a high-quality study. Scores between 10-15 were considered moderate quality, and scores below 10 were considered low quality.

Scores on the AXIS ranged from 14 to 18 out of 20, meaning that there were no low-quality studies. Ten out of the 17 studies were considered moderate quality, and seven were considered high quality.

The most common methodological problems were related to sample size and response rate. Twelve studies did not provide a power analysis to justify their sample size, and hence were at greater risk of Type II error. Furthermore, only six studies reported their response rate, with other studies being unable to determine their response rate due to sampling methods. This could raise the risk of non-response bias and reduce the validity of findings.

Measures of burnout

Five different measures of burnout were utilised across the studies included in this review, most commonly a version of the MBI. Eleven studies included a form of the MBI (Maslach *et al*., 1997), one used the Copenhagen Burnout Inventory (Kristensen *et al*., 2005), three used the professional quality of life scale (PROQOL; Stamm, 2010), one used the Shirom-Melamed Burnout Measure (SMBM; Shirom and Melamed, 2006), and one used the Meier Burnout Assessment (MBA; Meier and Schmeck, 1985).

Levels of burnout

Table II. reports findings in relation to burnout scores on the measures used by the included studies. Due to the correlational nature of the studies included, not all reported this data.

Three studies reported levels of 'high' overall burnout using the MBI; the levels reported were 13% (Lushington and Luscri, 2001, 41 trainees), 37% (Jovanović *et al*., 2016, 726 trainees), and 49% (Kaeding *et al*., 2017, 638 trainees). Both Kaeding *et al*. (2017), and Jovanović *et al*. (2016), had large sample sizes, increasing the validity of their findings as a representation of their study populations.

Of those which reported MBI subscales, all four studies reported moderate levels of emotional exhaustion within their sample, according to Maslach's suggested cut-offs (Maslach *et al*., 2001). Two studies reported moderate depersonalisation scores, whilst one reported low depersonalisation scores. Two studies reported moderate levels of personal accomplishment, and one study reported low levels. These findings should, however, be interpreted with caution as there is a lack of consensus regarding cut-off points for determining problematic levels of burnout and the validation of these cut-off points is lacking (Morse *et al*., 2012).

Although the heterogeneity of measures used limits the strength of conclusions that can be drawn, these findings tentatively indicate that trainee mental health professionals are at risk of experiencing burnout and on average experience moderate levels of emotional exhaustion, depersonalisation, and personal accomplishment.

Table II. Reported levels of burnout in participants

Study	Measure of burnout	Mean (SD)			Interpretation
Harr and Moore, 2011	PROQOL	26.67 (5.79)			Scores on their risk for burnout were slightly higher than averages for other helping professionals
Beaumont *et al*., 2016	PROQOL	21.6 (5.7)			Interpreted as low score
Butler *et al*., 2017	PROQOL	21.31 (5.45)			All students fell within the low (57.7%) or average (42.3%) ranges
Kovach Clark *et al*., 2009	MBA	2.54 (0.48)			Interpreted as low level of burnout
Richardson *et al*., 2018	CBI	51.24 (19.89)			Score was above mean of normative sample
Swords and Ellis 2017	SMBM	3.37 (0.99)			Higher than respective norms for both men and women
Studies utilising MBI					
		EE	**DP**	**PA**	
Basma *et al*., 2021	MBI	NR	NR	NR	NR
Lee *et al*., 2018	MBI	NR	NR	NR	NR
Lushington and Luscri, 2001	MBI	19.5 (10.4)	9.2 (5.6)	32.4 (7.5)	13.4% had high burnout scores, 10.7% had high EE scores, 7.8% had high DP scores, and 9.8% had low PA.
Newton *et al*., 2020	MBI-HSS	NR	NR	NR	NR
Rico and Bunge, 2021	MBI-HSS	NR	NR	NR	NR
Rose *et al*., 2019	MBI	21.65 (9.39)	3.18 (3.33)	36.14 (5.82)	30.8% experienced high EE, 1.4% experienced high DP, and 36% experienced low PA.
Testa and Sangganjanavanich, 2016	MBI	26.12 (10.12)	8.46 (4.03)	48.28 (6.26)	NR
Ying, 2008	MBI	18.75 (5.28)	NR	NR	NR
Kaeding *et al*., 2017	MBI	NR	NR	NR	49% of participants scored within 'high' range (M=35.35, SD=6.63). 50.8% scored within low-moderate range (M=19.56, SD=4.60)
		Exhaustion	**Cynicism**	**PE**	
Jovanović *et al*., 2016	MBI-GS	2.6 (1.4)	2.0 (1.4)	4.5 (1.1)	37% met criteria for severe burnout
Le Roux *et al*., 2018	MBI-SS	22.95	12.00	31.05	NR

Abbreviations: NR = Not reported, CBI = Copenhagen Burnout inventory, MBI – Maslach Burnout Inventory, MBI-HSS = Maslach Burnout Inventory Human Services Survey, MBI-SS = Maslach Burnout Inventory Student Survey, MBI-GS = Maslach Burnout Inventory General Survey, PROQUL = Professional Quality of Life Scale

Predictors of burnout

Table III. summarises the findings relating to factors associated with burnout in the included studies. Where data was available, effect sizes were reported according to convention (Ferguson, 2016).

Table III. Predictors of burnout

Study	**Variables measured**	**Findings**
Basma *et al*., 2021	Discrimination	Significant predictor of exhaustion (β =.28, p<.05), cynicism (β=.27, p<.05) and professional efficacy (β=-.22, p<.05)
	Age	Younger age significant predictor of exhaustion (β =-.04, p<.05), cynicism (β=-.16, p<.05) and professional efficacy (β=-.20, p<.05)
	Gender	Significant predictor of exhaustion (β =-.30, p<.05), cynicism (β=-.16, p<.05) and professional efficacy (β=-.20, p<.05)
Beaumont *et al*., 2016	Self-compassion	Negatively correlated with burnout (r=-.486**, p<.01)
	Compassion fatigue	Positively correlated with burnout (r=.580***, p<.01)
	Compassion for others	Negatively correlated with burnout (r=-.289*, p<.05)
Butler *et al*., 2017	Training re-traumatization	Positively correlated with burnout (r=.28*, p<.01). Predictor of burnout (β=.229, p=.003)
	Self-care effort	Negatively correlated with burnout (r=-.23*, p<.01). Negative predictor of burnout β =-.183, p=.018)
	Working with trauma clients	Not significant
Harr and Moore, 2011	Number of hours employed outside of training	Number of hours employed resulted in significant difference with burnout (p=.023, F = 1.736*)
	Age	No association
	Ethnicity	No association
	Number of enrolled classes	No association
	Distance travelled to field placement	No association
Jovanović *et al*., 2016	Working hours	Significant predictor of high burnout (p<0.001)
	Not having enough rest	Significant predictor of high burnout (p=0.001)
	Lack of supervision	Significant predictor of high burnout (p=<0.001)
	Not having psychiatry as a first career choice	Significant predictor of high burnout (p=0.043)
	Age	Younger age significant predictor of high burnout (p< 0.001)
	Gender	Not significant
	Not having children	Significant predictor of high burnout (p=0.010)
	Relationship status	Not significant
	Years in training	Not significant
Kaeding *et al*., 2017	Early Maladaptive schemas	Higher burnout group experienced higher mean scores on all EMS compared with low burnout group (p<.001). Unrelenting standards schema correctly predicted 61.8% of trainees with high burnout.
	Physical health	Higher burnout group experienced higher level of physical health symptoms than low burnout group (p = <.001)

Kovach Clark *et al*., 2009	Role conflict	Positively correlated with burnout (r=.39**, p<.001)
	Advisor support	Negatively associated with burnout (r=-.34**, p<.001). Significant predictor of burnout (β = -.12 p<.05)
	Student support	Negatively correlated with burnout (r=-.30**, p<.001)
	Sense of community	Negatively correlated with burnout (r=-.45**, p<.01) Significant predictor of burnout (β =-.27, p<.001)
	Family / friend support	Negatively associated with burnout (r=-.15*, p<.01)
	Global stress	Positively correlated with burnout (r=.51***, p<.001). Significant predictor of burnout (β = .38 p<.001)
	Years in training	No association
	Career satisfaction	Negatively correlated with burnout (r=-.27*, p<.001)
	Gender	No association
	Age	No association
	Ethnicity	No association
Le Roux *et al*., 2018	Place of origin	Respondents from city and small-town areas were less likely to suffer from exhaustion compared to those from township and rural areas (X^2 =9.598; p=0.002).
	Income	Respondents from middle-income households experienced lower levels of exhaustion compared to those from low-income households (Z=-2.874; p=0.004; r=-.4**)
	Race	Black students were more likely to experience higher emotional exhaustion than white students (Z=-2.902; p=0.004; r=-.4**)
Lee *et al*., 2018	Years in training	Positively correlated with cynicism (r=.17*, p<.05) Significant predictor of cynicism (p = .01).
	Age	Negatively correlated with EE (r=-.20*, p<.001) and global burnout (r=-.14*, p<.05) Lower age significant predictor of global burnout (p=.047).
	Attribution style	Stability and globality of attribution style were significant predictors of EE (p = .11), cynicism (p=.037), and professional efficacy (p=.011) and overall burnout score (p=.013)
	Gender	Not significant
	Race	Not significant
	Nationality	Not significant
	Living on campus	Associated with higher exhaustion (r=.25*, p<.01) and global burnout (r=.16*, p<.05)
Lushington and Luscri, 2001	Social intimacy	Social intimacy negatively correlated with EE (r=-.23*, p<.0001), DP (r=-.24*, p<.0001) and PA (r=.20*, p<.0005). Not significant predictor in regression analysis
	Loneliness	Positively correlated with EE (r=.41**, p<.0001) and DP (r=.28*, p<.0001). Negatively correlated with PA (r=-.27*, p<.0001). Significant predictor of EE (β =.39, p<.0001), DP (β = .11, p=.003) and PA (β =-.16, p=.001)
	Years in training	Negatively correlated with EE (r=-31**, p<.0001) and DP (r=-.26*, p<.0001). Positively correlated with and PA (r=.18*, p<.0005). Not significant predictor in regression analysis
	Age	Negatively correlated with EE (r=.34**, p<.0001), DP (r=-.29*, p<.0001). Positively correlated with PA (r=-23*, p<.0001). Significant predictor of EE (β =-.2 2 p=.02), and PA (β =.14, p=.001)
Newton *et al*., 2020	Emotion Regulation (cognitive reappraisal)	Significantly associated with lower burnout (r_s= .85)
	Emotion Regulation (expressive suppression)	Significantly associated with burnout (r_s= -.24)
	Mindfulness (awareness)	Significantly associated with lower burnout (r_s= .36)
	Mindfulness (acceptance)	Significantly associated with lower burnout (r_s= .36)
	Social support (significant other)	Significantly associated with lower burnout (r_s= .49)

	Social support (friends)	Significantly associated with lower burnout (r_s= .56)
	Social support (family)	Significantly associated with lower burnout (r_s= .43)
Richardson *et al*., 2018	Self-critical Perfectionism	Positively correlated with burnout (r =.52***, p<.01; β =.35, p <.01)
	Self-compassion	Negatively correlated with burnout (r = -.53***, p<.01)
	Depression	Positively correlated with burnout (r =.73***, p<.01)
Rico and Bunge, 2021	Years in training	EE in third and fourth year trainees higher than the other years (p=.04)
Rose *et al*., 2019	Relationship reciprocity with clients	Positively correlated with EE (r=.146*, p<.05). Negatively correlated with PA (r=-.195*, p,.001) Significant predictor of DP (β=.042, p<.05)
	Relationship reciprocity with supervisor	Positively correlated with EE (r=.191*, p<.001)
	Relationship reciprocity with placement team	Positively correlated with EE (r=.201*, p<.001)
	Relationship reciprocity with cohort	Not significant
	Relationship reciprocity in personal relationships	Significant predictor of DP (β=.580, p<.05)
	Relationship reciprocity with university staff	Not significant
	Relationship reciprocity with employing trust	Not significant
	Self-efficacy Academic	Significantly correlated with DP (r=-.135*, p<.05), EE (r=-.225*, p<.01) and PA (r=.326**, p<.01) Significant predictor of PA (β=.005, p<.001)
	Self-efficacy Clinical	Significantly correlated with DP (r=-.235*, p<.01), EE (r=-.296*, p<.01), and PA (R=.473**, p<.01) Significant predictor of DP (β=.-.068, p=.014) and PA (β=.192, p<.001)
	Self-efficacy Course	Significantly correlated with DP (r=-.165*, p<.05), EE (r=-.386**, p<.01), and PA (r=.316**, p<.01) Significant predictor of EE (β=.-.284, p<.001)
Swords and Ellis, 2017	Relationship conflict	Positively correlated with burnout (r=.38**, p<.01). Not significant predictor in regression analysis
	Financial strain	Positively correlated with burnout (r=.23*, p<.01). Not significant predictor in regression analysis
	Supervisory working alliance	Negatively correlated with burnout (r=-.33**, p<.01) and significant predictor (p<.001)
	Work related stress	Threat (r=.56***, p<.01) and pressure (r=.43**, p<.01) associated with burnout Threat subscale significant predictor of burnout (p<.0001)
	Vigour	Negatively correlated with burnout (r=-.71***, p < .01)
Testa and Sangganjanavanich, 2016	Mindfulness	Negatively correlated with burnout (p<.001)
	Emotional intelligence	Negatively correlated with burnout (p<.001)
Ying, 2008	Social support	Significant negative predictor of burnout (β= -.29, p=.04)
	Self-detachment	Significant negative predictor of burnout (β=-.47, p=.004)

Abbreviations: EE = emotional exhaustion, DP = depersonalisation, PA = personal accomplishment
Effect size conventions (Ferguson, 2016); r ≥.10 = small effect, r ≥ .30 = moderate effect; r ≥ ±.5 = large effect
*small effect size **medium effect size ***large effect size

Individual factors

Fifteen studies measured individual factors in relation to burnout.

Demographic factors. Age was observed to be a significant negative predictor of burnout in four studies (Basma *et al*., 2021; Jovanović *et al*., 2016; Lee *et al*., 2018; Lushington and Luscri, 2001), with two reporting medium effect sizes (Lee *et al*., 2018; Lushington and Luscri, 2001). Younger age was predictive of overall burnout in two high quality studies (Jovanović *et al*., 2016; Lee *et al*., 2018), and of emotional exhaustion, personal accomplishment (Lushington and Luscri, 2001), and exhaustion, cynicism, and professional efficacy (Basma *et al*., 2021). Two of these studies used an international sample, increasing the potential generalisability of the findings (Jovanović *et al*., 2016; Lushington and Luscri, 2001). In contrast, three studies of high and moderate quality (Butler *et al*., 2017; Harr and Moore, 2011; Kovach Clark *et al*., 2009) reported no significant correlation between age and burnout.

Race was investigated in three studies; one study of moderate quality (Le Roux *et al*., 2018) found that black students were more likely to experience high levels of emotional exhaustion compared to white students, whereas two moderate quality studies found no association (Harr and Moore, 2011; Kovach Clark *et al*., 2009), however these studies had limited diversity within their sample. Basma *et al*., (2021) found that experiencing discrimination on the basis of race, gender, and age in their societal context was a significant predictor of burnout amongst trainees who identified as black, indigenous or people of colour.

Three studies, two of high quality, found no association between gender and burnout (Jovanović *et al*., 2016; Kovach Clark *et al*., 2009; Lee *et al*., 2018), whereas one study (Basma *et al*., 2021) found that it was a significant predictor of burnout. One study investigated

relationship status which was found to be non-significant, however not having children was found to be a significant predictor of high burnout in one high quality study (Jovanović *et al*., 2016).

One study also found that trainees from cities and towns had lower levels of exhaustion than those from township and rural areas (Le Roux *et al*., 2018), whilst another found that living on campus was associated with higher exhaustion and global burnout in one high quality study (Lee *et al*., 2018). One study (Le Roux *et al*., 2018) found that trainees from middle income households experienced lower exhaustion compared to those from high income households, however the sample size of 43 and lack of power analysis make it unclear whether the study was sufficiently powered. Financial strain was also found to be positively correlated with burnout in one high quality study (Swords and Ellis, 2017).

Psychological factors. Three studies of high and moderate quality (Beaumont *et al*., 2016; Richardson *et al*., 2018; Ying, 2008) found a significant negative relationship between self-compassion, as measured by the Self-Compassion Scale (Neff, 2003) and burnout, reporting large (Richardson *et al*., 2018) and medium (Beaumont *et al*., 2016) effect sizes. This finding was consistent across professional groups including psychology, psychotherapy and social work. However, one of these studies (Ying, 2008) suffered from a low sample size (n=28).

Two studies of high and moderate quality also found mindfulness to be negatively associated with burnout (Newton *et al*., 2020; Testa and Sangganjanavanich, 2016).

Self-critical perfectionism was found to be associated with high burnout (Richardson *et al*., 2018), as was scoring highly for an unrelenting standards schema (Kaeding *et al*., 2017) within psychology trainees. Kaeding *et al*. (2017) found that this characteristic pattern of

relentless striving to a higher standard was predictive of scoring in the high burnout range. This was a large study with an international sample, increasing the likelihood that this finding would be replicated in other individuals, and strengthening its conclusions.

Other individual factors that were negatively associated with burnout included the cognitive re-appraisal facet of emotion regulation (Newton *et al*., 2020) emotional intelligence (Testa and Sangganjanavanich, 2016), and self-care effort (Butler *et al*., 2017), whilst attribution style was found to predict burnout in one high quality study (Lee *et al*., 2018).

Perceived self-efficacy across clinical tasks was a significant predictor of depersonalisation and personal accomplishment, whilst confidence on course related tasks was a significant predictor of emotional exhaustion, and academic self-efficacy was a significant predictor of personal accomplishment in one moderate quality study (Rose *et al*., 2019).

Situational factors

Situational factors were considered in twelve studies.

Interpersonal factors. Forms of social support or closeness with others were found to be associated with lower burnout in all six studies which investigated this factor. Kovach Clark *et al*. (2009) found that advisor support and sense of community were significant negative predictors of burnout in their regression analysis. This study had a moderate quality rating, with limitations in the transparency of reporting, which hinders the reproducibility of this research.

Two studies (Newton *et al*., 2020; Ying, 2008) found that social support was a significant negative predictor of overall burnout, with one of these (Newton *et al*., 2020) finding that support from friends explained 31.81% of the variance in burnout. Loneliness was also found to

be a weak but significant predictor of burnout in one study of moderate quality (Lushington and Luscri, 2001).

Rose *et al*. (2019) explored the role of perceived relationship reciprocity, or the sense of over-investment in relationships, and found that over-investment in client relationships and personal relationships were both significant predictors of depersonalisation in clinical psychology trainees. Their correlational analysis indicated that emotional exhaustion was associated with a sense of over-investment in relationships with clients, supervisors, and placement teams, whilst higher personal accomplishment was associated with more equal reciprocity in relationships with clients, with small effect sizes. One limitation of this study was its use of a novel and unvalidated measure of relationship reciprocity.

Relationship conflict with colleagues was also found to be positively correlated with burnout with a medium effect size within one study of high quality (Swords and Ellis, 2017). This finding is strengthened by the inclusion of a power analysis and the use of proxy comparative samples to contextualise results by the authors.

Work related factors. Supervision was investigated in two high quality studies; one study found that supervisory working alliance was a significant negative predictor of burnout with a medium effect size (Swords and Ellis, 2017), whilst another found that lack of supervision was a significant predictor of high burnout (Jovanović *et al*., 2016).

Role conflict, or the balancing of multiple demands within the trainee role, was investigated in one study of moderate quality, which found that this was positively associated with burnout with a medium effect size (Kovach Clark *et al*., 2009).

There were mixed results regarding years in training, with two high and moderate quality studies finding no association (Kovach Clark *et al*., 2009; Richardson *et al*., 2018), whilst two studies of high and moderate quality found evidence of a positive relationship between years in training and burnout (Lee *et al*., 2018; Rico and Bunge *et al*., 2021). In contrast, one study of moderate quality found a negative correlation between years in training and emotional exhaustion and depersonalisation, with small to medium effect sizes (Lushington and Luscri, 2001). It is possible that differences in training requirements across local contexts could explain the inconsistencies observed, indicating that there is a lack of consensus regarding when trainees are most likely to experience burnout.

Two studies investigated working hours; Jovanović *et al*. (2016) found that both longer working hours and not having enough rest were significant predictors of high burnout in psychiatry trainees, and Harr and Moore (2011) found that hours employed outside of training was associated with higher burnout in social work students.

Experiencing re-traumatisation on placement was found to be a significant predictor of burnout in one high quality study (Butler *et al*., 2017), although working with trauma-related content on placement was not a significant predictor of burnout.

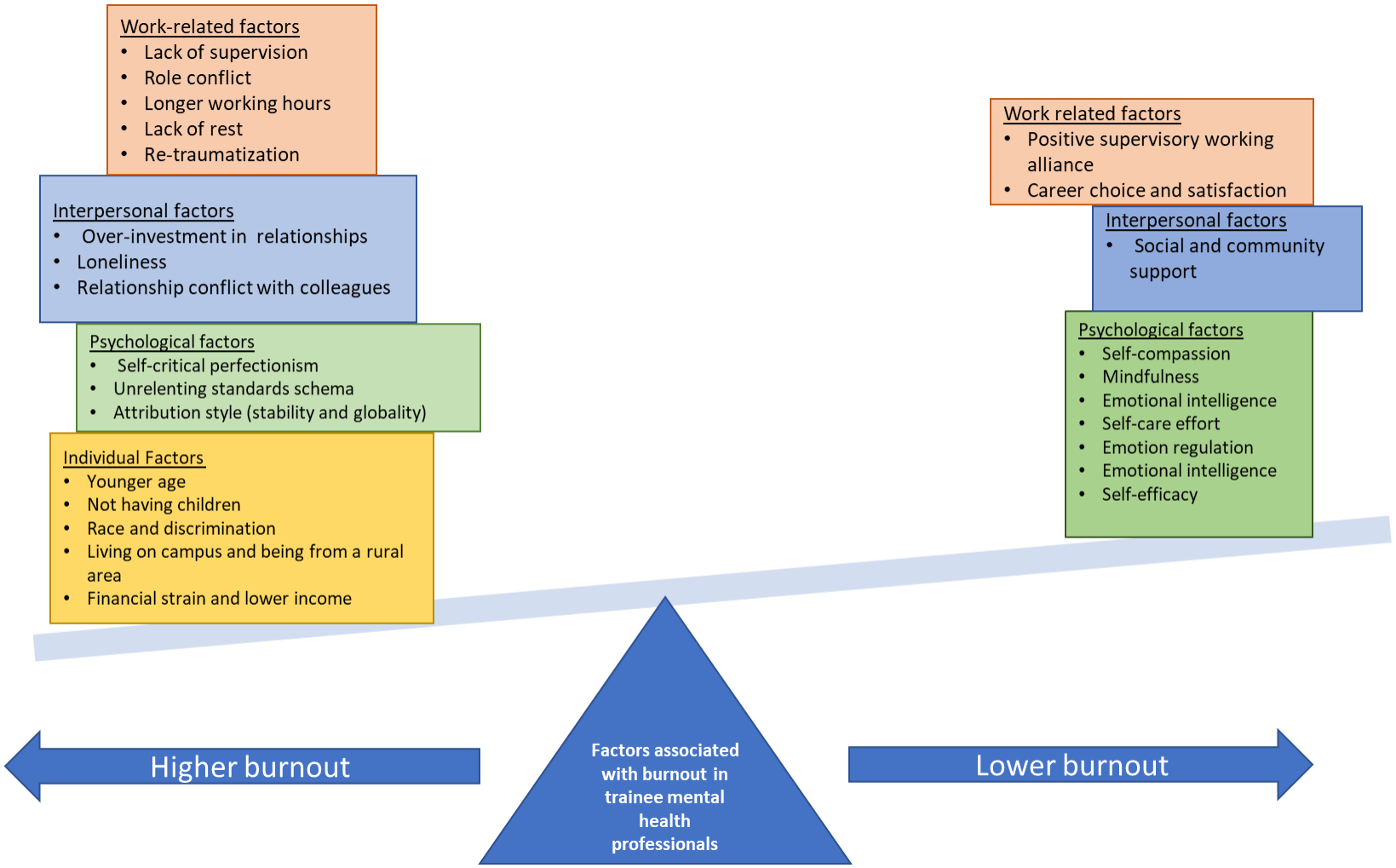
Career satisfaction was significantly negatively associated with burnout in one study (Kovach Clark *et al*., 2009) and not having psychiatry as a first choice of career was a significant predictor of burnout in another (Jovanović *et al*., 2016).

Discussion

This review sought to synthesise and critically appraise the literature regarding burnout in mental health professionals in training. Seventeen studies met the criteria for inclusion in the

review. The key findings of the studies were synthesised within the framework of individual and situation risk factors for burnout (Maslach *et al*., 2001), and are illustrated in Figure 2.

Figure 2. Summary of individual and situational factors associated with burnout



Individual factors

There was some limited evidence to suggest that younger age was associated with higher burnout, with age emerging as a significant negative predictor in four moderate to high-quality studies. This is consistent with some previous reviews in qualified mental health professionals (McCormack *et al*., 2018; Simionato and Simpson, 2018), although null results were also reported in the literature. It has been hypothesised that younger individuals may have learnt fewer coping mechanisms, thus increasing their risk of developing burnout (McCormack *et al*., 2018). Alternatively, it could be that age is a consequence rather than cause of burnout, and that this relationship is better explained by 'survival bias', where individuals who have experienced burnout have left the profession and those who remain are those who are less vulnerable to burnout (Maslach *et al*., 2001). Given that living on the training campus (Lee, 2018) and not having children (Jovanović *et al*., 2016) were also found to be associated with burnout, another explanation for these findings could be that younger trainees have fewer boundaries between home and work life, heightening their exposure to job demands; however, conclusions about causality cannot be inferred from correlational studies.

There was limited evidence for the role of other demographic variables such as gender, ethnicity, or relationship status in this review, although exploring these factors could have been limited by lack of diversity within included studies. Furthermore, not every study investigated demographic factors, meaning their role could have been underestimated.

A finding unique to this review was the trend in the literature towards an association between lower levels of self-compassion and burnout within a trainee population, with three studies supporting this finding. This is in keeping with the growing literature in this area, including the findings that self-compassion can buffer against negative self-related events

(DeLury and Poulin, 2018), increase healthcare provider resilience (Olson and Kemper, 2014), and promote relational wellbeing (Lathren *et al*., 2021). Self-compassion practices may enhance physiological self-soothing and reduce cortisol levels (Rockliff *et al*., 2008), which may be one mechanism for reducing the risk of burnout.

It is also of note that both self-critical perfectionism and the unrelenting standards schema were associated with higher levels of burnout. This is consistent with the view that mental health professionals may experience a strong desire to meet the needs of other people to reduce their pain and suffering and achieve successful clinical outcomes (Presley *et al.,* 2017). This review tentatively suggests that being highly critical and having high standards for oneself are linked to burnout during the training period, but that self-compassion may play a role in mediating this effect (e.g. Richardson *et al.,* 2018). Personal vulnerability factors have not typically been integrated into the JD-R model (Schaufeli and Taris, 2013), although it could be hypothesised that individuals who score highly on perfectionism take on greater job demands, or may be more likely to struggle with the difficulty in meeting service needs within under-funded and under-resourced healthcare systems.

There was some limited evidence that mindfulness was negatively associated with burnout, consistent with the growing literature on the role of mindfulness in burnout in the helping professions (Braun *et al*., 2017; Cohen-Katz *et al*., 2004; Goodman and Schorling, 2012). It is possible that mindfulness facilitates a greater awareness of emotional experiences, resulting in being better able to regulate ones' emotions and utilise coping skills, thus preventing the development of burnout. Mindfulness is also thought to be one of the core components of self-compassion and is critical to the awareness of suffering that is necessary to act with compassion (Germer and Neff, 2015); accordingly, both Acceptance and Commitment Therapy (Hayes *et al*., 2009) and Compassion Focused Therapy (Gilbert, 2010) may offer valuable lenses for understanding and approaching burnout within this population.

A recent systematic review concluded that there is promising but as yet inconclusive evidence for the use of mindfulness-based interventions in reducing burnout in mental health professionals and stressed the need for more high-quality research in this area (Klein *et al*., 2020).

There was also limited evidence that burnout was associated with emotion regulation, emotional intelligence, and stability and globality of attribution style, consistent with the view that psychological coping skills have a role in the experience of burnout. These findings are consistent with the conservation of resources model of burnout, in that personal coping skills are an important resource that if threatened or depleted, may result in burnout (Hobfoll, 1989). Alternatively, reduced use of personal coping skills could be an 'early warning sign' of burnout rather than a causal factor, and more experimental research will be needed to better understand this relationship.

This review also highlighted the role of racial discrimination, socio-economic background, and financial pressure in the experience of burnout in trainee mental health professionals, consistent with previous research into the stress burden of ethnic minority students (Cokley *et al*., 2013) and nurses (Johnson *et al*., 2019). This finding suggests that training providers have a role in examining and dismantling systemic barriers in order to support the wellbeing of trainees and ultimately increase access to their professions. It has been suggested that inclusive work environments must be facilitated by compassionate and inclusive leadership (West, 2016), an approach to leadership which values diversity, belonging, reflection, and quality improvement (West and Chowla 2017).

Situational factors

There is a substantial body of evidence to support the hypothesis that social support can both directly affect wellbeing and act as a 'buffer' to protect against negative stress related outcomes including burnout (Hobfoll, 1989; Maslach *et al*., 2001; Rhodes, 2004).

The most consistent evidence found in this review was that social support and closeness with others was associated with lower burnout. This review highlighted that within a trainee mental health professional population, multiple sources of social support have been linked to lower burnout, including support from other students, supervisors, placement teams, and personal relationships. This is consistent with prominent models of burnout including the conservation of resources model in that social support reflects a protective resource against burnout (Hobfoll, 1989). The findings are also consistent with social exchange theory (Cook *et al*., 2013), in that a sense of over-investment and lack of reciprocity in social relationships, particularly with clients may contribute to the experience of burnout. It is possible that support from others enables trainees to engage in other self-care strategies, or that social support directly reduces burnout. This finding was consistent across trainees within psychology, social work, and counselling, in multiple countries.

Two studies highlighted the role of supervision in burnout in trainee mental health professionals; one of these highlighted the role of perceived working alliance between trainee and supervisor, while the other only measured access to regular supervision. The findings are consistent with previous research indicating that both number of supervisions sessions attended, and perceptions of effective supervision were associated with lower levels of burnout with community mental health nurses (Edwards *et al*., 2006). It's possible that supervisors of trainees are also able to promote self-care practices and thus indirectly reduce risk of burnout among those they supervise (Franco, 2015). Proctor (1988) proposed three functions of clinical supervision, with the 'restorative' function thought to support wellbeing. Supervision that achieves this function may support recovery from the emotional effort of

trainees' work, in line with effort-recovery theory (Meijman and Mulder, 1998), possibly fostering motivation to engage in work and therefore reducing demands.

Unique to this review was the finding that role conflict, or managing the multiple demands of training, was associated with burnout. Although this factor was only investigated within one study of high quality, this is consistent with previous research showing that the multiple roles of trainees contribute to their stress burden (Cushway, 1992; El-Gourhey *et al*., 2012).

Other work-related factors including working hours and career satisfaction were also associated with burnout, consistent with previous research (Kumar, 2011; Prosser *et al*. 1997). One recent review found that workload and perceived time pressure were the most significant work-related contributors to burnout within psychologists, particularly regarding emotional exhaustion (McCormack *et al*., 2018). Experiencing re-traumatisation during clinical work was also found to be associated with burnout, consistent with the findings of a review which found that professionals exposed to traumatic material are likely to report similar levels of burnout and secondary traumatic stress (Cieslak *et al*., 2014).

In summary, these findings in mental health trainees are consistent with existing models of burnout and workplace stress including the job demands-resources model (Bakker and Demerouti, 2007) and conservation of resources model (Hobfall, 1989), but also extend these models by highlighting the role of personal vulnerability factors and resources in the experience of burnout in these trainee populations. This review makes a unique contribution, by highlighting a burnout profile within mental health trainees characterised by younger age, higher self-criticism and reduced self-compassion, and reduced support from personal relationships.

Implications

There was evidence for the role of psychological factors including self-compassion, mindfulness, and emotion regulation in the experience of burnout. Facilitating greater emotional awareness through regular mindfulness practice may be one mechanism for helping trainees identify their own emotions and when they may be at risk of burnout (Rupert and Kent, 2007). Incorporating self-practice of these skills in training may therefore be an avenue for preventing burnout, particularly as there is emerging evidence that mindful self-compassion training may reduce burnout in mental health professionals (Eriksson *et al*., 2018).

The findings of this review also suggest that being self-critical and having unrealistically high standards for oneself are associated with burnout, thus training providers may benefit from adapting compassionate leadership approaches in order to facilitate learning environments in which trainees feel psychologically safe to learn and develop (West and Chowla, 2017).

This review also highlighted the association between close and equitable relationships with lower levels of burnout. Trainees have access to a range of support networks including training cohorts, placement teams and personal relationships, and thus it may be beneficial for training providers to facilitate opportunities for building relationships on training, for example through forums such as peer supervision or reflective practice. The supervisory relationship may be particularly important during the training period, thus training providers should ensure they offer robust supervisor training and meaningful feedback mechanisms.

The findings of this review also highlight the need to look beyond individual coping strategies and consider the contextual factors that may play a role in the experience of burnout, including considering the impact of working hours, conflicting role demands, and lack of supervision. These factors could be targets for work-based interventions for this

population, and trainees may benefit from more support from their training providers in navigating their role, particularly within under-resourced healthcare systems. This finding highlights that interventions that are solely "person focused" and aimed at increasing individual resilience are unlikely to be successful in preventing or ameliorating burnout in this population; furthermore, focusing solely on personal resilience risks individualising systemic problems and encouraging individuals to tolerate adverse working conditions (Chamorro-Premuzic and Lusk, 2017).

The review's findings also support the need for training courses to ensure trainees from a diverse range of backgrounds are able to thrive in clinical training, by recognising that systemic factors including discrimination and financial pressure can contribute to the experience of burnout.

Strengths and limitations of the literature

The cross-sectional nature of the included studies limits our understanding of the directionality of the associations described. There are also theoretical limitations with the way burnout was conceptualised within the included studies; two studies (Jovanović *et al*., 2016; Kaeding *et al*., 2017) used the MBI cut-off values to identify 'cases' of high or severe burnout in order to perform a comparison of groups in their analysis; however, the criteria for burnout as a diagnosable condition is contentious and lacks the support of a robust theoretical rationale (Schaufeli *et al*., 2009), calling into the question both the reliability and validity of these results. Furthermore, even "mild" levels of burnout can be distressing and impact an individual's functioning (Morse *et al.,* 2012), suggesting it may be unhelpful to categorise burnout in this way.

Although the review included studies focusing on individuals across a range of professional backgrounds, some professionals such as mental health nursing students were not represented in the literature.

Lazarus and Folkman's (1984) theory of stress and coping emphasises the importance of person-environment fit, and suggests that it is the subjective appraisal of the stress along with availability of coping resources which determine an individuals' response to stress. Few studies addressed this concept and did not consider the perception risk factors such as working hours on participants.

Strengths and limitations of the review

A strength of this review was the systematic and replicable method, which facilitated original insights into the predictors of burnout within a trainee mental health professional population. By limiting the included studies to those which utilised a validated measure of burnout, there was homogeneity in the conceptualisation of burnout as distinct from related concepts such as stress, depression, compassion fatigue, and secondary traumatic stress.

This review was also subject to limitations. Included studies were limited to those published in peer reviewed journals, in order to privilege the quality of included results. As a result, grey literature was not included; this confers a risk of publication bias, in that studies with null results may have been missed from this review.

The research question warranted a focus on quantitative studies, due to the interest in investigating relationships between pre-determined phenomena; however, the decision to exclude qualitative studies means that a rich exploration of the experience of burnout was not captured.

The heterogeneity of included studies could also be considered a limitation, as local training contexts will undoubtably differ across professions and geographical location. The

decision to include a range of professions including counselling and social work also introduced heterogeneity into the review, however these studies were included on the basis that authors identified mental health as an area of practice for trainees. Whilst the variety of studies included makes it difficult to draw strong conclusions about the relative importance of the factors discussed, a strength of the review was its ability to synthesise a breadth of research and explore implications for practice beyond that which could be achieved by individual studies.

The concept of burnout does not translate to all languages and cultures (Maslach *et al*., 2001), thus limiting the generalisability of this research internationally. The decision to limit search results to the English language due to time and budget constraints further privileges a Western culture and increases the risk of bias towards significant results (Knobloch *et al*., 2011; Stern and Kleijnen, 2020).

Finally, this review did not include a meta-analysis in the synthesis of findings. Whilst this was justified by the lack of homogeneity in included studies, it limits the robustness of conclusions that can be drawn from the review.

Future research

Although all studies in this review utilised a cross-sectional design, there is evidence to suggest that burnout is a dynamic experience that evolves over time (Boersma and Lindblom, 2009). Future research may therefore benefit from longitudinal designs to explore the directionality of relationships between variables, and to scrutinise the long-term effects of burnout. Triangulation between self-report data and other sources such as supervisor observations may provide a more reliable understanding of burnout.

Future research could look to replicate the findings of key predictors of burnout as identified in this review, and to employ mediation and moderation analysis to explore how

these factors interplay. Research of this nature may ultimately support the development of questionnaire tools that can measure risk of burnout in a trainee population.

Studies in trainee populations of specific interventions that cultivate psychological resources such as mindfulness and self-compassion could also be conducted on the basis of this review, in order to consider their potential value in protecting against or ameliorating burnout, alongside a consideration of systemic factors.

Conclusion

The current review has highlighted the role of personal, psychological, and work-related factors in contributing to the risk of burnout within trainee mental health professionals. The most consistent evidence in this review was for the association between social support and lower burnout. There was also some consistent evidence for personal factors associated with burnout including younger age and perfectionistic traits. Psychological resources including self-compassion and mindfulness were also implicated within a possible role in reducing or preventing burnout.

Mental health professionals in training may benefit from interventions which enhance self-awareness and increase psychological coping skills, provide forums for social support, as well as those which reduce the work-related demands of training including workload and role conflict.

The strength of conclusions is limited by the cross-sectional, self-report designs adopted by all studies included in this review, and it is recommended that further research be conducted with longitudinal designs and validated measures.

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Part 2: Empirical Study

Clinical Psychologists' Experiences of Using the Power Threat Meaning Framework in UK Mental Health Settings: A Thematic Analysis

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Word count: 7940 (Main text)

244 (Abstract)

Prepared in accordance with author guidelines for Clinical Psychology and Psychotherapy (Appendix C.). For the purposes of this submission, the DClinPsy 8000-word limit has been used to ensure all relevant information has been included for the examiner.

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Abstract

The publication of the Power Threat Meaning Framework (PTMF) in 2018 followed calls for an alternative conceptual model of distress. This study aimed to address a gap in the literature by exploring the experiences of Clinical Psychologists who have drawn on the PTMF in adult mental health services, with a focus on the opportunities, perceived impacts, and challenges that they have experienced.

This study adopted a qualitative design utilising semi-structured interviews. Participants were eleven clinical psychologists who had drawn upon the PTMF in adult mental health settings. Participants took part in a semi-structured interview about their experiences, and transcripts were analysed using Thematic Analysis.

Four themes were generated through the analysis: Having an alternative framework of distress is valued; PTMF enhances sense making; Systemic change needed to implement PTMF; and Working alongside other perspectives as key to influencing practice.

Findings indicated that the PTMF was perceived as offering a valued alternative to the medical model of distress, however participants experienced challenges drawing on the framework within current contexts. Implications for future research and the practice of clinical psychology are discussed.

Key practitioner message:

- The Power threat meaning framework can be applied to multiple aspects of clinical psychologists' work in adult mental health settings
- The framework offers an opportunity to introduce alternatives to the medical model of mental health into multidisciplinary teams

- There are ongoing challenges negotiating the application of the framework within existing service structures

Keywords: Power threat meaning framework, clinical psychologists, qualitative

Introduction

Background

Diagnostic practice currently underpins the clinical and legislative structures of mental health services both in the UK and internationally, the organisation of evidence-based guidelines and the process of awarding research funding (Stupak & Dobroczynski, 2021). Psychiatric diagnosis is one practice emphasised by the medical model of mental health, a conceptual framework which emphasises the importance of biological factors in mental distress (Fuller, 2017). Limitations of the widely used Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5; American Psychiatric Association, 2013) have prompted a number of attempts to develop alternative conceptual systems (see Phillips & Raskin, 2021 for an overview); one such alternative gaining traction within clinical psychology is the Power Threat Meaning Framework (PTMF; Johnstone & Boyle, 2018).

The development of the PTMF followed on from the Division of Clinical Psychology's (DCP) 2013 position statement, which called for a 'paradigm shift' in the classification of distress and the need for an alternative conceptual model. The DCP's statement outlined conceptual and empirical limitations of psychiatric diagnosis including poor reliability and validity conveying limited clinical utility (Allsopp et al., 2019, Bentall, 2004a; Bentall 2004b; Frances, 2012; Kinderman et al., 2013; Pemberton & Wainwright, 2014), decontextualizing of experience through the masking of meaningful links between lived experience and distress (Bentall, 2004b), and ethnocentric bias with limited consideration of the importance of ethnicity, class, spirituality and culture (Fernando, 2010).

The statement also highlighted that although some individuals find diagnosis meaningful and protective (Stalker et al., 2005), other experiences include discrimination, stigmatisation, and disempowerment (Honos-Webb & Leitner, 2001; Longden, 2010; Read et

al., 2006). There are also inherent power imbalances in the process of diagnosis, which relies on psychiatric expertise (Stupak & Dobroczynski, 2021), strengthening calls for an alternative approach.

The power threat meaning framework

Developed by a group of senior psychologists and mental health service users funded by the British Psychological Society (BPS), the PTMF aims to empower individuals to develop their own meaningful narrative outside of this diagnostic paradigm. The framework considers the operation of economic, socio-cultural, and ideological power imbalances, threats resulting from the imbalance of power, and the personal meanings developed through social and cultural discourses. The PTMF aims to summarise and integrate a wide body of evidence, highlighting links between social inequalities, along with traumas including abuse and violence, with emotional distress or unusual experiences (e.g. Kessler et al., 2010; Varese et al., 2012).

The framework outlines a range of functional survival responses, such as hypervigilance or hearing voices, to threats such as bullying, discrimination, and inequality. It highlights the role of individual sense-making in understanding how these threat responses may serve different functions at different times, but ultimately serve to meet core needs such as seeking safe relationships, keeping a sense of control, and managing overwhelming emotions (Boyle & Johnstone, 2020). It therefore assumes coping and survival mechanisms rather than 'pathology' (Johnstone & Boyle, 2018).

The framework encourages the reframing of the question 'what is wrong with you', to 'what has happened to you', 'how did it affect you', 'what sense did you make of it', 'what did you have to do to survive', and 'what is your story'. It goes on to describe seven provisional patterns, aiming to reflect shared patterns of experience, which its authors suggest

could be used to organise research and service delivery without the need for diagnostic categories.

Although narrative based alternatives to diagnosis, such as psychological formulation, discussions within peer support groups, and community storytelling rituals (Johnstone & Boyle, 2018; Myerhoff, 1982), have been documented across different cultures, the PTMF aims to provide a supporting conceptual framework to these approaches. The PTMF is also aligned with Community Psychology, an approach which views psychological distress as arising within a social, cultural, historical and political context (Orford, 2008).

The PTMF's authors suggest that it could offer an alternative way of fulfilling the administrative and research functions of diagnosis, as well as providing implications for action within a wider social and political context (Johnstone & Boyle, 2018); however, research has yet to comprehensively explore what these principles look like in practice.

Application of the PTMF

The PTMF has been used to explore the concept of power in assessment, formulation, and intervention (Aherne et al., 2019), shape research and service evaluation (Aherne et al., 2019), and inform the education of mental health professionals (Fyson et al., 2019; Griffiths & Baty, 2019). It has also been adopted by peer-led organisations as a framework for developing a meaningful narrative without the need for input from a professional (SHIFT Recovery Community, 2020). Anecdotal accounts have suggested that the PTMF can enhance sense making, collaboration and safety within mental health services, for individuals, teams, and organisations (Bostock & Armstrong 2019; Mitchell & Thorne, 2019). Perceived outcomes at the individual level included enhancing personal agency, self-compassion and self-belief (Reis et al., 2019). Recently, an experimental study with the general public found that formulation using the PTMF was associated with less desire for social distance from a

person experiencing psychosis compared with diagnosis of schizophrenia, indicating that the PTMF may have a valuable role to play in reducing societal stigma (Seery et al., 2021).

At the mental health service 'team' level, the PTMF has been adapted to provide a model for team formulations (Nikopaschos & Burrell, 2020), defined as the process of "facilitating a group of professionals to construct a shared understanding of a service user's difficulties" (Johnstone & Dallos, 2013, p. 5). Team formulation is thought to be one forum through which psychologists can encourage psychological thinking, influence culture change (Dexter-Smith et al., 2010), and improve service effectiveness (Onyett, 2007). It can also be an opportunity for psychologists to introduce alternative models of distress within multidisciplinary teams (MDT) (Summers, 2006). Staff feedback indicated that using the PTMF in team formulation could enhance compassion for service users, increase understanding of the link between adversity and mental health, and foster a sense of responsibility, enjoyment, and enthusiasm for trauma-informed care (Nikopaschos & Burrel, 2020). This is consistent with previous findings that team formulation may enhance MDT cohesion (Christofides et al., 2012) and increase staff's reported understanding of service users (Hood et al., 2013).

A number of potential challenges with implementing the framework have been highlighted. These include the difficulty of communicating effectively with other health or social care organisations without a wider social and cultural paradigm shift around mental health (Aherne et al., 2019), and the inaccessibility of the language in the framework, which was published in the form a 414-page document (SHIFT Recovery Community, 2020; Griffiths, 2019). The PTMF has also received criticism on the basis that it rejects scientific positivism and research-led progress in mental health (Salkovkis & Sutcliffe, 2018), whilst others have suggested there is a lack of validity underpinning the narrative and its main claims (Bortolotti, 2018). Whilst debate has been generated about the potential utility of the

PTMF, the research literature has remained relatively sparse, and there have been calls to further investigate its use in mental health services (Phillips & Raskin, 2021).

Trauma informed care

The PTMF also intersects with trauma-informed care (TIC), an approach which similarly promotes a shift from asking 'what is wrong with you' to 'what has happened to you' and seeks to provide safety, trust, choice, empowerment, and collaboration within mental health services (Harris & Fallot, 2009; Johnstone & Boyle, 2018). Trauma-informed settings seek to acknowledge the role that healthcare services can play in re-traumatisation, through processes which strip individuals of their power and autonomy (Miller & Najavits, 2012).

Research has highlighted challenges in implementing TIC in mental health settings, despite perceived benefits from staff (O'Dywer et al., 2021). Lack of role clarity, absence of policies and procedures, and unclear therapeutic frameworks have emerged as factors which hinder the adoption of TIC practices (Isobel & Edwards, 2017; O'Dwyer et al., 2021). Current understanding of these challenges and how they might be navigated is limited by the lack of research into staff's experiences of TIC, particularly regarding professions other than nursing (O'Dwyer et al., 2021; Quadara, 2015). Understanding how clinicians using the PTMF in their practice navigate a range of professional perspectives is likely to be an important area for further research, given the finding that some professions report TIC to be a divisive concept, that can be met with wariness and defensiveness (Isobel et al., 2021).

Working beyond diagnosis

Previous research has also explored the experience of psychologists who draw on alternative understandings beyond the diagnostic model. Randall and Coles (2018) conducted a thematic analysis exploring psychological practitioners' responses to a survey about

working beyond diagnosis in light of the DCP's 2013 statement. The authors identified a key concept of "playing the diagnostic game" (P. 5) where necessary to manage the conflicts between practitioners' own beliefs and standard practice, maintain relationships with colleagues, and negotiate complex issues of power. Psychologists in the study reported that diagnostic practice felt inescapably interwoven within existing healthcare systems, noting the lack of coherent alternative to this approach.

The concept of 'playing the diagnostic game' aligns with findings from Cooke et al.'s (2019) study, where conflict, compromise, and collusion with the medical model emerged as strategies for managing the tension between diagnostic and psychosocial approaches. Similarly, Pilgrim (2007) observed that colluding with diagnosis provided a means of legitimising the profession and preserving power, at ideological and ethical cost. These studies have highlighted the dilemmas experienced by psychologists, particularly given the lack of alternative paradigm or language outside of the diagnostic framework, although it is unclear how the publication of the PTMF has impacted on these dilemmas.

Randall and Coles' (2018) findings also highlighted the opportunities for psychological practitioners as leaders, educators and public figures, to lead movements away from diagnostic practices; in turn this may facilitate greater choice within services about approaches to mental health. This research therefore suggests that there are possible impacts for service users and teams that warrant further exploration through a more in-depth methodology.

Rationale

The application of the PTMF to practice is still in its infancy, reflected by the dearth of available research; however, there is a clear rationale for the clinical and organisational importance of understanding the experience of psychologists using the PTMF. Firstly,

generating a more rigorous understanding of the potential opportunities and impacts of using this broad meta-framework may have implications for understanding best practice in formulation and intervention guided by the framework. Accordingly, this may support recommendations that enable services to become more trauma-informed, a priority aligned with international policy drivers (e.g. Adverse Childhood Experiences Support Hub 2022; Centre for Disease Control, 2020; Mental Health Co-ordinating Council 2013; NHS England, 2019).

To date, there has been a lack of rigorous qualitative investigation into the experiences of those who are drawing upon the PTMF in clinical practice, with the existing literature consisting primarily of anecdotal and descriptive accounts. Accordingly, little is known about the experiences of psychologists who may be trying to introduce these ideas, or about shared patterns in experiences across different settings. There is also a gap in our understanding about the longer-term use of the framework.

Existing accounts of using the PTMF and other TIC initiatives have highlighted challenges communicating with health and social care systems and navigating MDT dynamics (Aherne et al 2019; Isobel et al., 2021), thus research exploring the experience of clinicians implementing these ideas may shed light on how these difficulties can be negotiated and make recommendations for policy or practice.

Aims

The aim of this study was to enrich our understanding of clinical psychologists' use of the PTMF as applied to clinical practice in a UK adult mental health context. The study aimed to address the knowledge gap between theory and practice, in order to inform recommendations that may be of interest to clinicians, professional bodies, and researchers.

The research questions were therefore as follows:

- What are the experiences of clinical psychologists who have used the PTMF in their practice within adult mental health?
- Are there any opportunities or impacts of working in this way with individuals, teams, and organisations?
- What are the challenges, if any, of drawing upon the framework within current contexts, as well as possible ways forward?

Methods

Study design

This study adopted a qualitative approach, using semi-structured interviews. Interview transcripts were analysed using reflexive thematic analysis (Braun & Clarke, 2006; Braun & Clarke, 2019). Qualitative approaches allow for a greater exploration of personal experience than quantitative methods, and do not constrict researchers to measuring pre-determined phenomena (Willig, 2013). Accordingly, a qualitative approach was deemed appropriate for the research question.

Epistemology

The researcher's epistemological stance aligned with a critical realist position, an approach which can be consistent with thematic analysis (Braun & Clarke, 2006). It was acknowledged that observable phenomena are constructed through individual sense-making, shaped by language, attitudes, and beliefs within a broader social context, and that participants' responses imperfectly reflected actual experiences (Pilgrim, 2014).

Participants

A target of ten to fifteen participants was chosen after considering the scope of the research question, expected depth of data from each interview, expected diversity within the

sample, and the pragmatic requirements and constraints of the research (Braun & Clarke, 2021b). The study advert (Appendix D.) was shared via social media including Twitter and Linkedin, as well as within professional membership groups. The study was also advertised via DClinPsy programme staff with the aim of reaching a broad range of psychologists. Snowballing was used by asking participants to identify other eligible participants.

The inclusion criteria were:

- Qualified clinical psychologist
- Self-identified as having experience of using the PTMF in their work in an adult mental health setting in the UK for at least 6 months

The sample was limited to those in the role of qualified clinical psychologist in an adult mental health context in accordance with the aims of the study. The study was open to individuals who were no longer using the PTMF, in order to ensure the sample was not biased towards those with wholly positive experiences.

Procedure

The study was granted ethical approval by Cardiff University School of Psychology Research Ethics Committee (Appendix E.; reference: EC.20.12.08.6215R2).

Participants were provided with an information sheet (Appendix F.) and completed a consent form (Appendix G.) prior to participating. A demographics questionnaire (Appendix H.) was also used to collect data on participants' gender, ethnicity, age, and professional experience. A debrief sheet was provided following the interview (Appendix I.).

Semi-structured interviews

Interviews were guided by a semi-structured interview schedule (Appendix J.). Interview questions were informed by the existing literature, and were refined in

collaboration with the supervisors, one of the authors of the PTMF (LJ) and an expert with lived experience of mental health difficulties to ensure face validity. Questions were phrased in an open-ended manner in order to reduce bias. The interview schedule was piloted with a postgraduate researcher, after which some questions were reworded to enhance clarity.

Interviews were conducted via videocall, were recorded on an encrypted device, and transcribed verbatim. Interviews ranged from 42 to 66 minutes with an average duration of 55 minutes. Five were transcribed by the researcher and six by a professional transcribing service who were bound by a confidentiality agreement (Appendix K.).

The interview questions were designed to map onto the research questions stated above, and included exploration of areas such as how participants had introduced the PTMF into their work, what their experiences had been of communicating with others about the PTMF, and what their experiences had been of the impact of drawing on the PTMF with individuals or teams.

Analysis

Thematic Analysis (TA) was chosen, due to its ability to offer a rich and inductively-orientated interpretation of the data. TA is also thought to be appropriate for research questions which aim to have implications for clinical practice and policy (Braun & Clarke, 2021a).

Due to the aim of focusing on patterned meaning across the data set rather than a more idiographic focus, TA was deemed to be more appropriate than a possible alternative, Interpretive Phenomenological Analysis (Braun & Clarke, 2021a; Smith, 2004). Grounded Theory (Glaser & Strauss, 1967) was also considered, however this approach is thought to be best suited to research questions addressing social processes or factors that influence

phenomenon (Charmaz, 2006) and thus was also not considered the best fit for the current research question.

Braun and Clarke (2006; 2020) offer explicit yet flexible guidelines regarding the process of TA. Due to the exploratory nature of the study, an inductive approach to analysis was adopted, where the researcher was an active participant in the development of codes and themes (Clarke & Braun, 2020; Castleberry & Nolen, 2018). Data was coded at the latent as well as the semantic level, where the researcher sought to interpret the underlying meanings and assumptions within the data (Braun & Clarke, 2006).

Braun and Clarke (2006) outline six stages of TA which can be applied in a flexible and dynamic manner. Table 1. Presents a summary of how each of these phases were undertaken.

Table 1. Process of Thematic Analysis (based on Braun and Clarke, 2006)

Stage	**Description**
Stage 1	Familiarization with the dataset was achieved through listening to audio-recordings, transcription in some cases, and through re-reading of all transcripts.
Stage 2	The entire dataset was systematically coded, with equal attention given to each data item. This process was repeated twice, as codes continued to develop through the re-reading of the data. Appendix L. provides an example extract of coded data. Supervisors reviewed three coded transcripts and alternative interpretations of the data were discussed.
Stage 3	Codes were sorted into initial clusters of shared meaning (e.g. Appendix M.), and initial candidate themes were generated. In some cases, particularly rich codes were 'upgraded' to candidate themes, whilst in others, themes were generated based on identifying shared meaning across codes.
Stage 4	Themes were checked for internal homogeneity and external heterogeneity, resulting in the merging and disregarding of some themes. Themes were checked against the original dataset, and parts of the dataset were also re-coded. Appendix N. illustrates the themes and examples of associated codes, along with examples of themes that were disregarded or renamed.
Stage 5	Themes were named in a way that sought to capture the unifying meaning of each theme, and the researcher considered how each theme contributed to telling a story about the data in relation to the research aims
Stage 6	The analytic narrative was crafted for the final report. Data extracts which illustrated the analytic story were chosen and the report was written.

Quality assurance

In accordance with guidance on reflexive TA, the subjectivity of the researcher was integral to the analysis process, and thus quality assurance strategies addressed the rigour of the methodology rather than the 'accuracy' of the coding (Braun & Clarke, 2020; Terry et al., 2017).

Consistent with guidance (Elliot et al. 1999), the credibility of analysis was enhanced by the ongoing discussion of code and theme development with research supervisors and doctoral peer researchers. Themes were re-checked against coded extracts of data (Braun & Clarke, 2006). A focus on depth and engagement was maintained throughout the coding process, and quotations are presented throughout to enhance transparency (Elliot et al., 1999). Demographic information about participants is also presented to contextualise the results.

Reflexivity

Reflexivity describes the researcher's sensitivity to their own role in the research process, and is typically enhanced by self-reflection about experiences, values, and assumptions, and how they might influence the creation of knowledge (Berger, 2015). Reflexivity was facilitated through supervision and a self-reflective diary (Appendix O.) which informed the following positioning statement, in an attempt to acknowledge and 'bracket' these assumptions (Fischer, 2009):

The researcher's position was that of a trainee clinical psychologist undertaking a doctorate in clinical psychology. The researcher was drawn to this topic having read parts of the PTMF prior to training, and her interest in this research was influenced by clinical experiences working with individuals who had survived interpersonal trauma. The researcher had an active interest in exploring alternatives to the medical model of mental health in her clinical work. The researcher also recognised the tangible benefits that diagnosis can bring

and had seen this offer a containing and empowering experience for some, as well as providing access to certain services. The researcher therefore had a genuine curiosity to explore the breadth of participants' experiences, and was aware that she brought an interest and preference for psychosocial perspectives over diagnostic perspectives. This was important to continually reflect on during the analysis, through processes including actively searching for divergent data and discussing codes and themes in supervision.

Results

Participants

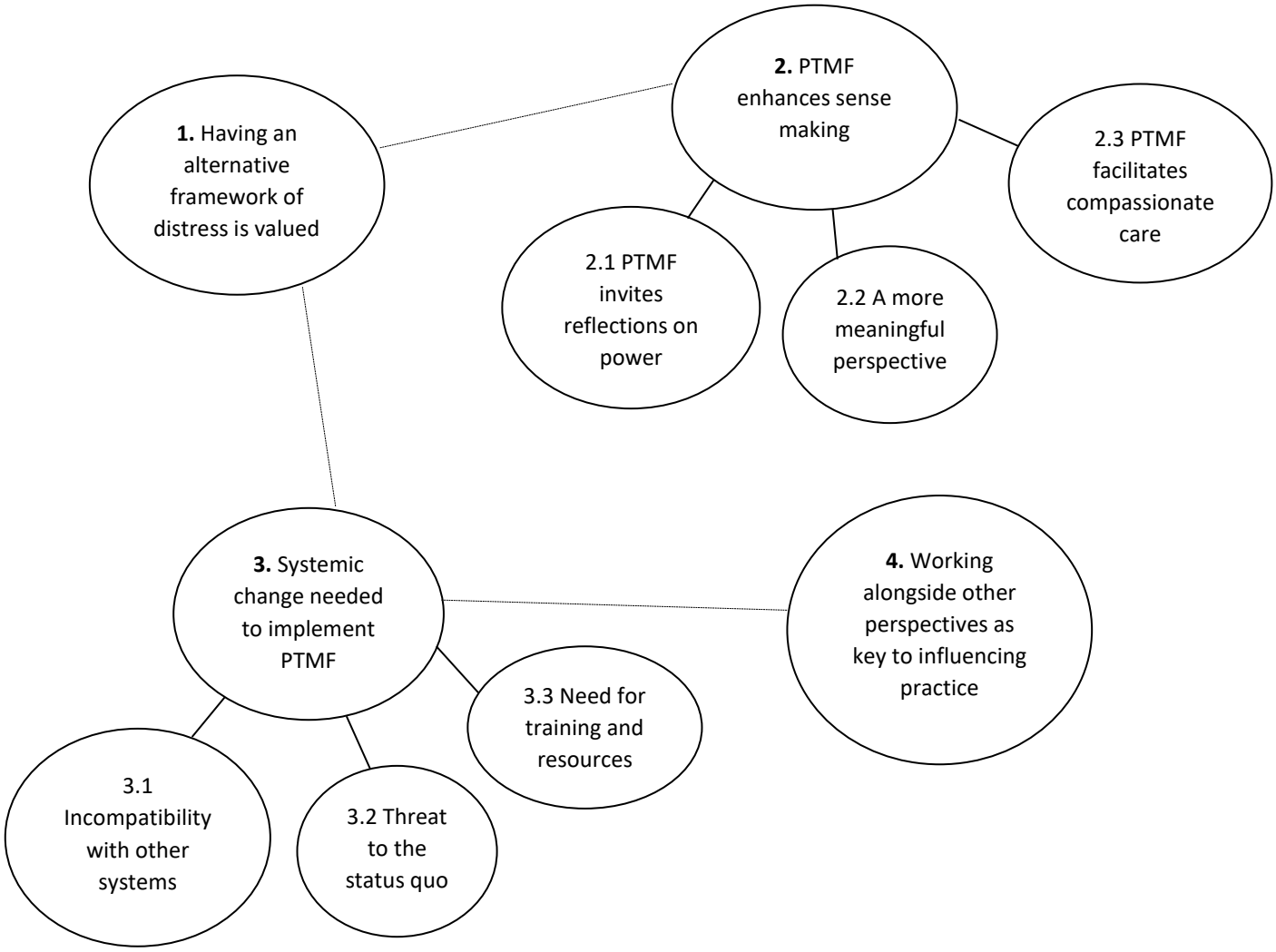
Eleven participants took part in the study. All worked as clinical psychologists within NHS adult mental health services in the UK. Eight worked primarily within the community, two in inpatient settings, and one across both types of service provision. All had previously attended conferences or professional training events related to the PTMF, and had used the PTMF in their practice for between one and five years.

Years since qualification ranged from four to 22 (mean = 8.5 years). Three males and eight females participated. The most common age range of participants was 30-39. Seven identified as White British or Irish, three as Asian or Asian British, and one as Black British.

Themes

Four themes were generated through the analysis: Having an alternative framework of distress is valued; PTMF enhances sense making; Systemic change needed to implement PTMF; and Working alongside other perspectives as key to influencing practice. A thematic map (Figure 1.) was created to illustrate the relationships between themes and subthemes.

Figure 1. Thematic map illustrating relationships between themes and subthemes



1. Having an alternative framework of distress is valued

This theme highlighted that having a coherent *"counter-narrative"* (Ppt 8.) to diagnostic practice was valued by participants. Having a published framework under the banner of BPS was felt to give justification and backing to the way that many participants felt they were already practicing. Some participants labelled themselves as critical psychologists who drew

on ideas from community psychology, and sought to incorporate a broader social and political context in their work with individuals and teams; being able to draw on the PTMF was therefore felt to compliment and strengthen existing practice.

> *"I was really excited when the framework came out and it was under the badge of the BPS. It felt like, suddenly, the things, the work that I do had an official stamp on it." (Ppt 6, p.1)*

Participants also felt that having a coherent, structured alternative to the medical model understanding of distress was also valued by service users and professionals, and that offering a different way of sense-making could facilitate trust and engagement for those who had previously found services unhelpful.

> *"I think if we'd kept pushing on that, you must accept this diagnosis, you must accept this way of framing things, [a service user] would have voted with her feet or with the chair. And, by having that flexibility, by having that alternative way of looking at this in her back pocket, it kept her in service" (Ppt 4, p.3)*

2. PTMF enhances sense making

This theme comprised three subthemes: PTMF invites reflections on power; a more meaningful perspective; and PTMF facilitates compassionate care. The PTMF was seen as providing a rich way of understanding service users' distress when used in formulation. This included using the PTMF guided discussion document with service users to explore how power has operated in a person's life, what threats this may have posed, and how a person may have made sense of this, as well as using these core questions within a team formulation space.

It commonly was felt that the PTMF provided a lens for making sense of experiences or behaviours, such as aggression or self-harm, by framing them as threat responses and placing

them in a meaningful context of people's experiences, with a particular focus on the impact of adversity. The PTMF could provide a way of foregrounding power and trauma in existing interventions, including within cognitive behavioural therapy, and within team formulation. As a result, participants felt that service users could be held in mind in a different way by staff, which could have an impact on care.

2.1 PTMF invites reflections on power

Exploring the role of power imbalances was one of the most valued elements of drawing on PTMF in participants' work. This included using the PTMF in team formulation to facilitate conversations about power imbalances within mental health services and the potential for services to replicate past experiences of trauma. Participants have observed multidisciplinary staff reflecting on the impact of power imbalances in service users' difficulties.

> *"If they are coming into an inpatient setting, what's happening with, every step of the pathway will recreate some form of adversity and the fact that teams can come back to us and say no we thought about their trauma and what would retraumatise them and how we can work collaboratively with them so they feel like they have agency rather than re-creating a power imbalance" (Ppt 3, p.4)*

2.2 A more meaningful perspective

Participants experienced the PTMF as offering a more meaningful perspective than traditional biomedical and biopsychosocial understandings of distress, and noted an impact on teams shifting towards reformulating service users' difficulties in a way that considered the role of past trauma and adversity.

"People ask questions about the people we work with histories with a genuine understanding that this is important rather than I'm just ticking this box on the triage form of my history." (Ppt 1, p.6)

"What [the PTMF] does, it gives you a fuller information about the person, as opposed to, well she's got OCD…and what are we going to do with that? You know, that tells us nothing. (Ppt 9, p. 10)

It was also felt that the PTMF could be used alongside existing psychological approaches, including cognitive behavioural therapy (CBT), to consider broader societal influences on distress. There was a sense that conversations about adversity, the operation of power and associated threats and meanings could be compatible with many evidence-based psychological therapies including CBT, compassion focused therapy, and acceptance and commitment therapy.

"I do think, if you feel confident and competent with your models, then actually, you can formulate with [the PTMF] using any of the therapy models; bringing in power and wider contextual factors." (Ppt 10, p.7)

2.3 PTMF Facilitates compassionate care

Participants felt that using PTMF to make sense of service users' difficulties with teams could facilitate a less blaming, more compassionate understanding than would otherwise be offered. Using the guided discussion document as the framework for team formulation was felt to facilitate a more empathic and empowering perspective within teams.

"If you can begin to understand the function of [self-harm], that it's a way of surviving unbearable stress and sadness and trauma and misery, it reframes it within

a much more compassionate way, rather than seeing it as a, a symptom of something that you should be able to control." (Pp4, p.3)

Participants found that this shift in thinking could translate into the way staff would then respond to service users by encouraging less restrictive practices.

"If we see [a service user] as this person is agitated and angry cause they've got schizophrenia, well of course it makes sense that we've got to do what we can as quickly as we can, to get a drug and to fix this, whereas if we see this as a person who's terrified, just the way we might approach them in terms of just maybe having less people around, saying something as simple as like 'it looks like you're really scared right now, it looks like you're feeling really unsafe right now', has a really big shift." (Ppt 1, p.6)

3. Systemic change needed to implement PTMF

This theme comprised three subthemes: Incompatibility with other systems; threat to the status quo; and need for training and resources. This theme captured the sense that there are limitations to the extent that the PTMF can be meaningfully implemented in practice without a wider cultural paradigm shift in mental health services, as called for by its authors. Trying to make use of the PTMF could therefore create challenges in communicating with other professionals as well as the public, given the dominance of the medical model. The PTMF was felt to be an ambitious project and at times participants were left feeling demoralised by working in silos without wider organisational support.

3.1 Incompatibility with other systems

Diagnostic practice was felt to be embedded across the systems in which participants worked – at an administrative, legal, and cultural level. Access to clinical and statutory

services were seen as dependent on the use of diagnosis, and thus this made it challenging for participants to meaningfully draw on PTMF as an alternative.

> *"One of the problems I have with the power threat meaning framework, when people criticise it very very importantly and say 'the department of work and pensions doesn't care about your formulation, the department of work and pensions want a diagnosis' and I don't think there was ever a satisfactory answer provided to that." (Ppt 2, p10)*

This theme also captured the difficulties with the complexity of the PTMF which, although seen as somewhat necessary, was also felt to hinder its use in fast-paced healthcare systems. The shorthand of diagnosis was felt to be well understood at a societal level as well as serving a valued function for communicating with other professionals.

> *"The fast-paced nature of the work especially in an acute setting, actually 100 percent its easier just to go medical and diagnostic … thinking about people in this way takes a lot more time" (Ppt 1, p.10)*

This theme also highlighted a sense of 'stuckness' that could come from locating distress at a societal level, whilst working within a system set up to offer intrapsychic interventions. At times, participants experienced hopelessness within their therapeutic work when sitting with an acknowledgement of the role oppressive power structures in the development and maintenance of distress.

> *"You know, if you are formulating someone's difficulties at the level of society, then it then gets you wondering, what do you as a person, sitting in this room for an hour a week, kind of do to change these massive mechanisms?" (Ppt 4, p.6)*

> *"So, in the one way, it's really daunting because it makes you realise how big the hurdles are and how many there are" (Ppt 7, p.13)*

This meant that, particularly during times of stress, the sense of certainty and agency offered by a more diagnostic led approach could be favoured. Strategies for managing this sense of hopelessness included engaging in community psychology approaches, public health campaigns, and political activism.

3.2 Threat to the status quo

The PTMF was felt to be divisive and threatening to the dominant narrative around mental health. Participants felt that colleagues in psychiatry as well as other clinical psychologists could be left feeling deskilled by the framework's criticisms of diagnosis and the individualisation of distress. This could lead to participants monitoring the extent that they openly supported the use of the PTMF with their team.

> *"Some people will find [the PTMF] really challenging because it's not what they've been trained to do or to understand. And some people will kind of feel a bit distanced or criticised by it." (Ppt 10, p.8)*

3.3. Need for training and resources

Persistence with change over time and "*chipping away*" (Ppt 5) slowly were perceived as necessary when drawing on the PTMF in current contexts and building towards wider cultural change. This could be supported by resources to scaffold change, and participants felt that there was a need for more guidance on implementation, more training for psychologists and other professionals, and jargon-free resources. Some participants had found they had time to create their own resources which could help with integrating the PTMF, whereas others had found this was beyond the scope of their role as a busy clinician. It was also felt that more opportunities to come together with other professionals using the framework would be valued.

"Training and teaching from, about the power threat meaning certainly, sort of taster sessions from the authors would be useful." (Ppt 8, p.15)

"I think it would also be really good to, for kind of, to work in less of a silo and reach out to other staff during their training" (Ppt 11, p.12)

Participants felt that change needed to be supported by both bottom-up and top-down initiatives, in that more organisational support would ultimately be necessary to implement a mental health paradigm shift.

"I wonder … whether it also needs to come from a higher point, you know, not just us trying to manage it within our own teams but maybe some kind of directorate type thing." (Ppt 5, p.11)

4. Working alongside other perspectives as key to influencing practice

Drawing on PTMF in team formulation or team discussions was thought to be aided by building good working relationships, crucially by collaborating across disciplines and with service users. Although all participants had led on introducing the PTMF into their services, being drawn into an 'expert' position was seen as unhelpful. There was a recognition of the importance of valuing all professional backgrounds; in practice this involved professionals from other disciplines facilitating team formulation meetings.

"It is definitely you know psychologically informed way of working but the fact that there are others that are senior clinicians across the MDT that are able to take a lead in facilitating is really important in being able to acknowledge the amount of trauma and adversity that we work with and that's really significant" (Ppt 3, p.3)

Being drawn into debates over 'PTMF vs diagnosis' or 'psychology vs psychiatry' was felt to be unhelpful for service users and teams. This theme captured the way participants commonly positioned the PTMF as a lens that could run alongside biomedical understandings

of distress as an addition rather than a direct challenge to this approach. A focus on flexibility, pragmatism and compromise with the medical model were emphasised as key strategies for influencing practice.

> *"I've pitched it as a separate story. But, potentially, sometimes a complementary story, an additional story. And I think that that probably has allowed for it to be less resisted." (Ppt 8, p.10)*

At times this positioning could be a strategic attempt to mitigate threats to other professionals and preserve relationships, but at other times reflected participants' belief in the value of holding multiple understandings of distress, of which PTMF could be one. The PTMF was not always felt to fit for service users or staff; participants recognised that diagnosis was valued by many individuals, for example, when describing neurodiversity. Recognising the limits of this approach and the need to draw on multiple understandings as part of a person-centred approach was emphasised.

> *"I absolutely agree with the principle about diagnosis being harmful and, you know, that absolutely aligns with my values and my beliefs. But, I don't think that is particularly helpful for practitioners working in health services whereby, you know, we work as MDT. And, that is of most benefit to service users and their families that you have a group of people coming together with different perspectives, different specialists and that the best way that we can benefit them is by bringing in all of our ideas and options." (Ppt 10, p.5)*

Discussion

The aim of this study was to consider the use of the power threat meaning framework by clinical psychologists, through a qualitative exploration of their experiences, including

possible impacts and challenges. A further aim was to explore implications of the findings for clinical practice and research.

The results of the thematic analysis indicated that the PTMF has been applied to clinical practice at multiple levels of clinical psychologists' work, including individual therapy, supervision, teaching, training, and team formulation. The theme 'having an alternative framework of distress is valued' captured the way that the PTMF was commonly viewed as fulfilling a need for a meta-framework of distress outside of the medical model. The theme 'PTMF enhances sense making' captured the way that the PTMF was felt to offer participants, their teams, and service users a meaningful way of understanding distress which centred on experiences of adversity and the impact of power imbalances, with tentative suggestions that this could lead to a more compassionate and non-blaming perspective.

However, the PTMF was considered largely incompatible with the wider organisational and cultural discourse around mental health, which could limit its use and create a sense of threat for other professional groups, as illustrated within the theme 'systemic change needed to implement PTMF'. The fourth theme, 'working alongside other perspectives as key to influencing practice' captured the flexible and collaborative approaches adopted by participants when drawing on the PTMF.

One challenge highlighted in the existing literature about working beyond diagnosis was the lack of alternative guidelines and frameworks (Randall & Coles, 2018; Weedon, 2017). A unique finding of this study was that the perceived BPS endorsement of the PTMF provided a sense of justification for those interested in embedding a non-diagnostic and trauma-informed approach within their clinical practice. Within individual therapy, participants had drawn on the PTMF primarily with individuals for whom a diagnostic approach had been experienced as unhelpful. Being able to offer something different to the

usual framing of mental health ‘disorders’ was perceived as being valued by some service users, consistent with the idea that non-diagnostic alternatives can introduce choice and empower individuals to develop their own narrative about their difficulties (Mitchell & Thorne, 2019; Randall & Coles, 2018). In practice, this involved using the PTMF guided discussion document and the framework’s core questions within individual assessments, and as a formulation template that could be shared with other staff through training and consultation.

The findings have also given coherence to and extended some of the more anecdotal claims that the PTMF offers a compassionate and empowering perspective on emotional distress and unusual experiences (e.g. Bostock & Armstrong, 2019). In particular, some of the benefits of using the PTMF experienced by participants included raising awareness of the potential for mental health services to overtly and covertly replicate past experiences of adversity or abuse, through their use of coercion, control, and restrictive practices. This finding suggests that the PTMF provided psychologists with a model for introducing the principles of trauma-informed practice (Harris & Fallot, 2001), a shift that aligns with the policy context for mental health services both in the UK and internationally (e.g. Mental Health Co-ordinating Council 2013; NHS, 2019).

By using the PTMF in team formulation to generate a shared understanding of service user’s difficulties, participants felt that they were able to facilitate a compassionate perspective by reflecting on the links between past experiences of disempowerment and current threat responses. They gave examples of colleagues openly reflecting about the role of power imbalances, threat responses, and re-traumatisation outside of the meetings, indicating that professionals can internalise and apply aspects of the PTMF to their practice. The finding that team formulation sessions using the PTMF were felt to facilitate staff’s understanding and empathy towards service users is consistent with the existing literature on

team formulation (e.g. Berry et al., 2017). Uniquely, these findings also tentatively highlight that the PTMF may lead to staff reflection on the importance of the role of societal systems of power and oppression (such as racism, sexism, and classism), which other theoretical models may not cover. The literature on using the PTMF as part of team formulation remains in its infancy, and thus it is recommended that clinicians continue to seek feedback and evaluate the impact of team formulation in accordance with the principles of practice-based evidence (Barkham & Mellor-Clark, 2003).

Diagnostic practice was felt to be embedded within all structures, from clinical notes systems to public health messaging, which presented challenges in applying the PTMF as a meaningful alternative. The academic language and format of the PTMF was also felt to hinder communication with other agencies and the public, compared to what Aherne describes as the "marketable" messaging of the medical model (Aherne, 2019, p.5).

Influencing systemic change in the conceptualisation of distress was thought to require top-down support as well as the bottom-up efforts of individual clinicians and grassroots service user and survivor groups. This is consistent with the assertion that a lack of managerial and organisational guidance can hinder the adoption of TIC principles by clinicians (Isobel, 2015; Isobel & Edwards, 2017). Bronfenbrenner's ecological systems model (1979) offers a theoretical framework for understanding the multiple levels at which clinical psychologists may be able to engage in order to influence systemic change. Implementing the PTMF more widely would likely require engaging those working at the 'macro' level, such as within academic publishing, public health policy, and the media. Clinical psychologists may therefore benefit from drawing on the extensive community psychology literature to inform their practice (e.g. Orford, 1992; Walker et al., 2022).

Brown's (2018) claim that "if the PTMF was fully implemented, it is questionable whether clinical psychology, or any other [mental health] profession – would even exist in their current form" captures the tensions experienced by clinical psychologists in this study. Participants acknowledged the limitations of psychological therapy alone in addressing societal power imbalances and often looked outside of the therapy room for opportunities to work on community psychology projects or engage in activism, such as political protests, outside of work, similar to participants in Cooke et al.'s study (2019). Findings also suggested that psychologists in this study recognised that a more individually focused and diagnostic approach could provide teams with a sense purpose and agency, similar to Mason's concept of safe certainty (Mason, 1993). Accordingly, there are likely to be added complexities for those using the PTMF in fast-paced and outcome-focused settings such as acute and crisis care, particularly within underfunded or understaffed services.

Consistent with recent accounts (e.g. Barnes et al., 2022), participants commonly reported that the diagnostic model remains the dominant approach within adult mental health services. Participants varied in the extent to which they chose to directly challenge this approach, but frequently positioned the PTMF as an addition rather than something in opposition to the medical model, most closely aligning with the strategy of 'compromise' over 'conflict' or 'collusion' as described in Cooke et al.'s (2019) model. This finding supports Randall and Cole's (2018) concept of 'playing the diagnostic game' in that participants described compromising their own beliefs about the limitations of psychiatric diagnosis in order to preserve professional relationships and maintain power. This positioning suggests that despite the feeling of being backed by their professional body, there continued to be a sense of trepidation at questioning diagnoses. Respecting the expertise of colleagues from different professional backgrounds, seeking opportunities to share responsibility for forums such as team formulation with other disciplines, and offering alternative hypotheses

tentatively from a non-expert position were some of the approaches that enabled psychologists to challenge this dominant discourse. These findings align with the wider literature on introducing change into systems, which emphasises the importance of professional relationships and working with those already open to change (Alvession & Sveningsson 2015).

Participants also emphasised the need to hold the PTMF's position lightly, recognising that it had not been a useful tool for all clinicians or service users and that many will find meaning, validation, and solidarity in a mental health diagnosis. Relatedly, a recent study of service users' perspectives on diagnosis and its alternatives found that framing people's difficulties as 'normal responses' to their circumstances can lead individuals to feel that the severity of their distress is not being acknowledged (Varney, 2021). Working in a truly multidisciplinary and person-centred way where pluralistic understandings of distress were valued and service users were provided with choice about their care emerged as a goal for psychologists in this study, an approach consistent with recent accounts of both staff and patient preferences for collaborative and multidisciplinary models of care (Barnes et al., 2022; Klingemann et al, 2020).

Strengths and limitations

This study analysed accounts from eleven individuals using a clear and robust methodology. The sample size was considered satisfactory for a qualitative study of this nature (Braun & Clarke, 2013), and demographic data suggests that the sample was representative of the clinical psychology workforce (BPS, 2015). However, participants were a self-selected sample who could have been biased towards positive experiences of engaging with the PTMF. Participants were also aware that the researcher was a trainee clinical psychologist with an interest in the PTMF, which could have impacted on what they chose to disclose in the interview. However, steps were taken to reduce bias and enhance the quality

of the research; an open-ended interview schedule did not limit any responses and explicitly asked about challenges and unhelpful aspects of the PTMF; the analysis process was reviewed and discussed within supervision to ensure its credibility; and the researcher engaged in a reflexive process to acknowledge and bracket their own views and assumptions.

The epistemological positioning of this qualitative study meant that it did not aim to achieve statistical-probabilistic generalisability in the positivist sense (Smith, 2018). By generating new conceptual insights and interpreting these in the context of existing literature, the study can be said to have 'analytic generalisability' (Smith, 2018). Providing contextual information also allows for 'transferability', in that readers are able to make a judgement about whether results may be applicable to local contexts (Smith, 2018).

The research question warranted a focus on the experiences of clinical psychologists in order to explore the perspective of those who may have a role in introducing the PTMF to multidisciplinary professionals, as well as shaping service design and delivery. This meant that the experiences of individuals accessing services as well as other professionals were not heard in this research; however, an individual with lived experience of accessing adult mental health services who was familiar with the PTMF provided consultation on the design of the study and development of the interview schedule to enhance the quality and clinical relevance of the research.

Research implications

Researchers could explore application of the PTMF within specialties other than adult mental health (e.g. child or learning disabilities settings) and whether similar or different impacts and challenges are present, which may continue to shed light on the implementation of the PTMF. Building on current findings, which have highlighted both the opportunities and challenges of working across disciplines, research with other professions including

psychiatry would be a valuable next step in understanding multidisciplinary views on the PTMF.

Further research could also build on the current finding that PTMF may enhance reflections on power and ultimately support more compassionate approaches to care. Researchers could for example study whether team formulation approaches using the PTMF lead to different outcomes (e.g. in terms of levels of compassion or reflection on power imbalances) in multidisciplinary staff compared to team formulation based on other models, and whether these findings are consistent across presenting difficulties. Future research could also seek to measure whether introducing the PTMF into a service though team formulation or training has any impact on clinical outcomes, an area not explored in this study.

Implications for practice

This study has highlighted the potential utility of the PTMF as a framework in team formulations, particularly to foster considerations of power, as well as its possible utility within therapeutic work, where it has been used within assessments, formulations, and interventions to offer an alternative understanding of distress. The findings have implications for psychologists who are interested in applying the PTMF in their work:

- Collaborate across disciplines so that ownership of initiatives involving PTMF is shared with colleagues

- Build on good working relationships with those already open to psychological perspectives

- Consider engaging at a macro level e.g. working with public health campaigns such as anti-stigma campaigns to increase public awareness of alternatives to the medical model

- Consider the role of buy-in from more senior management e.g. at a directorate level to support any initiatives involving PTMF

The findings of this study also suggest that clinical psychologists could benefit from more guidance from their professional bodies around implementation, particularly regarding navigating the time needed for reflection when using the PTMF within the target-driven culture of healthcare. Participants suggested that more training and supervision opportunities informed by the PTMF would be valued. Findings also indicated that there is a need for more accessible resources to share with colleagues and service users, such as short video summaries of the framework's principles.

Conclusion

This study has enriched our understanding of an approach which is gaining interest and momentum within the profession of clinical psychology. The findings have emphasised that applying the PTMF to practice is a challenging process with mental health services currently dominated by a diagnostic approach, with recommendations made for multi-disciplinary and collaborative approaches to care.

Where clinicians are able to negotiate these challenges, the PTMF may offer an empowering and compassionate approach to mental health care that can provide both teams and service users with an alternative understanding of distress. However, as yet there is little research evidence that applying the PTMF in mental health settings leads to improvements in service provision and clinical outcomes. Ongoing research into the use of the framework is required to further understand the impact of applying the PTMF and its role both within and beyond mental health services.

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Appendices

Appendix A. Guidelines for Authors – Journal of Mental Health Training, Education and Practice (Target journal for paper 1)

Appendix B. Systematic review search strategy

Appendix C. Guidelines for Authors – Clinical Psychology and Psychotherapy (Target journal for paper 2)

Appendix D. Study advert

Appendix E. Ethical approval

Appendix F. Participant information sheet

Appendix G. Participant consent form

Appendix H. Demographics questionnaire

Appendix I. Participant debrief sheet

Appendix J. Interview schedule

Appendix K. Transcriber confidentiality agreement

Appendix L. Example of data coding

Appendix M. Example of initial clustering of codes

Appendix N. Table of theme development

Appendix O. Research diary extract

Appendix A. Guidelines for Authors – Journal of Mental Health Training Education and Practice (Target journal for paper 1)

Manuscript requirements

Before you submit your manuscript, it's important you read and follow the guidelines below. You will also find some useful tips in our structure your journal submission how-to guide.

Format	Article files should be provided in Microsoft Word format While you are welcome to submit a PDF of the document alongside the Word file, PDFs alone are not acceptable. LaTeX files can also be used but only if an accompanying PDF document is provided. Acceptable figure file types are listed further below.
Article length / word count	Articles should be between 3500 and 6500 words in length. This includes all text, for example, the structured abstract, references, all text in tables, and figures and appendices. Please allow 350 words for each figure or table.
Article title	A concisely worded title should be provided.
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Biographies and acknowledgements	If you want to include these items, save them in a separate Microsoft Word document and upload the file with your submission. Where they are included, a brief professional biography of not more than 100 words should be supplied for each named author.
Research funding	Your article must reference all sources of external research funding in the acknowledgements section. You should describe the role of the funder or financial sponsor in the entire research process, from study design to submission.

Structured abstract	All submissions must include a structured abstract, following the format outlined below. These four sub-headings and their accompanying explanations must always be included: • Purpose • Design/methodology/approach • Findings • Originality The following three sub-headings are optional and can be included, if applicable: • Research limitations/implications • Practical implications • Social implications You can find some useful tips in our write an article abstract how-to guide. The maximum length of your abstract should be 250 words in total, including keywords and article classification (see the sections below).
Keywords	Your submission should include up to 12 appropriate and short keywords that capture the principal topics of the paper. Our Creating an SEO-friendly manuscript how to guide contains some practical guidance on choosing search-engine friendly keywords. Please note, while we will always try to use the keywords you've suggested, the in-house editorial team may replace some of them with matching terms to ensure consistency across publications and improve your article's visibility.
Article classification	During the submission process, you will be asked to select a type for your paper; the options are listed below. If you don't see an exact match, please choose the best fit: • Expert opinion paper/ viewpoint • Research Paper • Literature Review • Impact case study • Conceptual paper • Service user perspective • Case Study • Book Review You will also be asked to select a category for your paper. The options for this are listed below. If you don't see an exact match, please choose the best fit: Research paper. Reports on any type of research undertaken by the author(s), including: • The construction or testing of a model or framework • Action research • Testing of data, market research or surveys • Empirical, scientific or clinical research • Papers with a practical focus Viewpoint. Covers any paper where content is dependent on the author's opinion and interpretation. This includes journalistic and magazine-style pieces.

	Technical paper. Describes and evaluates technical products, processes or services. Conceptual paper. Focuses on developing hypotheses and is usually discursive. Covers philosophical discussions and comparative studies of other authors' work and thinking. Case study. Describes actual interventions or experiences within organizations. It can be subjective and doesn't generally report on research. Also covers a description of a legal case or a hypothetical case study used as a teaching exercise. Literature review. This category should only be used if the main purpose of the paper is to annotate and/or critique the literature in a particular field. It could be a selective bibliography providing advice on information sources, or the paper may aim to cover the main contributors to the development of a topic and explore their different views. General review. Provides an overview or historical examination of some concept, technique or phenomenon. Papers are likely to be more descriptive or instructional ('how to' papers) than discursive.
Headings	Headings must be concise, with a clear indication of the required hierarchy. The preferred format is for first level headings to be in bold, and subsequent sub-headings to be in medium italics.
Notes/endnotes	Notes or endnotes should only be used if absolutely necessary. They should be identified in the text by consecutive numbers enclosed in square brackets. These numbers should then be listed, and explained, at the end of the article.
Figures	All figures (charts, diagrams, line drawings, webpages/screenshots, and photographic images) should be submitted electronically. Both colour and black and white files are accepted. There are a few other important points to note: • All figures should be supplied at the highest resolution/quality possible with numbers and text clearly legible. • Acceptable formats are .ai, .eps, .jpeg, .bmp, and .tif. • Electronic figures created in other applications should be supplied in their original formats and should also be either copied and pasted into a blank MS Word document, or submitted as a PDF file. • All figures should be numbered consecutively with Arabic numerals and have clear captions. • All photographs should be numbered as Plate 1, 2, 3, etc. and have clear captions.
Tables	Tables should be typed and submitted in a separate file to the main body of the article. The position of each table should be clearly labelled in the main body

	of the article with corresponding labels clearly shown in the table file. Tables should be numbered consecutively in Roman numerals (e.g. I, II, etc.). Give each table a brief title. Ensure that any superscripts or asterisks are shown next to the relevant items and have explanations displayed as footnotes to the table, figure or plate.
References	All references in your manuscript must be formatted using one of the recognised Harvard styles. You are welcome to use the Harvard style Emerald has adopted – we've provided a detailed guide below. Want to use a different Harvard style? That's fine, our typesetters will make any necessary changes to your manuscript if it is accepted. Please ensure you check all your citations for completeness, accuracy and consistency. Emerald's Harvard referencing style References to other publications in your text should be written as follows: • Single author: (Adams, 2006) • Two authors: (Adams and Brown, 2006) • Three or more authors: (Adams *et al.*, 2006) Please note, '*et al*' should always be written in italics. A few other style points. These apply to both the main body of text and your final list of references. • When referring to pages in a publication, use 'p.(page number)' for a single page or 'pp.(page numbers)' to indicate a page range. • Page numbers should always be written out in full, e.g. 175-179, not 175-9. • Where a colon or dash appears in the title of an article or book chapter, the letter that follows that colon or dash should always be lower case. • When citing a work with multiple editors, use the abbreviation 'Ed.s'. At the end of your paper, please supply a reference list in alphabetical order using the style guidelines below. Where a DOI is available, this should be included at the end of the reference.
For books	Surname, initials (year), *title of book*, publisher, place of publication. e.g. Harrow, R. (2005), *No Place to Hide*, Simon & Schuster, New York, NY.
For book chapters	Surname, initials (year), "chapter title", editor's surname, initials (Ed.), *title of book*, publisher, place of publication, page numbers. e.g. Calabrese, F.A. (2005), "The early pathways: theory to practice – a continuum", Stankosky, M. (Ed.), *Creating the Discipline of Knowledge Management*, Elsevier, New York, NY, pp.15-20.
For journals	Surname, initials (year), "title of article", *journal name*, volume issue, page numbers.

	e.g. Capizzi, M.T. and Ferguson, R. (2005), "Loyalty trends for the twenty-first century", *Journal of Consumer Marketing*, Vol. 22 No. 2, pp.72-80.
For published conference proceedings	Surname, initials (year of publication), "title of paper", in editor's surname, initials (Ed.), *title of published proceeding which may include place and date(s) held*, publisher, place of publication, page numbers. e.g. Wilde, S. and Cox, C. (2008), "Principal factors contributing to the competitiveness of tourism destinations at varying stages of development", in Richardson, S., Fredline, L., Patiar A., & Ternel, M. (Ed.s), *CAUTHE 2008: Where the 'bloody hell' are we?*, Griffith University, Gold Coast, Qld, pp.115-118.
For unpublished conference proceedings	Surname, initials (year), "title of paper", paper presented at [name of conference], [date of conference], [place of conference], available at: URL if freely available on the internet (accessed date). e.g. Aumueller, D. (2005), "Semantic authoring and retrieval within a wiki", paper presented at the European Semantic Web Conference (ESWC), 29 May-1 June, Heraklion, Crete, available at: http://dbs.uni-leipzig.de/file/aumueller05wiksar.pdf (accessed 20 February 2007).
For working papers	Surname, initials (year), "title of article", working paper [number if available], institution or organization, place of organization, date. e.g. Moizer, P. (2003), "How published academic research can inform policy decisions: the case of mandatory rotation of audit appointments", working paper, Leeds University Business School, University of Leeds, Leeds, 28 March.
For encyclopaedia entries (with no author or editor)	*Title of encyclopaedia* (year), "title of entry", volume, edition, title of encyclopaedia, publisher, place of publication, page numbers. e.g. *Encyclopaedia Britannica* (1926), "Psychology of culture contact", Vol. 1, 13th ed., Encyclopaedia Britannica, London and New York, NY, pp.765-771. (for authored entries, please refer to book chapter guidelines above)
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For newspaper articles (non-authored)	*Newspaper* (year), "article title", date, page numbers. e.g. *Daily News* (2008), "Small change", 2 February, p.7.
For archival or other unpublished sources	Surname, initials (year), "title of document", unpublished manuscript, collection name, inventory record, name of archive, location of archive. e.g. Litman, S. (1902), "Mechanism & Technique of Commerce", unpublished manuscript, Simon Litman Papers, Record series 9/5/29 Box 3, University of Illinois Archives, Urbana-Champaign, IL.
For electronic sources	If available online, the full URL should be supplied at the end of the reference, as well as the date that the resource was accessed.

	Surname, initials (year), "title of electronic source", available at: persistent URL (accessed date month year). e.g. Weida, S. and Stolley, K. (2013), "Developing strong thesis statements", available at: https://owl.english.purdue.edu/owl/resource/588/1/ (accessed 20 June 2018) Standalone URLs, i.e. those without an author or date, should be included either inside parentheses within the main text, or preferably set as a note (Roman numeral within square brackets within text followed by the full URL address at the end of the paper).
For data	Surname, initials (year), *title of dataset*, name of data repository, available at: persistent URL, (accessed date month year). e.g. Campbell, A. and Kahn, R.L. (2015), *American National Election Study, 1948*, ICPSR07218-v4, Inter-university Consortium for Political and Social Research (distributor), Ann Arbor, MI, available at: https://doi.org/10.3886/ICPSR07218.v4 (accessed 20 June 2018)

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You will find a helpful submission checklist on the website Think.Check.Submit.

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All manuscripts should be submitted through our editorial system by the corresponding author.

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While all journals work to different timescales, the goal is that the editor will inform you of their first decision within 60 days.

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Need to make a change to the author list? See our frequently asked questions (FAQs) below.

Appendix B: Systematic Review search Strategy

Full search details for PsycInfo:

Line	Search Term	Results
1	mental health professional*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	17423
2	mental health nurs*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	3366
3	psychiatric nurs*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	7987
4	psychologist*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	97679
5	counsel*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	131809
6	psychiatrist*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	43413
7	social work*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	51234
8	psychotherapist*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	20358
9	mental health service*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	64683
10	psychiatric staff.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	353
11	therapist*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	95196
12	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11	444726
13	trainee*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	19607
14	doctorate.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	1552
15	doctoral.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	11064
16	training.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	298863
17	masters.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	8582
18	student*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	679231
19	intern.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	1160
20	interns.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	2415
21	internship.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	4153
22	13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21	928031
23	12 and 22	119353

24	psychology trainee*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	503
25	psychology doctora* student*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	296
26	psychiatric trainee*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	359
27	(doctoral trainee* adj2 psychology).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	21
28	burnout.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	15328
29	burn* out.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	1086
30	compassion fatigue*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	1341
31	occupational stress.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	23361
32	empathy fatigue*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	16
33	exp occupational stress/	22990
34	emotional exhaustion/	1071
35	28 or 29 or 30 or 31 or 32 or 33 or 34	29769
36	exp clinical psychology graduate training/	3309
37	therapist trainees/	1920
38	graduate psychology education/	4677
39	24 or 25 or 26 or 27	1159
40	23 or 39	119711
41	35 and 40	1400
42	36 or 37 or 38 or 40	123106
43	35 and 42	1401

Search String for databases:

Database	Search terms	Results (total = 4211)
PsycInfo and Medline	((("mental health professional*" OR "mental health nurs*" OR "psychiatric nurs*" OR "psychologist*" OR "counsel*" OR "psychiatrist*" OR "social work*" OR psychotherapist* OR " mental health service*" OR "psychiatric staff" OR "therapist*") AND ("trainee*" OR doctorate OR doctoral* OR training OR masters OR student* OR intern OR interns OR internship)) OR (("psychology trainee*" OR "psychology doctora* student*" OR "psychiatric trainee*" OR doctoral AND trainee* adj2 psychology))) AND ((burnout OR "burn* out" OR "compassion fatigue*" OR "occupational stress" OR "empathy fatigue*" OR "emotional* exhaust*"))	1401 (psycinfo) 412 (medline)
CINAHL	((("mental health professional*" OR "mental health nurs*" OR "psychiatric nurs*" OR "psychologist*" OR "counsel*" OR "psychiatrist*" OR "social work*" OR psychotherapist* OR " mental health service*" OR "psychiatric staff" OR "therapist*") AND ("trainee*" OR doctorate OR doctoral* OR training OR masters OR student* OR intern OR interns OR internship)) OR (("psychology trainee*" OR "psychology doctora* student*" OR "psychiatric trainee*" OR doctoral AND trainee* N2 psychology))) AND ((burnout OR "burn* out" OR "compassion fatigue*" OR "occupational stress" OR "empathy fatigue*" OR "emotional* exhaust*"))	488
Web of Science	TS=((("mental health professional*" OR "mental health nurs*" OR "psychiatric nurs*" OR "psychologist*" OR "counsel*" OR "psychiatrist*" OR "social work*" OR psychotherapist* OR " mental health service*" OR "psychiatric staff" OR "therapist*") AND ("trainee*" OR doctorate OR doctoral* OR training OR masters OR student* OR intern OR interns OR internship)) OR TOPIC: (("psychology trainee*" OR "psychology doctora* student*" OR "psychiatric trainee*" OR doctoral AND trainee* NEAR/2 psychology))) AND TS=((burnout OR "burn* out" OR "compassion fatigue*" OR "occupational stress" OR "empathy fatigue*" OR "emotional* exhaust*"))	912
SCOPUS	(((TITLE-ABS-KEY ("mental health professional*" OR "mental health nurs*" OR "psychiatric nurs*" OR "psychologist*" OR "counsel*" OR "psychiatrist*" OR "social work*" OR psychotherapist* OR " mental health service*" OR "psychiatric staff" OR "therapist*") AND TITLE-ABS-KEY ("trainee*" OR doctorate OR doctoral* OR training OR masters OR student* OR intern OR interns OR internship))) OR ((TITLE-ABS-KEY ("psychology trainee*" OR "psychology doctora* student*" OR "psychiatric trainee*" OR doctoral AND trainee* W/2	998

	psychology)))) AND ((TITLE-ABS-KEY (burnout OR "burn* out" OR "compassion fatigue*" OR "occupational stress" OR "empathy fatigue*" OR "emotional* exhaust*")))

Appendix C. Guidelines for authors – Clinical Psychology and Psychotherapy (Target journal of paper 2)

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a meeting or symposium.

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For help with submissions, please contact the Editorial Office at **CPPedoffice@wiley.com**

Clinical Psychology & Psychotherapy aims to keep clinical psychologists and psychotherapists up to date with new developments in their fields. The Journal will provide an integrative impetus both between theory and practice and between different orientations within clinical psychology and psychotherapy. *Clinical Psychology & Psychotherapy* will be a forum in which practitioners can present their wealth of expertise and innovations in order to make these available to a wider audience. Equally, the Journal will contain reports from researchers who want to address a larger clinical audience with clinically relevant issues and clinically valid research. The journal is primarily focused on clinical studies of clinical populations and therefore no longer normally accepts student-based studies.

This is a journal for those who want to inform and be informed about the challenging field of clinical psychology and psychotherapy.

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Before you submit, you will need:

- Your manuscript: this should be an editable file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract (which does need to be correctly styled), introduction,

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- The title page of the manuscript, including:
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        - funding statement
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        - clinical trial registration [OPTIONAL TEXT, if the journal has a double-blind peer review policy: Important: the journal operates a double-blind peer review policy. Please anonymise your manuscript and supply a separate title page file.]

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Measures Article: Articles reporting useful information and data about new or existing measures (assessment submissions should be limited to a maximum of 3,500 words).

Clinical Report: Shorter articles (a maximum of 2,000 words excluding captions and references) that typically contain interesting clinical material. These should use (validated) quantitative measures and add substantially to the literature (i.e. be innovative).

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Please provide five-six keywords (see **Wiley's best practice SEO tips**).

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2. Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

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For more information about APA referencing style, please refer to the **APA FAQ**.

Reference examples follow:

Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry, 159,* 483–486. doi: **10.1176/appi.ajp.159.3.483**

Book
Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document
Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from *http://www.youtube.com/watch?v=Vja83KLQXZs*

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Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

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Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

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4. **Trade Names:** Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses.

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3. Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; and
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Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in the Acknowledgements statement (e.g., to recognize contributions from people who provided technical help, collation of data, writing assistance, acquisition of funding, or a department chairperson who provided general support). Prior to submitting the article all authors should agree on the order in which their names will be listed in the manuscript.

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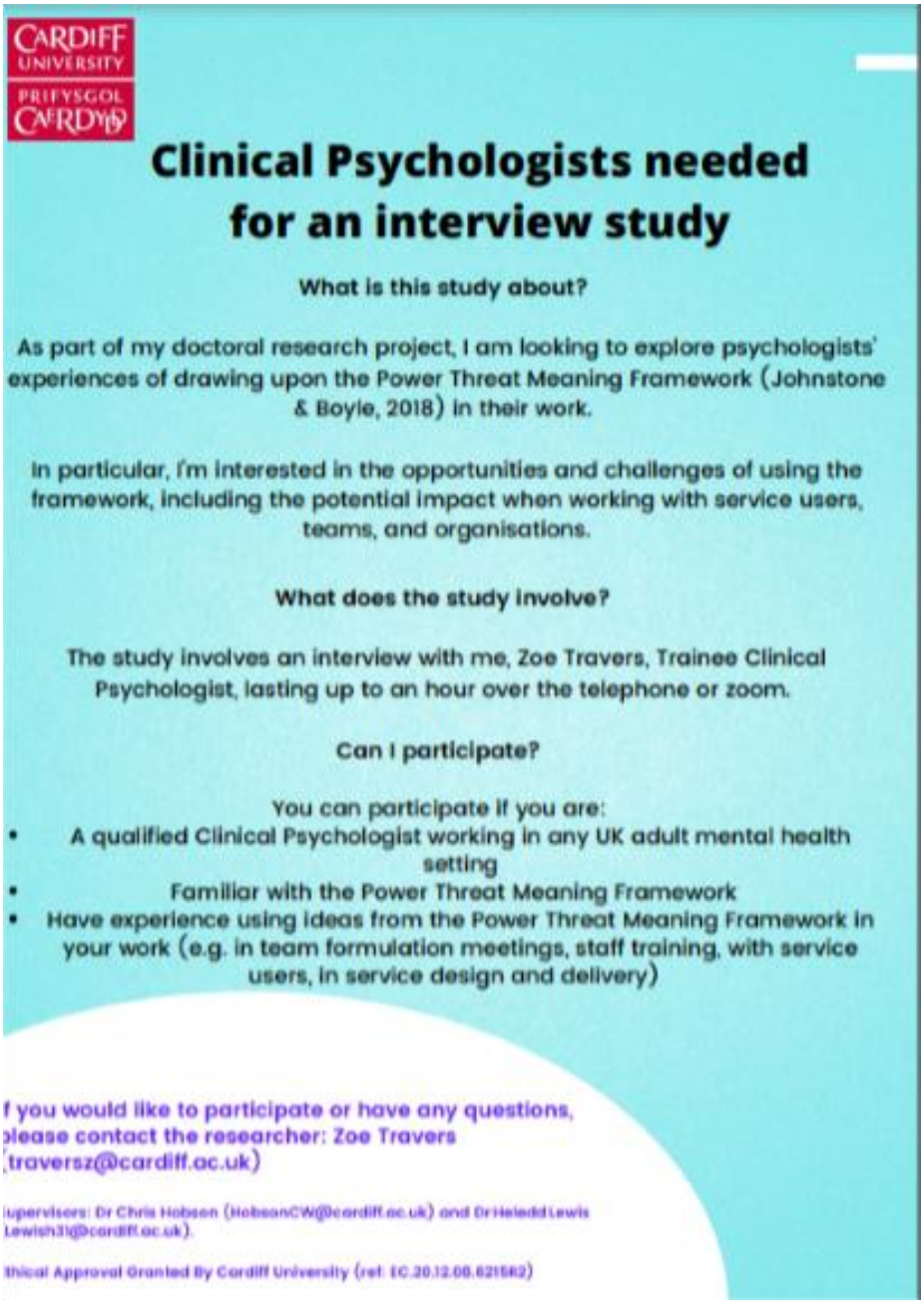
Appendix D. Study advert



Appendix E. Ethical approval

Ethics Feedback - EC.20.12.08.6215R2

psychethics <psychethics@cardiff.ac.uk>
Wed 17/02/2021 13:17
To: Zoe Travers <TraversZ@cardiff.ac.uk>
Cc: Christopher Hobson <HobsonCW@cardiff.ac.uk>

Dear Zoe,

The Ethics Committee has considered your revised PG project proposal: Integrating the Power Threat Meaning Framework (PTMF) into Clinical Practice in Mental Health Settings; A Qualitative Exploration of Clinicians' Experiences (EC.20.12.08.6215R2).

The project has been approved.

Please note that if any changes are made to the above project then you must notify the Ethics Committee.

Best wishes,
Sarah on behalf of Adam Hammond

School of Psychology Research Ethics Committee

Cardiff University Tower Building 70 Park Place Cardiff CF10 3AT	Prifysgol Caerdydd Adeilad y Tŵr 70 Plas y Parc Caerdydd CF10 3AT
Tel: +44(0)29 208 70360 Email: psychethics@cardiff.ac.uk http://psych.cf.ac.uk/aboutus/ethics.html	Ffôn: +44(0)29 208 70360 E-bost: psychethics@caerdydd.ac.uk

Please note that I do not expect a response to this email outside of your normal working hours
Nid wyf yn disgwyl ymateb i'r ebost hwn y tu allan i'ch oriau gwaith arferol

Appendix F. Participant information sheet

Participant information sheet

Title of Research Project: Integrating the Power Threat Meaning Framework (PTMF) into Clinical Practice in Mental Health Settings; A Qualitative Exploration of Psychologists' Experiences.

You are being invited to take part in a research study. Please take time to read the information below before you decide whether you would like to participate. This research study is being conducted by a Trainee Clinical Psychologist, Zoe Travers, who is studying for the Doctorate in Clinical Psychology at Cardiff University. Please do ask the researcher, Zoe Travers, if you have any questions about the research.

What is the study for?

This study is looking at psychologists' views and experiences regarding using the Power Threat Meaning Framework into their clinical practice. This research aims to improve our understanding of the experience of using the framework.

Why have I been invited to take part?

You have been invited to participate because you are a clinical psychologist working in the UK, who has used the power threat meaning framework in their work. It is important to remember that participation or non-participation in this study will have no bearing on your present or future employment.

What will the study involve?

If you agree to participate, you will be invited to take part in an interview with Zoe Travers, trainee Clinical Psychologist. You will be interviewed via telephone or zoom about your work experiences of using the framework in an adult mental health context. The interview will last up to an hour. The interview will be audio recorded on an encrypted device. Following this, the interview will be transcribed and anonymised.

What will happen next?

If you agree to participate, you will be contacted to arrange an interview.

Will there be any benefits to taking part?

There are no explicit benefits of taking part.

It is hoped that the study will lead to an increased understanding about the experience of using the framework, and thus may have implications for clinical practice or further research.

Are there any disadvantages of taking part?

Completing the interview will take up to an hour outside of your working hours. The study will invite you to reflect on your experiences at work. It is unlikely that there will be a negative impact of taking part in the study, but a debrief will be provided with the researcher.

Do I have to take part in the study?

No. It is your choice whether or not to participate. If you decide to participate you will be asked to sign a consent form. However, you are still free to withdraw at any point without having to give a reason.

What will happen to my data?

The interview will be audio recorded using an encrypted device. The recordings will then be transcribed, and all information will be anonymised at the point of transcription. This means that no identifiable information such as your name, geographical location or where you work will be linked to your data. A numerical code will be assigned to your data and will be used to link the consent form and audio recording to the anonymised transcript.

Direct quotes will be used in the final report, however they will not be paired with identifiable information. Made up names will be used to replace your name and will accompany direct quotes and basic demographic information such as years of experience.

The encrypted recordings will be securely sent to a transcribing service who are experienced in handling research data and have their own data storage arrangements. Recordings will be deleted following transcription and the anonymised transcripts will be kept for 5 years in a secure location to maintain confidentiality. The transcripts will be stored on a password protected computer.

If you disclose information which relates to your own or others safety, your confidentiality may be waivered. In this case, discussions regarding how to best ensure your own and others' safety will also be held with the other named researchers (as below).

What will happen to the results?

The results of the study will form part of a Doctoral Thesis in Clinical Psychology. They may also be written up for publication in academic journals. A summary of the research findings will be made available to you after the study has been completed.

Who else is involved in this research?

Project Lead: Zoe Travers, Trainee Clinical Psychologist (traversz@cardiff.ac.uk; Tel: 02920870582; Address: South Wales Doctoral Programme in Clinical Psychology, 11th Floor, School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT);

Supervisors: Dr Chris Hobson, Senior Clinical Tutor (HobsonCW@cardiff.ac.uk; Tel: 02920870582 Address: South Wales Doctoral Programme in Clinical Psychology, 11th Floor, School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT));

Dr Heledd Lewis, Senior Clinical Tutor (Lewish31@cardiff.ac.uk; Tel: 02920870582 Address: South Wales Doctoral Programme in Clinical Psychology, 11th Floor, School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT));

What if I have concerns about this research?

If you have any concerns or complaints about this project, please direct these in the first instance to: psychethics@cardiff.ac.uk

The data controller is Cardiff University and the Data Protection Officer is James Merrifield. The lawful basis for the processing of the data you provide is consent.

Thank you for taking the time to read this information sheet.

Appendix G. Participant consent form

Participant Consent Form:

Title of Research: Integrating the Power Threat Meaning Framework (PTMF) into Clinical Practice in Mental Health Settings; A Qualitative Exploration of Psychologists' Experiences.

Research Team:

Project Lead: Zoe Travers, Trainee Clinical Psychologist (traversz@cardiff.ac.uk; Tel: 02920870582; Address: South Wales Doctoral Programme in Clinical Psychology, 11th Floor, School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT);

Supervisors: Dr Chris Hobson, Senior Clinical Tutor (HobsonCW@cardiff.ac.uk; Tel: 02920870582 Address: South Wales Doctoral Programme in Clinical Psychology, 11th Floor, School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT));

Dr Heledd Lewis, Senior Clinical Tutor (Lewish31@cardiff.ac.uk; Tel: 02920870582 Address: South Wales Doctoral Programme in Clinical Psychology, 11th Floor, School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT));

Please initial each of the following statements if you agree:

	Please initial
I confirm that I have read and understood the information sheet regarding the above-named study.	
I have been given the opportunity to ask questions and have received satisfactory answers.	
I understand that my participation will have no impact on my employment either positively or negatively presently or in the future.	
I understand that relevant sections of the data collected during the study may be looked at by members of a Cardiff University research team, from regulatory authorities, where it is relevant to my taking part in this research.	
I understand that the results of this study will form a Doctoral Thesis and may be published in academic journals, but I will not be able to be identified by this information. I give consent for anonymous quotations of mine to be published in the study write up.	

I understand that participation in this study is entirely voluntary and that I am free to withdraw my name and information at any time without giving a reason by contacting the researchers.	
I consent to being interviewed about my experience of using the Power Threat Meaning Framework in my work.	
I consent to the interview being recorded and transcribed. I understand that the audio-recordings will be destroyed once they have been transcribed, but that the transcripts will be kept securely for a period of 5 years.	
I agree to take part in the above study	
Name of participant: (Please print) …… Signature: …… Date: ……	
Name of person taking consent: (Please print) …… Signature: …… Date: ……	

Appendix H. Demographics questionnaire

Demographic Information

What is your profession? _____

How many years has it been since you qualified? _____

How do you describe your gender? _____

How do you describe your ethnicity? _____

What is your age:
20-29 __
30-39 ___
40-49 ___
50-59 ___
60-69___
Over 70 ___

Which of these best describes the setting you currently work in:

1. Adult Mental Health (community) _____
2. Adult Mental Health (inpatient) _____
3. Child and Adolescent Mental Health (community) ____
4. Child and Adolescent Mental Health (inpatient) _____
5. Older Adults Mental Health (community) _____
6. Older Adults Mental Health (inpatient) _____
7. Forensic / Secure setting _____
8. Other: _____

Which of these best describes the organisation you currently work in:

1. NHS ___
2. Private Sector ___
3. Third Sector _____

Have you attended any training or events about the Power Threat Meaning Framework? If so, please describe this below:

_____

If yes, how long ago did you undertake this training?

_____

How long have you been using the Power Threat Meaning Framework in your practice?

_____

Appendix I. Participant debrief sheet

Participant Debrief Sheet

Title of Project: Integrating the Power Threat Meaning Framework (PTMF) into Clinical Practice in Mental Health Settings; A Qualitative Exploration of Psychologists' Experiences.

Thank you very much for taking part in this study. This debrief sheet will provide information about the purpose of this study. Please take the time to read through this information. Please do ask the researcher, Zoe Travers, if you have any questions about the research.

The purpose of this study

This project is exploring the experience of psychologists who draw upon the Power Threat Meaning framework in their clinical practice in an adult mental health setting. Specifically, this study will involve a thematic analysis of the data, which seeks to describe and interpret patterns of shared meaning.

It is hoped that this project will lead to a richer understanding of how the framework is being used in practice, and so the findings of this research might be used to inform recommendations for service delivery or further research.

The impact of taking part

You have participated in an audio-recorded interview lasting up to 60 minutes. During the interview you were asked about your experience of using the Power Threat Meaning framework. The questions may have aroused difficult thoughts or feelings for you which you may finding yourself thinking about over the coming days. If you have any points of concern about your wellbeing, I would encourage you to access support through supervision if that feels appropriate and useful for you.

What will happen next?

After your interview has been transcribed, Zoe will analyse the data using a qualitative methodology called thematic analysis.

The results of this analysis will form the basis of the Doctorate in Clinical Psychology thesis and the data and report will be submitted for publication in a relevant peer reviewed journal. A summary of findings will be available to participants. Please contact Zoe Travers on the email address below to request this summary.

Confidentiality

All information will be made anonymous and you will not be able to be identified by reading the report. This means that names of participants, services and specific geographical locations will not be specified, to protect your identity. Transcripts and audio recordings will be stored on a computer that is password protected. Recordings will be deleted following transcription and the transcripts will be kept for 5 years on a password protected computer.

If you disclose information which relates to your own or others safety, your confidentiality may be waivered. In this case, discussions regarding how to best ensure your own and others' safety will also be held with the other named researchers (as below).

Who else is involved in this research?

Project Lead: Zoe Travers, Trainee Clinical Psychologist (traversz@cardiff.ac.uk; Tel: 02920870582; Address: South Wales Doctoral Programme in Clinical Psychology, 11th Floor, School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT);

Supervisors: Dr Chris Hobson, Senior Clinical Tutor (HobsonCW@cardiff.ac.uk; Tel: 02920870582 Address: South Wales Doctoral

Programme in Clinical Psychology, 11th Floor, School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT));

Dr Heledd Lewis, Senior Clinical Tutor (Lewish31@cardiff.ac.uk; Tel: 02920870582 Address: South Wales Doctoral Programme in Clinical Psychology, 11th Floor, School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT));

What if I have concerns about this research?

If you have any concerns or complaints about this project, please direct these in the first instance to: psychethics@cardiff.ac.uk

The data controller is Cardiff University and the Data Protection Officer is James Merrifield. The lawful basis for the processing of the data you provide is consent.

Thank you for taking the time to read this information.

Appendix J. Interview schedule

Background:

1. How would you describe your understanding of the main principles of the power threat meaning framework?

2. What initially drew you to using the framework?
    a. What, if any, were your hopes for your clients, yourself, or your organisation?

3. How has it influenced your practice?
    a. Can you tell me about the process of introducing the PTMF into your work? Did you introduce it or was it already used?
    b. What was the existing setting / culture like?
    c. How is the framework similar / different to what's been used before?

Opportunities and Impact

4. In what ways have you used ideas from the framework?
    a. With service users, teams, organisations and/or in other ways?
    b. Which ideas from the framework have you used?
    c. What, if any, have been the most helpful elements?
    d. What, if any, have been the least helpful elements?

5. What, if any, has been the impact on service users, staff, or the wider system?
    a. Can you tell me a bit about whether there has been any impact on team culture or team functioning? (if yes, how do you know)?
    b. (If using with teams) What, if any, has been the impact on how staff thinking about service users? (if yes, evidence of this, impact on care, limitations)

6. Can you tell me a bit about the other theories or models do you draw upon alongside the framework?
    a. How do these go together?

7. How do other staff respond to you drawing on the framework?
    a. Can you tell me about whether you've encountered differing responses from professionals? If so, how do you navigate this?

Challenges

8. Have you experienced any challenges or difficulties when using the framework?
    a. Have you experienced difficulties engaging staff or service users with the PTMF?
    b. Have you experienced any difficulties communicating with staff or service users about the framework?
    c. Have you experienced challenges relating to the wider system and existing ways of working?
    d. How have you navigated these challenges and what's been helpful in overcoming them?
    e. Any skills in particular that you drew on?
    f. What do you feel would need to change in order overcome or manage these challenges?
    g. Have these challenges had an impact on you?

Future Directions

9. Do you think the PTMF should be used more widely, and if so, what would be needed to enable that to happen?
    a. What additional training, resources, or changes, if any, would be helpful?
    b. Do you have any plans to take this forward?

10. Do you have any other thoughts you would like to share?

Appendix K. Transcriber confidentiality agreement

TRANSCRIPTION
BOOK-KEEPING
SECRETARIAL SERVICES

Bridget Postlethwaite
VIRTUAL ASSISTANT

Tel: 07444 638803
E-mail: bridget.mrsp@gmail.com

CONFIDENTIALITY AGREEMENT

This confidentiality agreement has been prepared and is being distributed on behalf of Bridget POSTLETHWAITE ("the Service Provider") who acknowledges and accepts the terms and conditions of this Confidentiality Agreement. **This agreement is made between the Service Provider and Zoe Travers**

The Service Provider agrees that they shall not during the course of the contract and at all times (without limit) after the termination thereof (howsoever the same is determined), either directly or indirectly, make use of, or disclose (to a third person, company, firm, business entity or other organization whatsoever) or exploit for their own purposes or for those of any other person, company, firm, business entity or other organization whatsoever, any trade secrets or Confidential Information (as defined below) relating or belonging to my client or any of their clients.

Confidential Information includes, but is not limited to, any information relating to clients (including clients with whom my client is negotiating), client lists or requirements, charge out rates or charging structures, marketing information, intellectual property, business plans or dealings, precedents, technical data, financial information and plans, any document marked "confidential" or any information which the Service Provider has been told is confidential or which might reasonably be expected to be regarded as confidential, or any information which has been given to my client in confidence by clients, suppliers or other persons.

The obligations contained in this provision shall not apply:

To any information or knowledge, which may subsequently come into the public domain, other than by way of unauthorised disclosure (whether by the Service Provider or by a third party);

To any act of the Service Provider in the proper performance of their contractual duties where such use or disclosure has been properly authorised by my client;

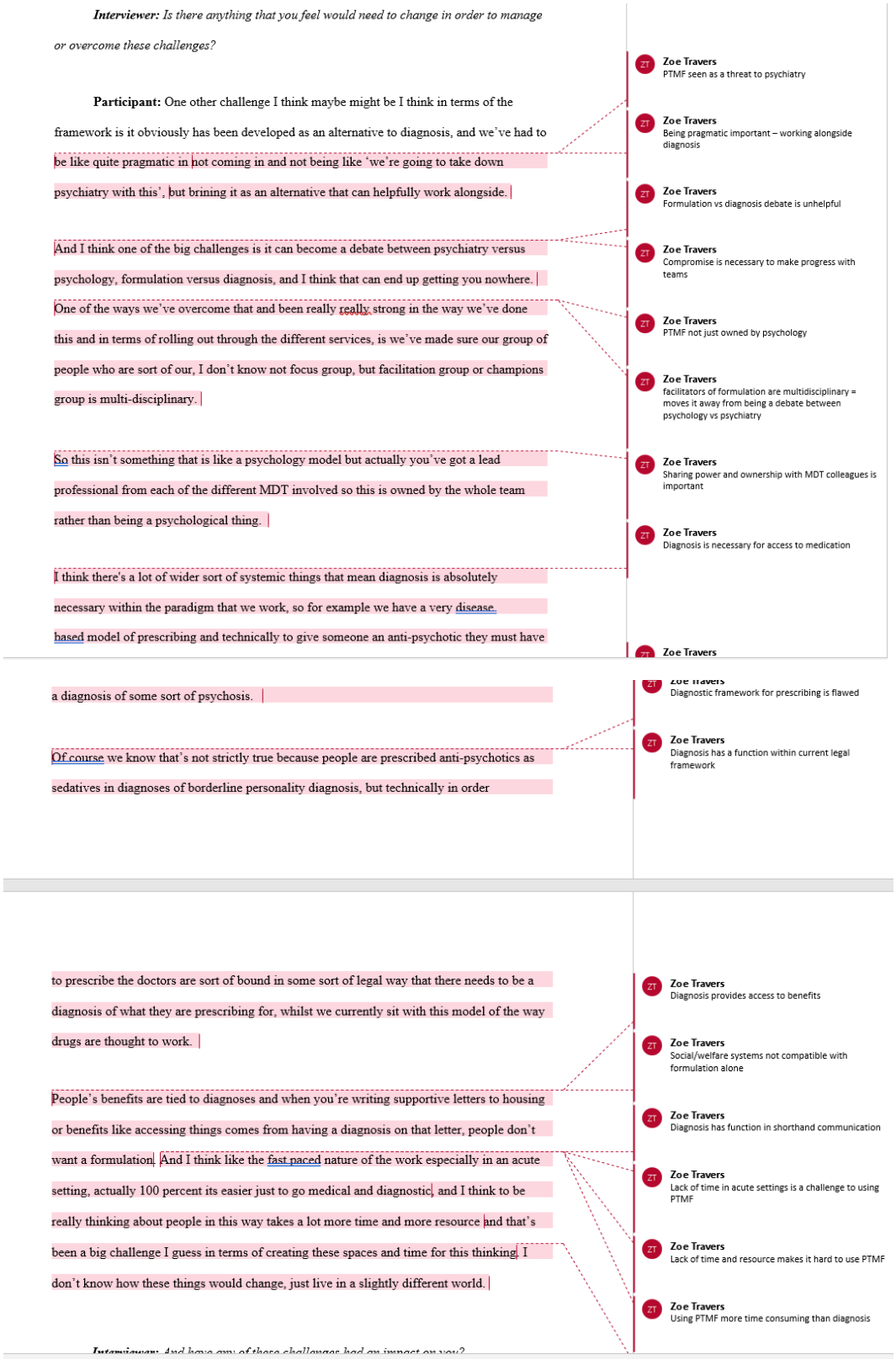
To any information which the Service Provider is required to disclose in accordance with an order of a Court of competent jurisdiction.

In complying with these confidentiality obligations, the Service Provider must refrain from discussing, reading or disclosing Confidential Information openly in public areas, such as, on trains, buses and airplanes, on mobile telephones, or in restaurants. If the Service Provider is in any doubt as to the extent and/or the ambit of these obligations they should, in the first instance address any queries to my client using the contact details supplied at the time of booking, either in writing (via email) or via telephone contact. The Service Provider acknowledges that the client reserves the right to terminate any contract should they become aware of any unauthorized use of the Confidential Information.

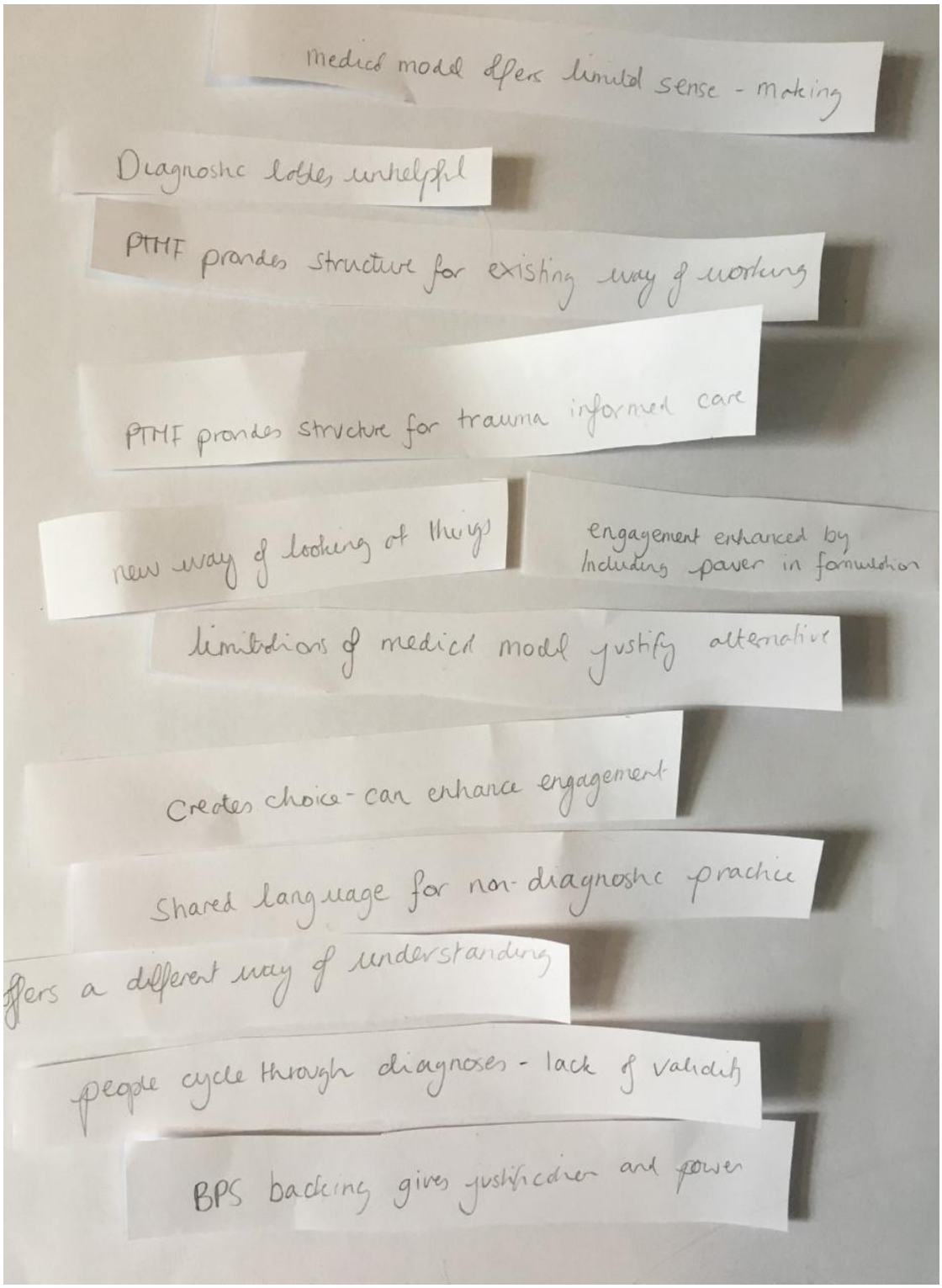
Signed [redacted]

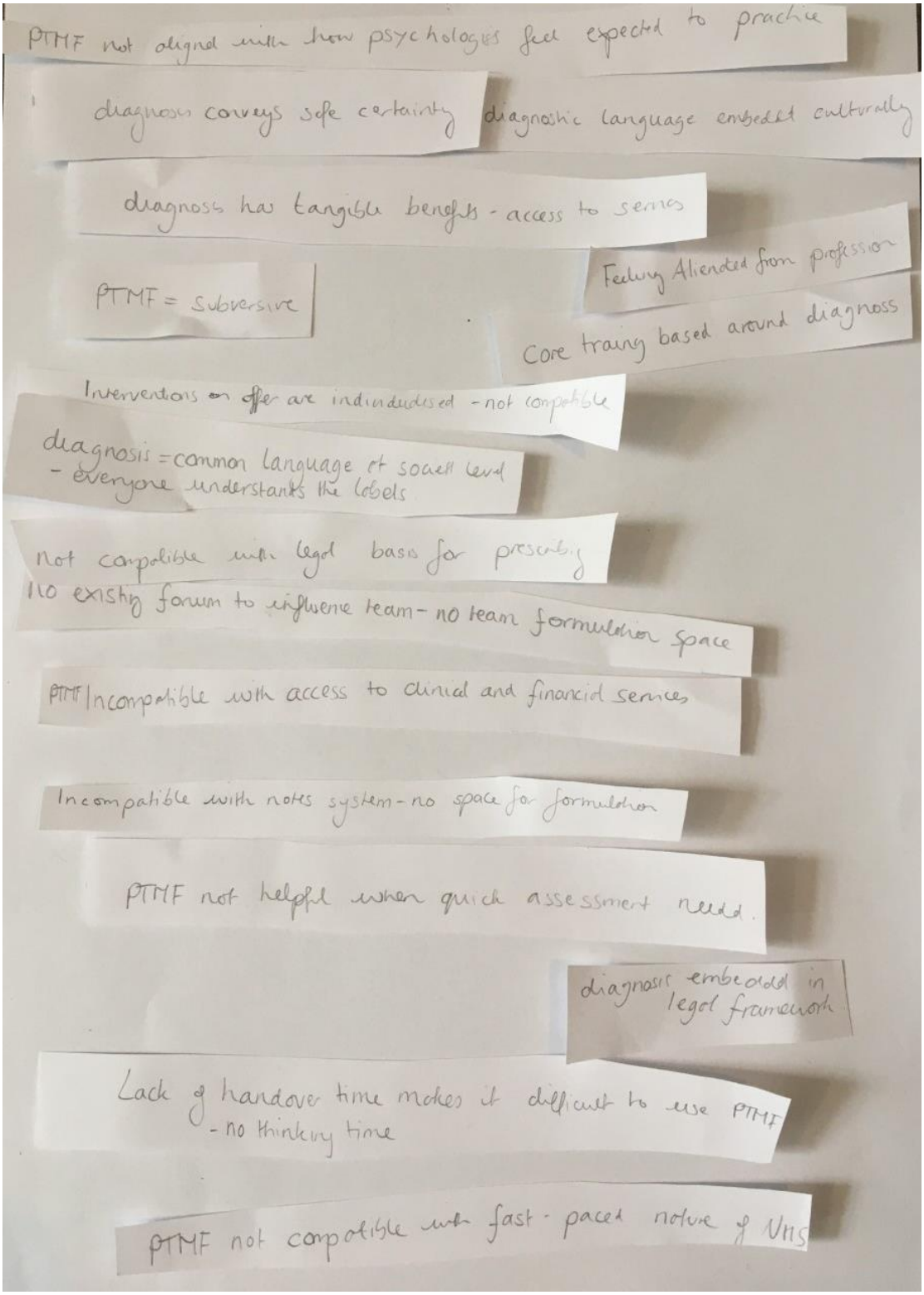
Dated 10th June 2021

Appendix L. Example of data coding



Appendix M. Example of initial clustering of codes




PTMF not aligned with how psychologists feel expected to practice
diagnosis conveys safe certainty
diagnostic language embedded culturally
diagnosis has tangible benefits - access to services
PTMF = subversive
Feeling Alienated from profession
Core training based around diagnosis
Interventions on offer are individualised - not compatible
diagnosis = common language at social level - everyone understands the labels
not compatible with legal basis for prescribing
No existing forum to influence team - no team formulation space
PTMF Incompatible with access to clinical and financial services
Incompatible with notes system - no space for formulation
PTMF not helpful when quick assessment needed.
diagnosis embedded in legal framework
Lack of handover time makes it difficult to use PTMF - no thinking time
PTMF not compatible with fast-paced nature of NHS

Appendix N. Table of theme development

Theme	Subtheme	Example Codes
Having an alternative framework of distress is valued ~~(PTMF creates choice)~~		Client engagement enhanced by including power in formulation Limitations of medical model justify an alternative PTMF provides structure to existing way of working PTMF seen as integral to the profession
PTMF enhances sense making	Invites reflections on power	One of the only psychological models to centre power Staff acknowledging role of services in re-traumatisation Crisis interventions such as sectioning can replicate trauma
	A more meaningful perspective	PTMF has more explanatory power than diagnosis Reformulating self-harm behaviours as threat responses help staff understand function of behaviour Bringing a wider context into formulation by using PTMF
	PTMF facilitates compassionate care	Creating a less blaming story by locating the problem at societal level PTMF offers a more compassionate understanding Reframing symptoms as threat responses enhances empathy
Systemic change needed to implement PTMF	Incompatibility with other systems ~~(the alternative is incompatible)~~	Diagnosis is common language at the societal level - everyone understands the labels No existing forum to influence team e.g. no team formulation space PTMF incompatible with access to clinical and financial services

	Threat to the status quo ~~(threat to psychiatry and psychology)~~	Challenging diagnosis is inherently controversial PTMF is deskilling to psychiatry by minimising role of medication PTMF can evoke defensiveness and hostility
	Need for training and resources	Jargon-free resources are needed Influencing training of psychiatrists would be helpful Ongoing need for training to use PTMF due to high staff turnover
Working alongside other perspectives as key influencing practice ~~(compromise and flexibility as key to change)~~		Putting aside the debate between PTMF and diagnosis for the benefit of service users Building good relationships across professions is vital to influencing change PTMF as one of many ways of understanding distress
~~Importance of MDT relationships~~		
~~Influencing practice can be challenging~~		

Appendix O. Research diary extract

December 2020
Working on my submission of my research proposal - I've decided to use thematic analysis for the analysis of my interview data after discussion in research supervision. I initially considered using IPA or grounded theory as these methods arguably have more interpretive power and could provide a greater depth of analysis, which feels fitting for something as big as an LSRP. However, having looked at the literature and discussed with course staff, I feel TA is the best fit for my research question, as it will give me the opportunity to interpret the shared meanings across the data and hopefully to generate findings which will have meaningful implications for clinicians.
….
August 2021
I have conducted several interviews now, really enjoying this part of the process. Participants seem really interested in the research process and want to hear about the results – will need to think about how and when I can share these. It's interesting to me that the conversation often carries on after the recording has been switched off and the official interview has ended – I wonder if this is about people feeling safer to share more openly in this context. I'm finding it tricky at times to remain fully engaged in the interviews and am noticing myself trying to monitor how the interview is going and almost listening out for quotes – I'm trying to notice when this is happening and remain present in the conversations.
The process of conducting the systematic review is a much bigger task that I could have anticipated – but the methodical nature of the process is quite containing at times. Reading about burnout in trainee mental health professionals is very interesting - I have approached this project primarily as clinician and want to be able to produce something that is of interest to other clinicians with real implications for practice, and I hope that the systematic review will also be able to offer that.
….
December 2021
The process of analysis has started - having so many codes feels very overwhelming. This is part of the process that I have felt most apprehensive about, as I feel a sense of wanting to 'do justice' to the voices of participants in the analysis, and am also aware that it's taking me a bit of time to feel confident finding my interpretive voice in the analysis.
Clustering codes around the idea of incompatibility of the framework with existing structures has been a useful starting point in the analysis as so many of the codes either directly or indirectly referred to this concept in some way. I'm also noticing there's something around the sense of threat that this can generate within participants (at having to challenge the medical model) as well as within their colleagues.
I'm also interested in the idea of choice or the framework giving people (both professionals and clients) a choice about how they make sense of their experiences rather than having this imposed on them by only having one dominant approach within services, this seems to be an idea that I keep generating in my analysis so I think I will start to cluster together codes in this area to explore the idea of a potential theme around this aspect of the data.