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Changing the client lens: giving voice and meaning to mental health clinicians' experience of trauma informed relational care training

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**Changing the client lens: Giving voice and meaning to mental health clinicians'
experience of trauma informed relational care training**

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Thesis submitted to the University of Limerick in fulfilment of the requirements for the Degree of Doctor of Clinical Psychology (PhD in Clinical Psychology) Department of Psychology, University of Limerick, April 2019.

Declaration

I hereby declare that this project is entirely my own work, other than the counsel of my supervisors. Any contributions made by other authors have been recognised appropriately. The work herein has not been submitted for any academic award or part thereof at this or any other establishment.

Paula Hurley

Date: 15th April 2019

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Abstract

Introduction: Existing research on Adverse Childhood Experiences (ACEs) confirms that ACEs are endemic in the lives of many of the people who attend and use mental health services. Although the trauma caused by ACEs is known to have enduring impacts on adult mental health, mental health services in Ireland have not taken a systematic approach to trauma-informed relational care and it is difficult for clinicians to obtain formal training in this topic. The current study therefore carried out research on clinicians' experiences of a locally-devised, trauma-informed relational care training and how this experience impacted on their perception of self, client and clinical practice in the twelve months afterwards.

Methods: A qualitative design using purposive sampling and semi-structured interview was used to explore participants' experiences. Interpretative Phenomenological Analysis (IPA) was used as a method of analysis to give voice and meaning to eight clinicians' experiences of training and how it impacted on their perception of self, client and clinical practice.

Results: Four superordinate themes were identified using IPA. These themes were best conceptualised as a process of change or metamorphosis which included; Engagement of Self; Changing the Lens; Change in Self as Clinician; and Change in Clinical Practice.

Conclusion: The study provided insight into the metamorphic process clinicians experienced through training. For clinicians to change the client lens, they had to subjectively and objectively connect with the client experience through reflection which developed empathy and mentalisation skills. This is the first known evaluation of trauma-informed relational care training in an Irish context. Implications and recommendations are discussed for clinical practice, education and future research with a particular emphasis on how the client lens impacts the relational aspect of care.

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Chapter One: Introduction

“10. Things you should not talk about: Abuse of any kind, patterns in your relationships because of this abuse, existential dilemma, perceived flaws in the system or anything to do with individual staff members.”

(Anderson, 2016, p.29)

1.1 Overview of the Present Study

The client is the ostensible *raison d'être* of the mental health system. Nonetheless, there is considerable evidence to suggest that the current mental health system is more likely to traumatise clients than act as a healing sanctuary (Bloom & Farragher, 2010; Bateman, Henderson & Kezelman, 2013; Knight, 2015; Sweeney, Clement, Filson & Kennedy, 2016). The current mental health service is structured to help clients by detecting and categorising symptoms in order that the professional may “diagnose and treat” (Bateman, Henderson & Kezelman, 2013). Unfortunately, the effect on some clients can be to alienate, isolate, stigmatise, and potentially re-traumatise, while the impact on the clinician may reinforce a sense of detached professionalism which inevitably distances them from the client. In fact, the client becomes “other” (Bloom and Farragher, 2010) and an embedded “power over” (Sweeney et al., 2016) relational dynamic can impede any meaningful connection between the clinician and client. Rather than privileging authentic client testimonies, clients may be shut down, pathologised, and/or labelled (Sweeney et al., 2019) to such an extent that the mental health service can inadvertently promote iatrogenic trauma. Dr Jay Watts (2017) describes the ensuing “iatrogenic dance” as the need for meaningful contact which motivates clients to search for help and a services response which generally invalidates their experience and deepens the trauma.

The Adverse Childhood Experiences (ACEs) research, conducted over three years (1995-1997) on 17,000 people, demonstrated the long-term effects of developmental trauma on health, health risk behaviours, cognitive functioning, and social problems (Felitti *et al.*, 1998). Much extant research on ACEs (Bellis et al., 2015; Felitti et al., 1998; Rossiter et al., 2015) concurs that ACEs are endemic to the lives of the majority of people who attend and use mental health services (Kessler, 2010). Clearly then, better comprehension of the corollary between developmental trauma and the

development of mental distress can support mental health professionals to devise and offer more successful needs-based services.

This has led to a call for Trauma Informed Care (TIC) (Harris & Falot, 2001) which de-pathologises and de-stigmatises clients by asking: “What *happened* to you?”

Along with a dearth of research in the area, there is a conspicuous gap in the provision of trauma informed care across Irish mental health services. This study therefore focuses on the response of one Community Health Organisation (CHO) in Ireland, as clinicians embarked on Trauma Informed Relational Care training and practice over a 12 month period. The study uses Interpretative Phenomenological Analysis (IPA) to capture clinicians’ experience both of the training and of its enduring impact on their perceptions of self, client, and clinical practice.

1.2 Conceptual Framework

The primary focus of this research is an examination of how clinicians in a mental health service in Ireland responded to training in trauma informed relational care. To this end, the conceptual frameworks used in this research study integrate aspects of: 1) developmental trauma; 2) attachment theory; and 3) trauma informed care:

1. Developmental trauma educes the complexity of interaction between the cognitive, emotional, and physical development which takes place in early childhood. Repeated exposure to traumatic events in the absence of an appropriate care-giver support can negatively affect the way an infant’s brain develops and functions. The impact of this is experienced in later life.
2. Attachment theory provides an evidence-based framework to assist an understanding of human development as a relationship process. Since it is not a clinical theory, it hypothesises development as a fundamentally relational process which can provide coherent understanding of client’s thoughts, feelings, and behaviour, along with mechanisms for therapeutic work. A combination of both developmental trauma and relational (attachment) matrices of development can afford key clinical insights into how a client’s current presentation (psychological/behavioural/emotional) can be broached in the context of their past. It also yields useful relational-focused mechanisms and a shared language through which the client can be understood.

3. Trauma informed care supports a philosophical change of perspective toward both client and service provision. In so doing, it rehearses a service delivery model which is used across numerous professions including homelessness, schooling, and substance-abuse services and mental health services.

1.3 Researcher Positionality

The researcher's interest in this topic arose from a commitment to person-centred care and a belief in the healing power of relationships. Having worked in community rehabilitation and mental health services over the last decade the researcher has accumulated considerable practice-based evidence which supports the value of prioritising the intersubjective relationship between client and clinician through a respectful collaborative framework. As such, the researcher was interested to ascertain how other multi-disciplinary clinical colleagues respond to a perspective which is predicated on the centrality of client experience rather than symptomology.

1.4 Thesis Structure

Chapter Two will examine the existing literature in the areas of ACEs and their relationship to severe mental illness. Relevant mental health system responses to developmental trauma via trauma informed care (TIC) will also be explored, as will the implementation of TIC in the context of mental health service. Finally, a locally-designed training in response to trauma need will be delineated and the mechanisms through which clinicians encounter and begin to operationalise practice elucidated.

Chapter Three will review the ontological and epistemological foundation of the research design and methodology. Approaches to participant recruitment, participant profiles, illustrations of the procedural steps, and mode of analysis will be outlined. Furthermore, the steps taken to ensure research trustworthiness and rigour will be detailed and the attendant ethical issues discussed.

Chapter Four will present a synthesis of the findings from eight transcribed participant interviews. As these were conceptualised as a process of change or metamorphosis occurring across four stages, each stage will be discussed in sequence with illustrative quotes drawn from the data used to demonstrate and support the researcher's interpretations.

Chapter Five will outline the findings in relation to the existing literature. The strengths and limitations of the research will be evaluated and the implications for clinical practice, education, policy, and further research considered. The chapter will close with a critical reflection of the researcher's process and an overall summary of the study.

Chapter Two: Literature Review

2.1 Setting the Research Scene

The research objective of this study is to explore the experience of clinicians working in a Community Adult Mental Health Service 12 months after attending a two day training event on Trauma Informed Relational Care. The aim is to make meaning from the way clinicians experience locally developed training and how it impacts their view of self, client, and clinical practice. It is hoped the findings will bring understanding to the significance bestowed by the participants on the training, as a means to inform future development of the clinical practice and training

This review therefore examines the relationship between developmental traumas, adverse childhood experiences (ACES), and severe mental illness in the adult mental health service using surveys, systematic reviews, and quantitative studies. It also enquires into how the current adult mental health system understands and addresses trauma and assesses the potential of Trauma Informed Care (TIC) as a model for supporting clients. It further examines qualitative and quantitative research in respect of the achievements and failings of current models in order to determine which elements make the TIC model preferable within the adult mental health services. Finally, a locally developed 2-day Trauma Informed Relational Care Framework training course designed to fill the gap in understanding trauma in adult mental health services is described and the mechanisms through which clinicians encounter and begin to operationalize it in practice are explored.

At this juncture it is noted that the aim of this study is not to undertake a transition to TIC but rather to explore how clinicians experience training in Trauma Informed Relational Care Framework and the diverse ways such training informs their view of self, client, and clinical practice.

Below is a brief introductory ‘mind-map’ (see figure 2.1) to orientate the reader to the areas of exploration in the literature review. The areas of exploration include Adverse Childhood Experiences research; how trauma is approached in the mental health service; trauma informed care; the response of one Community Healthcare Organisation (CHO) through trauma informed relational care training; how this training is operationalized and the identification of research questions.

Figure 2.1: “Mind-map” of Literature Review



Source 1
Source 2

2.2 Literature Search Strategy

Databases such as PubMed, CINAHL, PsycInfo, PsycARTICLES, Web of Science and the Cochrane Database were searched for articles pertaining to the research topic. In various combinations, the following search terms were utilised in the overall literature search: *adverse early childhood experiences (ACEs); developmental trauma; childhood trauma; complex trauma; psychiatric disorders; mental illness; psychopathology; adult mental health setting; community mental health setting; attachment theory; trauma informed training; reflective practice; mentalisation; and empathy.*

Building on the initial search results, further relevant titles and abstracts were also reviewed and germane articles identified for full reading and critique.

The search was delimited to English language papers published between 1995 and 2019.

2.3 Developmental Trauma

Since the present study primarily concerns the impact of early childhood trauma on adult mental illness, this section of the review offers childhood trauma and mental illness definitions. It thereafter reviews the literature on the inter-relational aspects of the two as identified in quantitative studies, systematic reviews, and prior surveys.

2.3.1 Definition

There is significant variation in trauma definitions. These hinge upon the occurrence of a single or multiple traumatising events, when the trauma occurs, the response of the victim, the harm inflicted, or the ability to cope with threat. For the purpose of this research Courtois & Ford (2009) provide a comprehensive definition of complex psychological trauma which incorporates elements of both Van der Kolk's (2015) and Gregorowski & Seedat's (2013) definition of developmental trauma. They define complex psychological trauma as:

experiences that are (1) repetitive, chronic or prolonged; (2) involve harm, such as physical, sexual, and emotional abuse and/or neglect or abandonment by parents, caregivers and other ostensibly responsible adults; and (3) occur at developmentally vulnerable times in a person's life, especially over the course of childhood, and become embedded in or intertwined with the individual's development and maturation" (Courtois & Ford, 2009, p.442).

The importance of early attachment relationships in infancy and childhood mean that disrupted caregiver relationships can have lifelong developmental consequences including psychopathology, and can therefore be considered traumatic (Gregorowski & Seedat, 2013). This research underscores the theoretical concept of complex developmental trauma and attachment theory as a useful framework within trauma informed approaches for the clinical understanding and management of clients in adult mental health services.

2.3.2 Adverse Childhood Experiences (ACEs): Definition

Adverse Childhood Experiences (ACEs) is the term used to describe stressful experiences during childhood (0-18 years) which act to harm the child. These early negative life events can lead to negative health outcomes as adults.

These include all types of abuse (physical, emotional, sexual), neglect (physical, emotional), and household dysfunction including mental illness, domestic violence, divorce, incarcerated relative and substance abuse (Felitti et al., 1998).

2.4 Severe Mental Illness (SMI): Definition

Severe Mental Illness (SMI) is a term used to describe severe and persistent mental disorders such as depression, bipolar disorder, personality disorder, and psychosis. Symptoms associated with SMI exert an ongoing adverse impact on a daily functioning, difficulty in establishing and maintaining relationships, and cognitive functions such as impulsivity, delusions, and hallucinations (American Psychiatric Association, 2000).

2.5 Adverse Early Childhood Experiences and Severe Mental Illness

In exploring the relationship between mental, physical health, and health-harming behaviours, the 1998 Adverse Childhood Experiences (ACE) study undertaken by Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards & Marks precipitated a seminal shift in understanding how adverse childhood experiences impact health adult outcomes. This seminal study reported that at least 64 per cent of respondents (n=13,494) experienced at least one or more ACEs, with 12.5 per cent of the respondents experiencing four or more ACEs. The research demonstrated a graded relationship between ACEs and mental and physical illness. There was also evidence of a dose-response relationship pattern, so that the greater the number of exposures, the stronger the relationship with depression, suicide attempt, and health-harming behaviours (Felitti et al., 1998). Compared to those who reported none, participants who reported four or more adverse exposures, had a 12.2 fold increased risk of suicide attempt and 4.6 fold increased risk of depression (Felitti et al., 1998).

The World Mental Health (WHO) Survey of 21 countries (Kessler et al., 2010) found that exposure to adverse childhood experiences had a comparable rate of occurrence in high-income (38%), high-middle income (39%) and low and lower-income countries (39%). In a retrospective cross-sectional survey of 1500 general population aged

between 18-70 years conducted in the UK (Bellis, Lowey, Leckenby, Hughes, & Harrison, 2013) 47 per cent of the sample (n=1500) reported at least one adverse childhood experience while 12.3 per cent reported four or more ACEs. Unlike the Felitti et al. study (1998), the British research also measured mental well-being and life-satisfaction rates and found the prevalence of low life satisfaction ranged from 8.3 per cent in the sample with no ACEs to 29.9 per cent in those with four or more ACEs. Diminished mental wellbeing was also associated with increased reporting of ACEs (from 14.2% to 34.6%).

An additional finding of this UK-based study revealed that ACEs were likely to produce an intergenerational cycle of ACEs in as much as they are linked to health-harming behaviours such as substance abuse, risky sexual behaviour leading to unplanned pregnancy, and violence (Bellis et al., 2013). However, Bellis et al.'s (2013) assertion that people with ACEs are likely to perpetuate an intergenerational cycle of abuse must be qualified. While studies suggest that up to 30 per cent of those abused go on to abuse or neglect their children (Ben-David, Jonson-Reid, Drake & Kohl, 2015; Widom, Czaja & DuMont, 2015) research confirms that not every adult abused in childhood perpetuates the cycle. In any event, instances of such abuse are not found to be the result of direct imitation (Granqvist, Sroufe, Dozier, Hesse, Steele, van IJzendoorn & Duschinsky, 2017). Rather, these behaviours arise through the indirect impacts. For instance, children who experience childhood abuse are predicted to demonstrate poorer emotional regulation skills, less supportive relationships, and be more likely to experience physical violence in their adult lives. These factors, in turn, reinforce the likelihood of an intergenerational cycle of abuse (Granqvist et al., 2017).

A number of studies have revealed a clear correlation between childhood adversities and adult psychiatric disorders, including psychosis and Severe Personality Disorder (Aas et al., 2016; Maniglio, 2013; Williams, Bucci, Berry & Varese, 2018). Additional research which illuminates the link between ACEs and suicide ideation (Fuller-Thompson, Baird, Dhrodia, & Brennenstuhl, 2016; Choi, DiNitto, Marti & Segal, 2017), purports that even when mental disorders and substance abuse are controlled, a significant connection obtains between ACEs and lifetime suicide attempts. Similarly, in a 21-country survey of mental health, Kessler et al. (2010) found that ACEs increased the risk of mood disorders, anxiety disorders, and behavioural disorders across the lifespan. However, such studies have attracted a certain degree of criticism

regarding the tenuous nature of the causative effect of ACEs on mental health outcomes. In reality, there remains little or no firm agreement on the aetiological role or predictive value of ACEs in adult psychiatric disorders.

Researchers claim other mitigating and mediating factors such as the severity and duration of original trauma and resilience plays a role in onset of mental illness (Padilla, 2011). Research conducted by Chiesa, Larsen-Paya, Martino & Trinchieri (2016) addressed this issue by investigating the associations and predictive power of childhood adversity on later onset of axis 1 and axis 2 conditions. In a cross-sectional study over 14 NHS psychotherapy centres comprising a sample population (n=1136), 87 per cent had been diagnosed with a psychiatric disorder, 44 per cent of whom reported experiencing one or more adverse childhood experiences.

Using regression linear analysis, the researcher demonstrated that childhood experiences of sexual and physical abuse significantly aligned with the severity of adult psychiatric distress (Chiesa et al., 2016). They concluded that early experiences of loss and physical abuse were predictive of severe personality disorders. Unlike Kessler et al. (2010) however, they did not find abuse to be predictive of other personality disorders or axis 1 disorders. Nonetheless, Chiesa et al.(2016) confirmed that undergoing the experience of two or more adverse childhood experiences increased the severity of psychiatric distress, with sexual abuse the strongest predictor of the severity of symptomatic distress. Of equal note, Chiese et al. (2016) contended that the correlation between ACEs and psychiatric disorder is not a directly linear relationship but is rather mediated and moderated by a number of other variables such as personal resilience, reflective functioning, and genetic predisposition.

A systematic review of quantitative evidence over 37 papers and 9057 participants investigated potential psychological mediators between childhood adversities and psychosis (Williams, Bucci, Berry, & Varese, 2018). To this end, Williams et al. (2018) identified five groups of mediating factors: namely, 1) post-traumatic sequelae; 2) affective disturbance; 3) cognitive processes; 4) appraisal of subsequent stressors or life circumstances; and 5) exposure to other psychosis triggers in the relationship between ACEs and psychosis, such as substance misuse. Previous systematic and meta-analysis of the association between hallucinations and delusions in psychotic disorders suggest that trauma-focused psychosis interventions should be developed (Bailey et al., 2018).

This study argues that the five groups of mediators could provide meaningful targets for clinicians to develop treatment plans for trauma clients presenting with psychosis. A significant limitation of this systematic review was the exclusion of non-English language papers and grey literature from its search profile which may have resulted in cultural and/or other selection biases in evaluating mediating factors.

Further research (Putnam, Harris & Putnam, 2013) explored the synergistic relationship between ACEs and the number of lifetime DSM-IV diagnoses. One such clinical view maintained that exposure to a greater number of ACEs increases the complexity of presentation and co-morbidity of disorders in adult mental health settings (Cloitre et al., 2009). Putnam et al., (2013) used logistical regression models on data (number of ACEs, DSM-VI diagnoses and internalising/externalising behaviours) gathered from the National Comorbidity Survey-Replica sample (n=5,692) in order to investigate the impact of childhood adversities on psychopathology in adulthood.

Their first major finding was the identification of a significant link between ACEs and complex adult psychopathology. In fact, Putnam and colleagues revealed that the number of DSM-VI diagnoses increased as the ACEs scored increased for both men and women, with an OR (odds ratio) 7.3, 95 per cent confidence interval. As such, an absence of childhood adversity acted as a protective factor which significantly reduced the risk of adult mental health difficulties. As with the original ACEs study, one arguable limitation of this study is reliance on the retrospective reporting of childhood adversity which is open to under-reporting or the impact of increased negative reporting due to mental health diagnoses such as depression.

Roberts and colleagues (2015) in a two cohort longitudinal study, mothers (n=8882) and offspring (n=11402), examined the relationship between maternal history of abuse, depressive symptoms of offspring and offspring experience of abuse. They found that offspring whose mother was exposed to childhood abuse were 1.5 times more likely to have high depressive symptoms and were 2.5 times more likely to have persistent depressive symptoms than mothers who had not been abused. Mediating factors such as maternal mental illness accounted for 20 per cent of the association in outcome and offspring abuse accounted for 30 per cent. The recommendations from this research were to screen pregnant women and young mothers for ACEs so that intervention could be provided to decrease likelihood of intergenerational harm.

2.5.1 Critique of ACEs Studies

A robust criticism of ACEs study over recent years stresses that the relationships between childhood adversity and mental health outcome continue to be measured by simplistic associations (Johnson, 2018). Although, Williams et al. (2018) look towards ACEs as mediating factors it is important to pursue scientific exploration of the relationship through prospective studies. In keeping with Felitti et al. (1998), the prospective longitudinal study conducted by Newbury et al (2017) observed a measurable correlation between remembered ACEs and ACEs assessed at 5,7,10 and 12 within the same cohort. Further prospective longitudinal research is required to consolidate these findings.

Further criticism of the ACEs study approach is the relatively blunt and unrefined method of measuring ACEs, in which the severity or duration of abuse is left unconsidered. Given Terr's (1991) definition of type 1 and type 2 traumas, differences are evident in the sequelae of the particular trauma experiences. In fact, to presume homogeneity is to ignore the magnitude of experiencing or witnessing repeated acts of abuse. Shankoff (2012) proposed the concept of "toxic stress" such as poverty, racism, and community violence to be another version of childhood adversity. In his book *Miller's Children*, James Garbarino (2017) explores the impact of "toxic stress" on the mental, physical, and incarceration outcomes in the penal system in America. In this context the level of adversity is omitted from the ACEs definition, the ACEs approach is arguably a limited generalization of a highly complex mechanism which can profoundly impact childhood development.

Finally, the ACEs study could be viewed as "fatalistic" in outcome since it does not consider that a child may cope or recover from adversity (Johnson, 2018). While various other factors, such as resilience or "angels in the nursery" (Liebermann, Padron, Van Horn & Harris, 2005), could prove a positive determining factor in the outcome, they are unexamined in the same population research. Although the ACEs studies do contribute to an epidemiological understanding of health determinants within the adult mental health system, they nonetheless fail to provide a clinical elucidation of how such experiences impact child development throughout the lifespan and inform therapeutic engagement and practice.

There is an increasing evidence-base and awareness of the pervasiveness and long-term impact of developmental trauma and ACEs on mental health outcomes. The focus of research has permeated general population studies with little enquiry into how mental health services and clinicians apprehend the connections between an individual's trauma history and their current symptoms and presentation. This underscores the need for mental health services to be both alert and responsive to the impact of trauma on those receiving their services. This research therefore aims to qualitatively explore clinician's experience of a 2-day training specifically targeted to fill this gap of knowledge. To this end, the following sections outline current responses to trauma within the mental health systems and further scrutinises the gap in trauma-care sensitivity.

2.6 Prevalence of Trauma in the Mental Health System

There is a dearth of research literature in the Irish context which directly explores childhood trauma and the relationship between ACEs and adult mental health. In the Sexual Abuse and Violence in Ireland (SAVI; 2001) study, 3120 adults (general population) were interviewed by telephone using random digit dialling and asked about experiences of childhood sexual abuse (CSA) and unwanted sexual experiences in adulthood (McGee, Garavan, Byrne, O'Higgins & Conroy, 2010). The results reported rates of CSA in 20 per cent of the female and 16 per cent of male population (McGee et al., 2010).

A recent cross-sectional study to assess the prevalence of childhood trauma in an Irish adult mental health population found 76 per cent of the sample reported childhood trauma with emotional neglect most frequently reported (61%) (Wota et al., 2014). The findings from a Childhood Trauma Questionnaire (CTQ) and other psychometric instruments applied to 136 individuals attending mental health service suggested a dose-response relationship between the types of traumas and the severity of distress. Individuals who experienced childhood trauma had a higher rate of inpatient admissions to adult mental health unit ($t=5.36$, $p<0.001$). While there was no significant difference between the rate or type of Axis 1 disorder in individuals who reported childhood trauma, there were higher rates of personality disorder ($p<0.01$), substance abuse, and paranoia compared to those who did not report trauma (Wota et al., 2014). These results were comparable to the Chiese et al. (2016) study which similarly confirmed that childhood trauma was significantly associated with severe

personality disorder. A particular strength of this study was the utilisation of the CTQ; a sensitive instrument, which can be further utilised within clinical practice. Nonetheless, since this instrument does not take account of other childhood adversities such as Shankoff's "toxic stress" factors, parental loss, separation, and so on, childhood trauma should not be considered an isolated phenomenon but one which operates in a socio-cultural context (Horwitz, Widom, McLaughlin & White, 2001).

2.6.1 ACEs Research and Mental Health Service Provision

As is evident from the research above, people suffering severe mental illness are at a particularly elevated risk for trauma. Yet little emphasis is placed on ways to respond to people who experience the effects of these adversities across services, such as mental health services (Johnson, 2018). As such, childhood trauma in individuals with severe mental illness is frequently unrecognised or unaddressed in mental health settings as the presentations are often complex and there is a tendency for clinicians to focus on acute psychopathology (Mihelicova, Brown & Shuman, 2018). The emphasis on responding to individual pathology diminishes the connection and exploration of personal history to social context and psychological well-being, thereby reducing the likelihood of an exploration of trauma informed care (Becker-Blease, 2017). Moreover, clinicians have voiced concerns that requesting clients with severe mental illness to rehearse their trauma history could potentially exacerbate their symptoms (Frueh, Cusack, Grubaugh, Sauvageot & Wells, 2006). In light of this, the UK Department of Health (2003) made certain recommendations regarding routine enquiries of abuse in AMH setting. As such, NHS staff have been trained to ask basic questions about trauma in mental health services, such as "Have you ever experienced physical/emotional/ sexual abuse at any time in your life?" (McNeish & Scott, 2008). However, there is little evidence to show that the question is actually being asked (Hepworth & McGowan, 2013).

A further study in Ireland by Rossiter et al (2015) examined the clinical reporting of childhood trauma compared to trauma rates (n=129) recorded in clinical notes and those ascertained with structured validated clinical questionnaire. The results revealed that 77 per cent had experienced one or more of the five childhood adversities examined by the CTQ. However, only 38 per cent had had their ACEs noted in the clinical records ($p < 0.001$).

The greatest discrepancies between CTQ and clinical note documentation were found to concern emotional neglect (62% versus 13.2%), physical neglect (48.1% versus 5.4%), and CSA (24.8% versus 8.5%). This study confirms elevated ACEs rates for adults attending mental health services in Ireland and also demonstrates high rates of either non-enquiry or non-documentation of ACEs by mental health professionals (Rossiter et al., 2015).

The delivery of trauma responsive services is impeded by systematic neglect of conducting trauma informed assessment and treatment in mental health services (Becker-Blease, 2017; Jorm & Mulder, 2018). As such, there is considerable scope for mental health professionals to play a more active role in reducing the impact of adverse childhood experiences. This thesis therefore aims to identify how the Irish community adult mental health system can best respond to the needs of its clients from a multidisciplinary base.

2.7 Why TIC in the Provision of Mental Health Services?

Despite the significant increase in treatment provision and uptake over the recent decades, figures demonstrate there has been no reduction in the prevalence rates of mental illnesses (Jorm & Mulder, 2018). Several reasons have been proposed for this lack of progress including the quality and targeting of treatment (Jorm & Mulder, 2018) which may be a consequence of not being screened, assessed, or treated for trauma. Research suggests that regardless of the event which triggers peoples contact with mental health services, client trauma history is rarely explored (Butler, Critelli & Rinfrette, 2011; Rossiter et al., 2015). This lack of awareness can result in: (1) failure to understand the presenting problem; (2) failure to provide appropriate trauma specific interventions; and (3) the potential to re-traumatise vulnerable clients (Butler et al., 2011; Sweeney, Clement, Filson & Kennedy, 2016; Sweeney, Filson, Kennedy, Collinson & Gillard, 2018).

2.7.1 Re-traumatisation in the Mental Health System

The re-traumatisation of clients may well be an unintended and unanticipated consequence of services and clinicians who fail to recognise the sequelae of trauma. The current mental health system tends to pathologise extreme behaviours rather than conceptualising them as coping mechanisms born of past or current trauma (Sweeney et al., 2018). Re-traumatisation refers to the process of re-experiencing past trauma(s) in

the present by triggering feelings and reactions evocative of past events (Sweeney et al., 2018). The current mental health system largely adopts a “diagnose and treat” (Bateman, Henderson & Kezelman, 2013) biomedical model which tends to operate via control and containment rather than empowerment and choice: in other words, clinicians operate regimes of restraint, seclusion, and/or the power dynamic of accepting medication. For some clients the inherent control of the paternalistic doctor-patient hierarchy can be troublingly reminiscent of early abusive power dynamics.

The reliance on power and medication to manage distress obviates the relational capacity of the clinician to engage collaboratively with the client; the priority is risk management (Sweeney et al., 2018). Working in trauma uninformed mental health services can also have a negative impact on the staff. Knight (2015) suggests that staff forced to draw upon “power” differentials in mental health systems to manage extreme behaviours which can deteriorate from “*I am compassionate*” to “*Just get through the day*”. Bloom and Farragher (2010) suggested another way in which staff cope may be “shutting off” their ability to empathise in viewing the client as “other”.

Chambers et al. (2014) interviewed 19 individuals who were detained under the Mental Health Act (UK) about their experiences. In the subsequent thematic analysis key themes such as powerlessness, lack of autonomy, staff/service user relationships, and staff attitudes were highlighted as having an important effect on recovery. This qualitative study demonstrated that building trusting relationships based on positive attitude and understanding was intrinsic to maintaining client dignity and supporting recovery.

It is evident that trauma informed approaches can support both clients and staff in preventing re-traumatisation by recognising the adverse impact of “power over” relationships and seeing the client as “other” and rather offer services which acknowledges trauma within foundational care on a collaborative/relational basis that explicitly seeks to reduce and eliminate sources of coercion and triggers (Sweeney et al., 2018). Since there is a gap in qualitative research in exploring this topic from clinician’s perspective, this study provides an opportunity to explore experience of training and working in a trauma informed way,

2.7.2 Recovery Orientated Practices and Trauma Informed Care

TIC is currently nascent in Ireland and often applied in settings other than mental health such as homeless services. However, it is evident that trauma informed approaches align well with recovery models in working with people with severe mental illness (AVC, 2006; Mental Health Commission, 2017; Mihelicova et al., 2018). The qualitative study undertaken by Mihelicova et al. (2018) explored what is ‘helpful’ in recovery from the perspective of service-users (n=15).

Their findings suggested that services should be tailored to the specific needs and preferences of the client rather than trying to ‘fit’ them into existing services. Moreover, it concluded that professionals who responded compassionately, worked collaboratively, and encouraged agency in service-users’ lives, promoted recovery-orientated services. As with the recovery-orientated model, TIC encourages empowerment, choice, and strengths-based collaboration with service-users. As such, TIC and recovery-orientated service provision are not mutually exclusive but rather, each trauma informed approach provides clinicians with an alternative perspective on how to talk about and envision recovery and therapeutic engagement (Isobel & Edwards, 2017). Extant recovery-orientated practices which are person-centred and focus on shared decisionality and service-user involvement can integrate TIC at an organisational level and potentially meet the commitment to reduce suicidality in policies such as Connecting for Life: Ireland’s National Strategy to Reduce Suicide 2015-2020 (DOH, 2015).

2.8 Trauma Informed Care (TIC): Definition

Trauma Informed Care (TIC) can be defined as “a system development model that is grounded in and directed by a complete understanding of how trauma exposure affects service user’s neurology, biology, psychology, and social development” (Paterson, 2014). As a result, TIC is informed by neuroscience, psychology, social science, attachment and trauma theories, and privileges the impact that trauma exerts on a person’s worldview and relationships (Sweeney et al., 2016). This approach rests on the assumption that anyone who enters the service has the possibility of trauma in their lives and as such may experience difficulties in developing trusting relationships with providers or in ‘feeling safe’ within a service. Trauma informed care conceives trauma not simply as a past event but as a formative experience that may contribute to the individual’s current presentation (Butler et al., 2011).

2.7.1 Principles of Trauma Informed Approaches

TIC first originated in the USA in the 1990's and the credibility and momentum of the approach was sealed by the instantiation of a trauma-centre funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). In the wake of this, Canada, New Zealand and Australia have also developed TIC principles within their policy documents and mental health system practices. The New South Wales Strategic Plan 2014-2024 specifically ring-fences the need for the development of a "service system that understands trauma and responds appropriately" (Mental Health Commission of NSW, 2019, Jan. 03. Retrieved from <https://nswmentalhealthcommission.com.au>, p.51). Both the UK and Wales have conducted their own ACEs studies (Bellis et al., 2015; Bellis et al., 2013) while the Scottish NHS has established the Scottish Adverse Childhood Experience Hub in order to provide guidance to education and health systems regarding trauma informed care.

TIC can be viewed as a meta-framework with a set of guiding principles (Mihelicova et al., 2018). Since it emphasises the impact of trauma rather than trauma-specific interventions, it influences the general organisation and practices of an entire system (Hopper, Bassuk & Olivet, 2010).

The key paradigm shift in trauma informed approaches was best encapsulated by Foderaro (as cited in Bloom, 2010) which highlighted the shift in thinking from "What is *wrong* with you?" to "What *happened* to you?" In real terms this means that all clinicians in mental health services are required to acknowledge the prevalence of trauma and understand the impact of trauma on people and how it might influence their practice (Sweeney et al., 2018).

The principles of TIC include the following (adapted from Abuse, 2014; Harris & Fallot, 2001; Sweeney et al., 2018; www.samhsa.gov.) As illustrated in Table 2.1, there are at least eight key principles of TIC which can be utilised to drive a cultural shift in the way clients are perceived, clinician relationships with clients, how client needs are conceived, and overall clinical practice.

Table 2.1: Principles of TIC (adapted from Abuse, 2014; Harris & Fallot, 2001; Sweeney et al., 2018; www.samhsa.gov.)

Principles of TIC	Description of Impact
Seeing through a trauma lens:	<i>TIC acknowledges the prevalence of trauma and the neurobiological and psychologically effects across the lifespan which manifest in development of behavioural and emotional dysregulation, poor coping mechanisms, mental illness, and health harming behaviours.</i>
Sensitive discussions about trauma:	<i>Asking about trauma is done in a sensitive, timely, and appropriate way which enables the individual to make a choice about disclosure (Read, 2007).</i> <i>The re-traumatising impact of repeating one’s story if nothing changes should also be considered.</i>
Preventing trauma in mental health:	<i>Deliberate steps to be taken to reduce/eliminate policy and practices which cause re-traumatisation or vicarious trauma, i.e. coercion or force.</i>
Collaboration & Mutuality:	<i>The recognition that roles within mental health services can replicate power differentials, i.e. ‘helper’ and ‘helpee’. Collaboration should be prioritised through transparency and understanding about ‘what is helpful’ from different perspectives.</i>
Trustworthiness & Transparency:	<i>Trusting relationships are built between staff and clients based on respect, transparency, and openness.</i>
Empowerment, Voice & Choice:	<i>Adopting a strengths-based approach supports the individual to recognise their capacity to take control of their own lives and make choices about their own care.</i>
Safety:	<i>Being aware of the potential presence of trauma and focusing on how psychological and physical safety can be provided through relationship, environmental and policy.</i>
Survivor Partnership:	<i>Collaborative relationships strive towards parity of esteem between staff and service-users.</i>

Bath (2017) raises a word of caution in relation to the proliferation of trauma informed care over the past ten years. He is concerned that TIC is now hailed as a panacea for all mental, physical, and behavioural disorders, to the exclusion of valid alternative theories and interventions such as attachment theory, CBT, or DBT, all of which can support therapeutic change. Bloom and Farragher (2010) postulate that “trauma theory

proposes that the origin of a significant proportion of physical, social and moral disorder lies in the exposure to external traumatic agents” (p.123). The training framework under evaluation in this study recognises that trauma informs a “significant proportion” of mental disorders in AMHS, but by no means all. Therefore, trauma theory incorporates a relational framework (Trauma Informed Relational Care Framework (TIRCF)) embedded in attachment theory which supports the development and understanding of how relationships can support mental wellbeing and recovery.

2.8.2 Research and TIC Implementation

Isobel and Edwards (2017) conducted a qualitative study with five nursing staff in an Australian acute inpatient mental health unit in order to explore the experience of implementing a Trauma Informed Model of Care. Using content analysis of the semi-structured interviews, the researchers identified conflicting opinions about the role of TIC and ambivalence about the enforcement of change. The nurses reported difficulties with the lack of clarity, consistency, and guidance about how practice would be changed. Whilst this research study provided insight into some of the challenges faced in TIC implementation, the limitations of the study were significant. The content analysis methodology used did not clearly outline whether conventional, directive, or summative content analysis was utilised (Hsieh & Shannon, 2005). Furthermore, the results were not reported in identified coded themes which meant interpretation of results in respect to literature was difficult.

A similar qualitative study using content analysis (Chandler, 2008) explored staff experiences (N=10) of introducing the TIC approach within an inpatient mental health unit in the USA. The study used interviews to garner in-depth descriptions of the experiences of staff who had transitioned to TIC. The themes identified in this study were changing perspective, developing collaborative relationships and prescribing educational resources. Limitations of this study included the use of content analysis since it did not yield any insight as to why the shift in perspective occurred, but simply recorded what had taken place. Moreover, the positionality of the researcher in relation to the topic and participants was not addressed. As such, the impact of the researcher on the findings was not addressed as their biases and assumptions were not declared. The fact that the researcher used the self as a primary tool in data collection was similarly unacknowledged.

Further qualitative research by Kirst, Avery, Matheson & Stergiopoulos (2017) explored facilitators and barriers to implementing TIC in mental health and addiction services in Canada. To this end, they interviewed 13 service providers and research experts who were trained in and using TIC, to capture their views on important aspects of TIC implementation. They also interviewed 6 service-users to elicit their experiences and level of satisfaction with trauma informed services. The semi-structured interviews were thematically analysed, and both provider and service-user perceptions were captured. The study suggested several key findings to support TIC implementation including organisational support, leadership, community partnership, staff awareness of trauma, safe environment, peer support, quality of consumer-provider relationship, readiness to change, and staff supports. The challenges identified included provider reluctance to address trauma, limited funding, and staff burnout. These challenges align with a systematic review conducted by Coyle et al. (2019) who explored trauma informed training and its impact on mental health clinicians' trauma enquiry behaviour. They found six out of nine studies demonstrated a statistically significant increase in the enquiry and reporting of trauma due to TIC training. Whilst, the sample numbers of studies are low, this review demonstrates promise in the impact of TIC training on clinical practice; albeit requiring further rigorous studies to advance understanding of behavioural changes arising from TIC training.

A significant limitation of trauma informed care models is the lack of enquiry into how TIC is operationalised within clinical practice and the way TIC theory and principles are actually applied in daily practice. Indeed, the majority of the research focuses on inpatient care settings and the reduction of coercive measures (Isobel et al., 2017). Sweeney and colleagues (2016) conducted a pilot project to initiate Trauma Informed Care to an acute mental health ward within an NHS Trust in the North of England.

To this end, they introduced and trained staff to implement a TIC pathway of care which entailed training staff in trauma and risk management, providing trauma-related information to clients, treatment algorithms, devising good practice guidance for the management of trauma disclosure, and staff support through supervision. The findings from this case study suggest that successful embedding of TIC occurred when staff took ownership and awareness deepened over time of the proliferation of trauma in the service. Empathetic engagement with clients and other staff members was found to be

essential in building alliances so that staff could see the differences TIC could make to clients and their own work.

The use of qualitative methods such as case study, semi-structured interviews, and focus groups to explore the experiences of both clients and clinicians is utilised in the evaluation of models. Therefore, qualitative research using semi-structured interviews is deemed an appropriate methodology to access the experience of clinician’s making sense of the training and how it impacts their practice (Isobel & Edwards, 2017; Moloney et al., 2018; Mihelicova et al., 2018).

2.9 Irish Response to TIC Need:

Trauma Informed Relational Framework-Attachment and Trauma

The table below describes a 2-day training event developed within CHO 4 Ireland, in response to the growing awareness of the need for the adult mental health service to be trauma responsive. The training is further described thereafter.

Table 2.2: Trauma Informed Relational Care Framework Training Profile

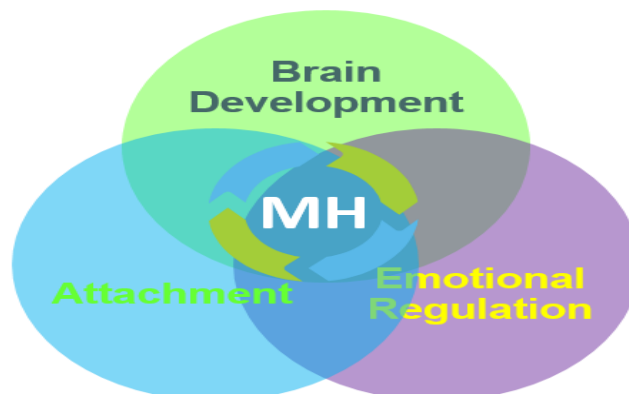
Theoretical Framework	Trauma-informed attachment framework
Topics Covered	<ul style="list-style-type: none"> • Childhood trauma – epidemiological perspectives: the ACE studies • Impact of early trauma on brain development – physiological development and allostatic load • Attachment – developmental importance and relationship to emotion regulation and social/emotional outcomes • Putting it all together – experiential learning, witnessing developmental trauma: a window for reflection on developmental trauma and the need for relationship repair • Integrating these understandings into trauma-informed practices – moving from what is wrong with you to what happened to you • Reflective practice as the bedrock for trauma-informed care
Learning Aims & Objectives	<ul style="list-style-type: none"> • Understand the impact of trauma in early childhood • Understand developmental trauma and its impact on long-term functioning, in particular mental health • Apply the felt experience of developmental trauma in

	understanding mental health presentations <ul style="list-style-type: none"> • Use reflective practice to understanding the impact of childhood trauma in mental health presentations
Type of Learning	Blended Learning

Trauma theory has resulted in a paradigm shift in how clients are understood and responded to within mental health services. As such it is imperative to have a relevant and theoretically coherent framework which encourages flexibility in responding to client needs. Since it is now broadly accepted that trauma which occurs in infancy and early childhood has an impact across the lifespan, attachment theory incorporating trauma theory can provide a conceptual understanding for clinicians regarding how developmental trauma impacts mental health outcomes.

It also reinforces awareness of how adverse early life experiences can impact on a client’s current behaviour and presentation. The figure below is a representation of how early attachment relates to the development of individual mental health.

Figure 2.2: Theoretical Foundation of Attachment Theory in Mental Health



2.9.1 What is Attachment Theory?

Attachment theory incorporates evolutionary theory, developmental psychology, and neuroscience as a means of understanding how infants develop through relationships and an internal working model of the self in relation to others, which guides attention, interpretation, and predictions about future interpersonal interactions and relationships. As the figure above illustrates, attachment works in concert with both brain

development and that of the emotional regulation system to influence mental health outcomes.

Bowlby (1969) suggests that infants develop a sense of themselves initially in the attachment relationship with their primary care-giver. Since infants utterly depend on their attachment figure for survival, the brain stem-based reflexes kick-start attachment-seeking behaviours such as eye-tracking and gaze at birth (Siegel, 2007). These later develop into proximity seeking, and so on. It is through such primary attachment relationship that infants develop the internal working models which inform how they interact with care-givers and others throughout their lives (Bowlby, 1988). Infants are not born with the capacity to recognise or regulate their emotions due to the underdeveloped frontal cortex. Thus, primary attachment relationship helps infants to develop emotional regulation (Wallin, 2007) and, as such, their social and emotional development takes place within the context of the primary relationship.

Mentalisation is an essential part of a secure attachment (Fonagy et al., 2002) whereby the child develops the internal ability to reflect on the intentions, behaviours, and motivations of self and others. Mentalisation is thought to occur when the child uses the care-givers ability to mirror the child's affective states and inferred mental processes to make sense of both visceral and inner experiences. This takes place through the daily interactional processes between child and parent (Siegel, 2007).

2.9.2 Types of attachment, development and impact on mentalisation skills

Attachment theory purports that infant/children develop attachment styles (internal working model) are predicated on how parents attend to their attachment needs (Ainsworth et al., 1978; Bowlby, 1988). As parental sensitivity and responsiveness are a key determining factor, their capacity to recognise the infant's distress, and to tolerate and respond in a timely manner whilst managing their own emotional state, ensures a secure attachment. In avoidant- dismissive attachment pattern, parents consistently respond with little or no care or attention to emotional needs. Since it follows that the child's ability to be self-reliant is correspondingly validated, long-term emotional withdrawal becomes the internal working model. In an ambivalent-anxious attachment pattern the parent responds inconsistently to the child's needs: either they are not at all available or they are excessively intrusive on the child. In this case, an internal working model emerges whereby emotions are expressed in an excessive manner: the child

cannot self-regulate and therefore develops an over-reliance on the care-giver resulting in anger towards the caregiver. Such attachment styles inhere a protective function during childhood since they enable the attachment dynamic to be maintained. However, in adulthood these attachment dynamics can give rise to mental distress and psychopathology.

Disorganised attachment is more common in maltreated infants. However, it does not necessarily follow that an infant displaying behaviours such as stereotypies, misdirected movements, freezing, apprehension regarding parent, and so on (Granqvist et al., 2017), has been maltreated. The aetiology of disorganised attachment is varied and can include neurological or developmental difficulties, genetic predisposition, or excessive situational stress (Granqvist et al., 2017). However, disorganised attachment associated with maltreatment occurs because the child has no way of coping with the caregiver who is simultaneously the source of fear, and to whose “safe-haven” they are “genetically driven” (Danquah & Berry, 2014). This causes confusion and a fundamental breakdown in the child who is unsure whether to approach or flee from their care-giver.

Disorganised attachment is often the result of intergenerational trauma whereby the caregiver has also experienced unresolved early emotional trauma and may enter mildly dissociative states, looming over the child and arousing fear (Schoore, 2015, p.122). Therefore, the type of attachment relationship established in early infancy and childhood can be a risk factor which impacts the developmental trajectory, internal working models and brain development. Disorganised attachment is a known risk factor for developing behavioural problems (Granqvist et al., 2017). However, it is more likely that a child with disorganised attachment has also encountered other stressful life events through its lifespan which perpetuate behavioral and psychological difficulties (Granqvist et al., 2017). Attachment then is not a static trait, and the impact of parents seeking help, a supportive relationship, or therapeutic intervention, can significantly alter the pathway (Granqvist et al., 2017).

2.9.3 Brain Development

Experience is responsible for the majority of postnatal brain development (Nelson, Zeanah & Fox, 2019). Thus, the quality of caregiving in early relationships is vital for healthy psychological development as it supports growth in neurobiological structures,

the stress response system, and attentional systems (Nelson et al., 2019). The stress response system or hypothalamic-pituitary-adrenocortical (HPA) axis is the hormone system responsible for the speed with which the body responds to stressful events. As its development occurs within the first few years of life it is vulnerable to early-life environment (Nelson et al., 2019; Van Der Kolk, 2015). Studies in children who experience early social deprivation (Dozier, Manni & Gordon et al., 2006; Fries, Shirtcliff & Pollak, 2008, cited in Nelson et al., 2019) suggest that severe psychosocial neglect has a lifelong negative impact on the functioning of this system. One protective factor in the HPA axis development is the quality of attachment relationship, as caregivers act as co-regulators in response to infant behaviours, emotional states, and biological needs. The infant is supported by the caregiver to build bio-behavioural structures through experiences which progress to healthy stress response systems and secure attachment.

2.9.4 Emotional Regulation

Emotional regulation is defined as the capacity to influence the experience and expression of one's emotions (Rutherford, Wallace, Laurent & Mayes, 2016), and there is some evidence to suggest that emotional regulation is influenced by a genetic component (Eisenberg & Morris, 2002). There is also agreement that familial socialising with the parent shapes this ability (Bariola et al., 2012; Zeman, Cassano, Perry-Parrish & Stedegall, 2006).

Siegel suggested it is “in the face” of the early attachment relationship through marked mirroring and partial contingency mirroring that the infant begins to recognise and internalise differing emotional states (Siegel, 2007). Parents are believed to socialize their child's emotional regulation through: 1) learning through direct observation of the parent (modelling); 2) the parenting practices, i.e. if a parent responds to a child with conditional regard whether positive or negative is associated with internalising or externalising difficulties; and 3) parent-child attachment (Rutherford et al., 2016).

At the heart of emotional regulation is the ability to recognise and reflect (*reflective function*) our own and others' emotions and to decide how we will respond. The impact of developmental trauma as understood within the attachment relationship provides clinicians with an understanding that supports a paradigm shift in how the client's current behaviour is understood in relation to past experiences. The relational aspect of

attachment theory also provides mechanisms through which clinicians can begin to reflect on and change their practice.

2.10 Trauma Informed Relational Care and the Mental Health Setting

Ludy-Dobson and Perry (2010) propose that while relationships have the capacity to negatively impact brain development, and social and emotional development they can also be reparative and healing. There are significant opportunities at clinical level for mental health clinicians to be trauma- informed in their day-to-day practice through relational interactions.

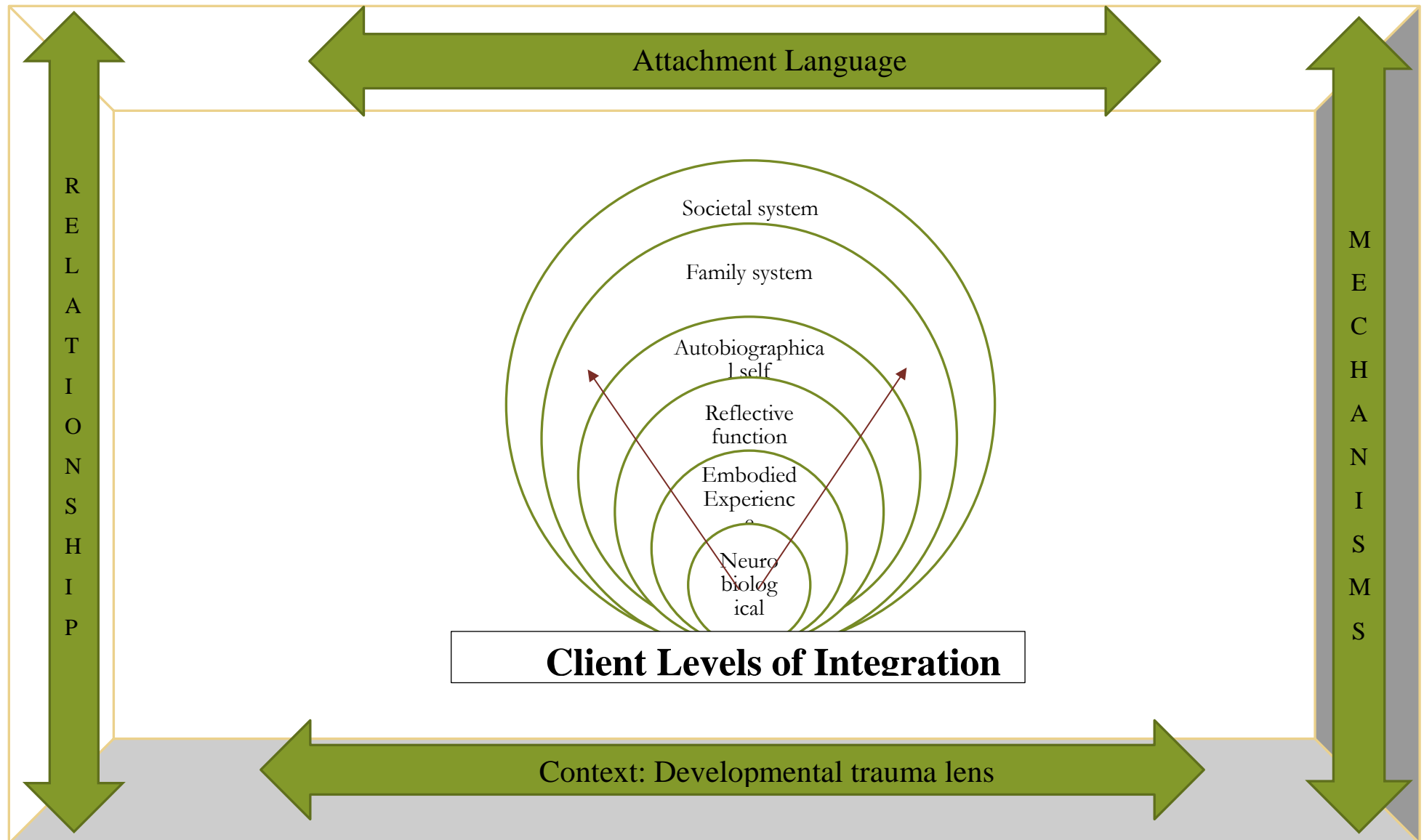
Regardless of the theoretical orientation of the clinician, the therapeutic relationship accounts for a positive therapeutic outcome, or at least as much as the treatment model (Norcross & Wampold, 2011). The quality of the therapeutic alliance as an active collaboration between the participants (Horvath, Del Re et al, cited in Norcross, 2011) is a robust predictor of outcome (Safran, Muran et al. cited in Norcross, 2011). Attachment theory provides a framework upon which this therapeutic alliance can be understood as an integral mechanism of change.

Holmes (2014) suggests that the architecture of a therapy involves a similar sequence in that a person in distress (client) seeks a safe haven, and secure base. The care-giver (therapist) offers security, soothing, and warmth in a supportive and exploratory companionship which results in a unique interactional relationship. Bowlby (1988) proposed that one of the main functions of the therapist was to “provide the patient with a secure base from which he can explore various unhappy and painful aspects of his life, ...without a trusted companion to provide support, encouragement, sympathy, and on occasion, guidance” (p.138).

The mental health service as envisioned within the attachment framework could provide a place of safety and acceptance for its clients.

Figure 2.2 offers a schematic representation of how the trauma informed relational care framework incorporates attachment theory understanding of development on an individual level and within a mental health system utilising relational focus, mechanism and shared language to create a paradigm shift.

Figure 2.3: Trauma Informed Relational Care Framework



2.10.1 Relational (Bowlby, 1988; Holmes, 2017)

As indicated in figure 2.2 the prioritisation of the therapeutic relationship is one of the key aspects of trauma informed relational care. Holmes (2017) proposes that therapists who operate with an attachment informed framework utilise the meta-competencies that emerge from the infant-parent interactional processes such as marked mirroring and partial contingency mirroring. It is these meta-competencies that assist the client to build a reflective functioning which enables them to see themselves as other see them.

Table 2.3: Meta-competencies utilised in Attachment Informed Practice

Meta-competencies utilised in Attachment Informed Practice	
Marker mirroring	Creativity imagination
Partially contingent mirroring	Rupture/repair
Positive comments	Therapist as secure base

2.10.2 Client levels of Integration

The client levels of integration (figure 2.2) illustrate the various systems; internal and external to the person, impacted by the attachment relationship and developmental trauma. This framework integrates concepts from Bronfenbrenner's (1992) understanding of the impact of multiple systems on the way disability is experienced in the world. Bronfenbrenner proposes interplay of psychological, social, and biological influences in the pathway that takes a child through adolescences and adulthood (Garbarino, 2015). Shankoff (2012) introduced the notion of "toxic stress" such as poverty, racism, and community violence as an additional element of childhood adversity. The societal system, in the world of developmental trauma offers little safety or security. In *Listening to Killers*, James Garbarino (2015) identified "social toxins" and "war zone mentality" as exosystem factors which influence the violent and criminal outcome of the people he interviewed, all of whom had a history of developmental/complex trauma. Social toxins as defined by Patricia Falk (1996) are social environmental factors that affect mental functioning.

The theory of "social toxins" and "war zone mentality" has certain implications for a population of people who experience developmental trauma. It suggests that each community has its own "social toxins" and moral views, reasoning, and behaviour that

justifies their way of being in the world. A mental health clinician who can incorporate multiple levels of understanding of a client and build that awareness into their relational interactions can arguably respond more flexibly to their client (Courtois & Ford, 2009).

2.10.3 Context and Language

As previously discussed, integrating trauma evidence from the ACEs study and enabling this to change the lens as described in the core principles of TIC, provides clinicians with a paradigm shift in how the client is viewed. Thus the narrative about the client changes from “What’s *wrong* with you?” to “What *happened* to you?” (Foderaro, cited in Bloom, 2010). Attachment theory provides clinicians with an understanding of how these early life experiences of relational trauma can be supported through relationship with the clinician. It also provides a shared mental health team language with which to properly hypothesise how a client’s past may influence their current presentation.

The integration of developmental trauma theory and attachment theory in the training provides clinicians with an understanding of the lifespan impact of trauma from infancy to adulthood in terms of mental health. This bridges the gap identified in literature whereby the epidemiological impact of trauma may be understood but the psychological impact on the client’s behaviour and presentation is absent. It is this gap that the training aimed to close, and the impact on the clinician which this research study seeks to determine.

2.11 How is TIRC operationalised in Mental Health Setting?

“How can we develop the practitioner from the practice?” (Bolton, 2017)

“How can we know the dancer from the dance?” (Yeats, 1989, p.128)

As discussed in the section above, normative development within a secure attachment supports the appropriate development of mentalisation in an environment which affords opportunity for growth. The capacity and skills of mentalising continue throughout the lifespan in environments that encourage a focus on internal states (Allen, Fonagy & Batemen, 2008; Luyten, & Fonagy, 2015).

The Trauma Informed Relational Care (TIRC) Framework utilises attachment theory as a major concept which assists clinicians to understand client presentations in the context of relational difficulties, emotional dysregulation, and poor mentalising capacity. Therefore, mechanisms of experiential learning (learning-by-doing) and

reflective practice were utilised in training to provide opportunities for participants (clinicians) to engage their own mentalising skills by fostering a training environment with a slow pace and focus on the internal by examining their personal experience, a conceptual framework (TIRCF), and allowing space for interaction between the two in a reflective process.

Reflective practice is increasingly regarded as a fundamental attribute of competent health professionals who are prepared to evolve with the ever-changing and complex healthcare problems (Mann, Gordon & MacLeod, 2009). As such it is ubiquitous across the fields of psychology, nursing, medicine, other allied health professions, and education (Nguyen, Fernandez, Karsenti & Chrlin, 2014). There is a broad range of definitions for reflection in the literature, including that of Dewey (1933); Argyris & Schon (1974); Kolb (1984), Moon (2004) and Mann et al. (2009) to name a few, with little consensus on the core features. For this reason Nguyen and colleagues (2014) conducted a systematic review of 430 studies across nursing, psychology, education, and so on, to properly hone a definition and model of reflection. They subsequently proposed a theory-informed, five component definition and model of reflection which incorporated certain extrinsic elements, such as trigger and context, which influence reflection:

Reflection is the process of engaging the self in attentive, critical, exploratory, and iterative interaction with one's thoughts and actions, and their underlying conceptual frame, with a view to changing them and with a view on the change itself. (Nguyen et al., 2014, p.1182)

The five components stated to comprise reflection in this meta-definition include;

1. **TA:** thoughts and actions which are related to the content of reflection, i.e. what one thinks about- beliefs, experiences, knowledge, actions and ideas.
2. **ACEI:** attentive, critical, exploratory, and iterative component which are related to the process of reflection, i.e. how one thinks about the content. Combining these two components suggests that to activate reflection requires an analytical and enhancing way of processing one's thoughts which transform to a new form of knowing and is further enhanced by the last three components.
3. **CNF:** underlying conceptual framework.
4. **VC:** a view on change, i.e. reflection incorporation TA, CF and VC creates a new, deeper meaning and change in conceptual perspective.

5. **S:** the self-component. The self-component highlights the significance of personal beliefs and assumptions considering TA, CF and VC.

Nguyen et al. suggest that reflective practice can only change one's way of being, doing, and thinking when there is interactive reciprocity between one's thoughts and actions (TA) and underlying conceptual framework within the context of understanding how personal beliefs and assumptions relate to and inform the self. Therefore, reflection can be hard to access and goes beyond the moment of meaning (trigger) created in training.

Personal beliefs and values affect clinical practice in the adult mental health setting and opportunities for self-reflection through training and/or supervision can support clinicians to appropriately respond to clients and their needs. Therapists' own attachment history can be a source of impasse but also of inspiration (Wallin, 2014). Schon, who first coined the term "reflective practice" (1987, cited in Bolton, 2017), suggested that all education required entering a space of "not-knowing", asking questions and trusting that reflective practice is the best piece of "equipment" to encourage learning through a process of internal and external exploration. Reflective practice in training can provide the participant with the space to explore both what they know and do not know. Dewey (1933, cited in Bolton, 2017) claimed that doubt and uncertainty were essential elements of reflective practice. Therefore, reflective practice helps us tolerate uncertainty, and enables us to say, "I don't know but I want to find out". Brookfield (2017) suggests that reflective practice allows a person to explore the type of practitioner they are and to integrate a new understanding of self and the conceptual framework as a means to explore the practitioner-self.

Wallin (2007) suggests there is a continuum of consciousness and people are capable of interacting within states of mind from embeddedness to mentalising (reflection) and mindfulness. Embeddedness refers to an unreflective state of mind where "*we are the experience as long as the experience lasts*" (Wallin, 2007, p135). The next state of mind, mentalising, is the ability to reflect on thoughts, feelings, sensations and mental representations about the experience of our inner and outer world. This allows a person to process information about an experience and reflects on it before they act. In Wallin's (2007) view strengthening the reflective self is an important aspect of therapy, supporting the client to move from embeddedness to mentalisation so they can make sense of self. Finally, mindfulness moves beyond reflection to being aware of

awareness itself. The mindful clinician cultivates the inner observer that becomes aware of awareness itself, can identify the reactivity and defences of self and others more skilfully.

A systematic review of 29 studies to evaluate the use of reflective practice in health professional education found that whilst reflection is demonstrated among practicing professionals, there are several factors that promote it, i.e. complex problem and length of experience (Mann, Gordon, & MacLeod 2009). The learning environment can enhance or inhibit reflective thinking and is hugely influenced by the behaviours of the educators (Mann et al., 2009) and the ability to reflect is amenable to development over time. The findings also purported a connection between reflection and deep learning, which supports Moons' (1999) preposition that the iterative process of reflective thinking moves from surface to integrated understanding of theory and practice (Mann et al., 2009).

Robert Emde (2009) views reflective practice as an integral aspect of learning to use yourself as a tool in clinical practice. Thus reflective practice affords the space for clinicians to focus on their own internal states and thereby create an environment which promotes mentalising about self and clients.

2.11.1 Mentalising and its Relationship to Empathy

Mentalising is defined as the capacity to understand the mental states, i.e. beliefs, desires, intentions, wishes, and goals, of both self and others (Luyten & Allen, 2015). This human capacity is principally a developmental skill initially acquired within the primary caretaking attachment relationship in infancy and continuing throughout the lifespan in relationships and environments which foster a focus on internal states (Luyten & Allen, 2015). The ability to mentalise is a cornerstone of interpersonal relationships since it contributes to the formulation of perspective and to the epistemic trust which is integral to collaborative working with clients of mental health services (Hooker, Verosky, Germine, Knight & D'Eposito, 2008; Fonagy, & Allison, 2014). In instances when a client feels understood and the clinician can utilise a trauma informed relational care framework to validate their experience as a 'felt truth', there is potential for epistemic trust to grow (Fonagy & Allison, 2014). In collaborative work, the clinician models how to mentalise for the client through open active listening with empathy and genuine care.

An individual's mentalising capacity is a transactional social process, in that it is developed within the context of a primary attachment relationship and is influenced by the mentalising capacity of others. Neuroscience has found that mentalising has four different dimensions: namely, a) automatic or controlled; b) mentalising about self or other; c) mentalise based on internal/external features of self or other; and d) cognitive versus affective mentalising. Neuroscience further suggests that two factors determine the quality of mentalising: namely, a) stress or arousal levels; and b) the individual's attachment history (Luyten & Fonagy, 2015). Thus impairments in psychopathology can be understood in terms of different combinations of these dimensions.

Stress acts as a 'roadblock' to mentalising. Indeed, when it goes off-line the mind resorts to automatic, unconscious processing of social information which rely on subjective bias and safety modes (Holmes, & Slade, 2018; Luyten, & Fonagy, 2015). For instance, when confronted with the disturbing behaviour of a client the mental health professional may feel threatened and highly anxious. This reduces mentalising capacity so that the client may be perceived as 'deliberately aggressive' or dangerous and a non-mentalising response may ensue such as discharge from the service or risk aversive strategies.

Through training the clinician is provided with the opportunity to integrate a developmental trauma perspective and relational understanding of development that's supports their ability to understand how the client's past experiences impact on their present way of being. Mentalising is a fundamental skill in working therapeutically with people since "being understood in therapy is a first step towards understanding self" (Holmes & Slade, 2018). The safe space in training provides clinicians with the opportunity to develop mentalising skills about clients, which in turn, promotes empathy in the therapeutic relationship (Liotti & Gilbert, 2011).

2.11.3 Why is Empathy Important to Develop in Clinicians?

Empathy and empathetic understanding have been recognised as integral elements of fostering communication and trust in therapeutic relationships since the early 20th century. The common factors approach (Egan, 2010) to psychotherapy suggests that an enhanced empathetic understanding through the building of therapeutic relationship, promotes greater compliance, therapy satisfaction, and involvement in care (Bohart, Elliot, Greenberg & Watson, 2002).

Empathy taps into the affective component of mentalising about others. While empathy and mentalising are similar in that they both require an understanding of another person's mental and emotional state, empathy necessitates *sharing* in the emotional experience of others (Hooker et al., 2008). The various systems which guide empathy include affective empathy which is instigated in the mirror neuron system (MNS) in the brain (Gallese, 2007) and is thought to be an automatic function. The second system is cognitive empathy which may be stimulated by the emotional empathetic response but also requires cognitive perspective-taking and mentalising (DeWaal, 2007). These two components intertwine to form an empathetic state (Shamay-Tsoory et al., 2009). While empathy does inhere some features of automaticity, people do not always empathise automatically (Zaki, 2014). Context effects such as intergroup conflict, i.e. seeing a person as "other" and level of expertise, are purported to dissipate empathetic response (Zaki, 2014). However, as Bloom and Farragher (2010) explain, the "othering" of clients through the shutting down of empathy can help clinicians to cope in stressful environments such as AMHS.

In training, the didactic element of attachment theory, evocative visual materials, and reflective exercise based on own attachment experiences, provide the space for clinicians to develop mentalising skills about self and clients, along with the emotional resources for experience sharing with clients.

This has the potential to develop empathetic understanding and overcome potential blocks to empathy in the therapeutic relationship since it advances both affective empathy and higher-level perspective taking empathetic capacity in clinicians.

2.11.4 Empathy: An Integral Model

Rogers (1964, cited in Clark, 2010) suggested that clinicians' focus on clients should not primarily rest on interpersonal empathy but should also incorporate subjective and objective empathy. Clark (2010) built on the integral model of empathetic understanding through three ways of knowing the client: subjective empathy; interpersonal empathy; and objective empathy.

Subjective empathy is a reciprocal process between the clinician's awareness of their internal reactions in response to experiencing the client. Momentarily, at a felt level, the clinician experiences what it is like to be a client. In this way, the clinician utilises skills such as identification, imagination, intuition, and "felt level experiencing" in an attempt to empathetically understand the client. In a sense, the clinician uses the self as

a tool for empathetic understanding and to aid hypothesis in team meetings (Clark, 2010).

Interpersonal empathy involves trying to understand the clients' phenomenological experience within the relational dynamic to determine how that might impact on how the client perceives life.

Objective empathy relates to evidence-based knowledge, conceptual frameworks, or normative self-report questionnaires which can contribute to an idiographic understanding of a client. Fonagy & Allison (2014) postulate that integrating accurate and helpful evidence-based information, contributes to epistemic trust and openness as the information may serve to further validate the phenomenological experience. When the clinician integrates multiple ways of knowing the client, reflects upon their own reactions within the relational dynamic, and regards themselves as role models within the relationship, i.e. mentalising, the therapist is more likely to enhance their boundary management and manage personal stress reactions (Courtois & Ford, 2009).

2.12 Operationalizing TIRC Framework in Practice

There is a dearth of research around the operationalization of trauma informed care and attachment theory in the adult mental health setting.

The literature maintains a narrow focus on the implications of attachment theory for single schools of psychotherapy (Danquah and Berry, 2013).

As TIC is relatively new approach in Ireland there is currently scant literature on its impact in mental health settings. Most research is focused on the USA with no randomised control trials (Sweeney et al., 2016). Moreover, there is limited qualitative exploration of how clinicians operate using attachment informed practice. Burke and colleagues (2015) conducted a qualitative grounded theory exploration of the use of attachment theory in adult psychological therapy (Burke, Danquah & Berry, 2015). They explored how therapists use attachment informed theory in their practice. Six themes were identified describe how attachment theory informed practice: namely, (1) complementing other therapeutic models; (2) providing a framework for understanding the development of client's mental health; (3) working with different attachment styles; (4) influencing stages of therapeutic process; (5) thinking about the therapeutic relationship as an attachment relationship; and (6) influencing clinical service design. The limitations of study included the homogeneity of the sample population and potential researcher bias given the knowledge of attachment prior to conducting

grounded theory exploration. Moreover, while the researcher purportedly utilised a ground theory method, given the nature of the existing theoretical construct, the research may more accurately be described as grounded theory informed.

Further evaluative studies on TIC training within mental health services were conducted in Australia in 2018 (Moloney, Cameron, Baker, Feeney, Korner, Kornhaber *et al.*, 2018; Palfry, Reay, Aplin, Cubis, McAndrew, Riordan & Raphael, 2018). Palfry *et al* (2018) applied mixed methods to evaluate the trauma informed care training specifically designed to meet the needs of mental health practitioners. The participants self-reported significant increases in confidence, awareness, and attitude towards assessment and to acknowledge trauma with clients. The qualitative element focused on the participants answering three written questions (most important aspects of TIC training; changes in their practice; and future needs) with the answers subsequently coded into themes. The findings demonstrated that more than half of the participants would include routine questions about trauma history and twenty per cent discussed improving therapeutic alliance and having increased empathy. A limitation of this study is evident in the self-report measures that were used as they were not validated, and did not measure the actual knowledge of participants. The qualitative method of written response also offered limited understanding of experiences and constrained responses. The purpose of the limited qualitative aspect of the research was unclear and other methods such as interview would have elicited a richer understanding to inform the needs of the participants.

2.13 Impact of short-term post-qualification training on clinical practice

Short-term post-qualification training also known as continuous professional development (CPD) is “any process or activity that provides added value to the capability of the professional through the increase in knowledge, skills, and personal qualified for appropriate execution of professional and technical duties, often termed competence” (PSI, 2017, p5). The focus of CPD is to maintain and enhance the quality of work and ensure that professionals are fit for purpose, safe to practice and update throughout their careers (Golding & Gray, 2006). The Trauma Informed Relational Care training falls into the category of CPD therefore it is important to consider the impact of CPD training on mental health practice and how it is assessed.

CPD lies within adult education and is predominantly self-directed. On assessing the impact of post-qualification training it is imperative to take into consideration some of

the pitfalls associated with self-appraisal in relation to professional competence. Green (2006) reported that health care professional's ability to accurately assess their own competencies can be skewed by a "systematic positive bias" (Green, 2006, p.9). This view supports Kruger and Dunning (1999) research who reported that it is the least capable members of a training cohort who are likely to have the most positive view of themselves. This coupled with another psychological strategy, one christened from "chump to champ" by Wilson and Ross (2000) suggests that health professionals often compare their current ability to former practice as a means bolstering self-esteem and positive appraisal. The impact of positive bias and relying on the wisdom of hindsight can impact on how a professional self-appraises their competency and reports on their skill accomplishment.

Most common evaluations of CPD are satisfaction evaluations which are open to multiple bias including social desirability bias and self-affirming bias. Therefore, consideration of additional methods for assessing the impact of training beyond self-report could be considered. These evaluations could include assessing learning outcomes and the transfer of skills to routine work. The use of audio or video recording of sessions and analysis of this data to determine the presence of theoretically important items within the sample (Milne, James & Sheikh, 2006, p.156) by the course trainers could be a method of exploring skills use and growth in competencies. Direct observation and review of client outcomes could also provide insight into the integration of knowledge and skills into real-life practice. In gauging the impact on the client, a post therapy outcome questionnaire could be provided such as the Helpful Aspects of Therapy Questionnaire (Llewellyn et al., 1988) to assess the transference of skill to practice (Milne et al., 2006).

The question arises- Does CPD result in changes to the clinical competence, care and improved treatment outcomes for clients? Do practitioners learn from engaging in post qualification training? Adult education tends to be self-directed and rely on self-appraisal as a means of identifying effectiveness (Green, 2006). However, as discussed previously self-appraisal in terms of competency development is not always reliable. There is an assumption that once professionals have engaged in CPD that it will be transferred into clinical practice (Green, 2006). Miller and Mount (cited in Golding and Gray, 2006) reviewed, through direct observation, the clinical practice of counsellors four months after participating in a motivational interviewing workshop. They stated the real-life practice did not match the counsellors self-reports. The lack of impact

could be accounted for the ‘one-off’ brief training events which seem to typify CPD. Evidence suggests there is short term impact of this type of training event (Davis et al., 1995).

Milne, James and Sheikh (2006) suggest a number of ways the evaluation process of short-term post-qualification training could increase the likelihood of staff training transfer which includes ‘problem-solving’ approach and ‘self-control’ approach. The ‘problem-solving’ approach highlights the transfer of skills difficulties in environment i.e. work practices, management and tries to counter-balance them with transfer reinforcing factors (Milne, Gorenski et al., 2000 cited in Golding and Gray, 2006). The ‘self-control’ approach introduces reflexivity into the CPD module where almost like a ‘relapse-prevention’ approach to the transfer problem the learner anticipates ‘slips’ and plan remedies for any such slips.

Given the focus of this research (clinician’s lived experience) it was decided that one form of evaluation (semi-structured interview) would provide information on how the clinician’s experienced the training from the inside (impact on self) out (impact on their view of client). No doubt the objective exploration of the impact of this post-qualification training through recording or direct observation would yield interesting data on the impact of this training on clinical skill development objectively. This research is a theoretically driven qualitative investigation to extend our understanding of the learner’s experience.

2.14 Current Study

2.14.1 Researcher Positionality

Just as the clinician in the trauma informed relational care framework integrates multiple ways of knowing the client, the researcher must honour the multiple lenses they bring to the research study. As researcher, novice clinician working within adult mental health services, and “model absorbed student” (Holmes, 2015), it is important that theoretical foundations, clinical experience, systems knowledge, and personal experience are held in a known yet distanced stance to allow for objective critique of literature which is tantamount to a credible research process.

2.14.2 Gap in Existing Knowledge

This extensive literature review has presented a comprehensive overview of the research literature from both a quantitative and qualitative perspective. A number of significant gaps are clearly evident from the critique. There is a conspicuous lack of enquiry into the operationalisation of trauma informed care frameworks on workforce training and development in the mental health setting. Indeed, the extant literature largely maintains a narrow focus on the implications of attachment theory for the various discrete schools of psychotherapy (Danquah & Berry, 2013). As TIC is a relatively recent approach in Ireland there is little local literature on its impact in mental health settings and the majority of research to date has focused on the USA and Australia with no randomised control trials (Sweeney et al., 2016).

Training is essential to the implementation of TIC since it boosts awareness and sensitivity to trauma-related issues and offers guidance on how to modify practice. This research examines how one Community Healthcare Organisations (CHO) within the Irish context responded to the growing need for trauma informed care. The primary aims of the Trauma Informed Relational Care two-day training were to increase clinician's awareness and understanding of trauma in adult mental illness, and to consider how that may influence clinical practice. The objective of this research is to interrogate the clinician's experience of attending this training and to capture a rich understanding of their experience of training and how that impacts on their understanding of self, client, and clinical practice.

2.14.3 Research Questions:

1. How does a mental health clinician's first experience of attending a 2-day training course on trauma informed relational care impact their understanding of self and client?
2. How does the clinician's experience of training impact their relationship with client?
3. What is their experience of translating this training into clinical practice?

2.15 Reflective Box

Pillow (2003) describes four reflexive strategies including ‘reflexivity as recognition of self; reflexivity as recognition of other; reflexivity as truth; reflexivity as transcendence’ (p.181). During the literature review phase of the thesis I began self-monitoring through journal writing. It was in this space that I became aware of the struggle within myself between the ‘model consumed student (Holmes, 2015) and the objective researcher. My enthusiasm for the subject matter, trauma informed care, and its potential in adult mental health meant that I was ‘blinded’ to potential weaknesses in the model because of ‘self-confirming biases’. The challenge was set to me by research articles and particularly Bath’s (2007) article that yielded a firm warning “Be careful not to see it as a panacea to everything”. This warning weighed heavy as it sullied the ‘hope’ I held for this model in terms of changing how a client is viewed in the relationship with the clinician. It grounded me to the reality of practicing in a mental health setting. It is foolish to think that ‘one size fits all’ or one model can meet all needs. Therefore a literature review must be objective and open to including multiple perspectives and critically looking at the model through the lens of all sides of the literature available. It has awoken the integrationist view, every model offers advantages and disadvantages to working with clients. Researchers and clinicians are best equipped when they are fully informed from an objective evidence based perspective. Therefore my role as researcher is invaluable in providing the space for honest, objective exploration of this subject matter. Engaging and challenging my own thoughts and feelings through this literature review enabled me to produce a rounded representation of the data.

Chapter Three: Methodology

3.1 Introduction

The following chapter outlines the ontological and epistemological principles upon which this research study was developed. As such it delineates the research methods such as sampling, analysis, and so on, as a means of ensuring replicability. Aspects of credibility are also discussed within the qualitative framework in this chapter. Finally, this chapter addresses ethical considerations and the role of the researcher through reflexivity and positionality within the research. The reflexive role of the researcher is evident throughout as a crucial aspect of IPA which was adopted as the methodology informing the research question, methodology, and analysis.

3.2 Interpretative Phenomenological Analysis (IPA)

Ontological and Epistemological Positioning

The process of research design was fundamentally influenced by the ontological and epistemological position and the researcher's inclination to the subject (Furlong & Marsh, 2010). Interpretative Phenomenological Analysis (IPA) conceptualises the individual as an inclusive part of reality, and embedded in the world s/he inhabits (Larkin, Watts & Clifton, 2006). Since Heidegger proposed that "What is real is not dependent on us, but the exact meaning and nature of reality is" (Larkin, Watts & Clifton, 2006), IPA is located on a continuum between relativism and realism. As such, it is a position of critical realism which acknowledges that while the world exists, individual realities are constructed through thoughts and meanings derived from their subjective interactions with the world. Heidegger's phenomenological view of the person was as a 'person-in-context'. Thus IPA does not view reality as objective or try to remove the self from the world as in the positivistic ontological view. Rather it seeks to give voice to the lived experience of a person and make meaning of the experience through the interpretation of the researcher.

The implications of an ontological approach in terms of psychological research are that all meaning and knowledge is held to be created in the relationship between the research and the subject matter (Larkin et al., 2006). From an epistemological stance IPA adopts an interpretivist perspective which is concerned with how people make sense of their experience of a specific phenomenon. Smith (2018) describes a person as "self-reflexive" and "sense making" agent in the world. Advocates of IPA therefore

regard the role of the researcher as pivotal to the participants' sense-making and refer to it as "double hermeneutics" (Smith et al., 2009).

The researcher is also an inclusive part of the world the participant inhabits in creating meaning through empathy and questioning. This is the second level of double hermeneutics. The primary goal of IPA then, is to access the lived experience of a person-in-context and to make meaning of their experience. The researcher aims to provide an account of how the participant is thinking by using empathy and the application of existing theories to make sense of the experience (Smith et al., 2009, p.80). IPA is underpinned by the three principles of phenomenology, hermeneutics, and idiography.

3.3 Principles of Interpretative Phenomenological Analysis

Phenomenology explores the lived human experience and how things are perceived to the consciousness (Tuffour, 2017). Husserl (1859-1938), the pioneer of phenomenology, proposed that the essential components of an experience could only be accessed by systematic and reflective engagement with the everyday 'lifeworld' (Smith, et al., 2009). Thus researchers try to identify the essential components which make an experience special. Husserl placed the role of the researcher on the periphery by espousing the 'bracketing' of researcher preconceptions and allowing the experience to speak for itself. Heidegger (1962) further developed the phenomenological position towards an existential and hermeneutical perspective (Shinebourne, 2011) by theorising the person as a conscious being who participates in the constructs of reality (Yalom, 1980). The "daesin" as the meaning-giver or knower therefore, inhabits its own world. Heidegger goes on to suggest "the meaning of phenomenological description the method lies in interpretation" (Smith, 2009). The interpretative role of the researcher enables the researcher to gain insights from the person by actively utilising curiosity, empathy, and flexibility to listen to their narratives as a way of understanding how their experiences and behaviours are shaped by their personal, social, cultural, and work worlds (Tuffour, 2017). Thus, in so far as is practicable, the core aim of this study is to understand the impact of Trauma Informed Relational Care training on a practitioners' sense of self, their relationship with clients, and their clinical work practice in AMHS.

The second philosophical underpinning of IPA, namely, hermeneutics, is concerned with the art of meaning-making or interpretation (Pietkiewicz & Smith, 2014). Ricoeur maintained experience and meaning to be entwined, and further held that language, as

the expressive force of experience, has an essential role to play (Smith, Flowers & Larkin, 2009).

For the IPA researcher, the subjective experience is revealed through the interpretation of language: that which is conscious and unconscious. Heidegger and Gadamer (cited in Smith, Flowers, & Larkin, 2009) similarly proposed that all understanding of events or phenomena requires interpretation based on pre-existing knowledge of the world. As such, interpretation is a dynamic process moving between the interpreter and the object of interpretation (Shinbourne, 2011). In short, a dual quality of interpretation exists, where on one level meanings are visible in the conscious interpretation of language and context, and on another, they are hidden to the participant and only exposed by the interpretations of the researcher. As objective analysis is beyond the scope of hermeneutics, the role of the researcher is recognised as operating a “double hermeneutic” (Smith, Flowers & Larkin, 2009).

Idiography, the third theoretical underpinning of IPA, is concerned with the detailed and subjective analysis of phenomenon which gives precedence to in-depth analysis of a single case and the examination of individual case studies prior to the formulation of general theoretical statements (Pietkiewicz & Smith, 2014). Most crucially, it assumes a worldview wherein the individual actively participates in the meaning-making of their own subjective experience, while the researcher plays an active and dynamic role in interpretation of the same. Given the idiographic nature of IPA, no empirical findings per se are produced. Rather the research attempts to capture “what it is to be human at its most essential (Smith, Flowers & Larkin, 2009, p.38). One recognised strength of the IPA approach is the inclusivity of incorporating the perspectives of both participant and researcher (Wagstaff, Jueng, Nolan & Whelan, 2014). By interweaving of the participant’s phenomenological account and the interpretative process, the methodology gives voice to specific events or emotions which enable the researcher to learn from direct subjective experience. In other words, “We gather other people’s experiences as they allow us to become more experienced ourselves” (Van, Manen, 1990, p.62).

3.2.1 Rationale for Choosing IPA

In devising this study, a range of qualitative methodological approaches were considered, However, given the exploratory impetus of the research and the desire to focus on the lived experience and impact of attending training on clinicians’ perception

of self, client, and work within the Adult Mental Health Settings (AMHS), Interpretative Phenomenological Analysis (IPA; Smith, et al., 2009) was deemed most appropriate. As IPA aims to capture the specific experience of an individual within a specific ring-fenced situation, it focuses on the various divergences and convergences between accounts to establish commonalities of experience (Smith et al., 2009). This research hopes to do the same.

Smith et al (2009) purport identity and emotion to be the main constructs to have emerged within IPA studies. In addition to the central aims of the research, the objectives additionally explore the impact of the experience both on each clinician's internalised self and on their professional attributes and skillsets. Since the trajectory of the phenomenological approach privileges the lived experience of a phenomenon, the person is instrumental in uncovering the meaning of the experience through their perceptions and meaning-making of an event (Smith et al., 2012). Thus, this research seeks to explore the experience of adult mental health clinicians making sense of Trauma Informed Relational Care training.

The various qualitative options which were considered in this research design included *discourse analysis* which explores how reality is constructed through language, *grounded theory* which interrogates how the individual constructs and makes sense of the world in order to allow a theory to evolve or emerge, and *thematic analysis* as suggested by Baum and Clarke, 2006) as a practical tool for any research that identifies themes. Table 3.1 below presents all three methods considered along with the rationale for rejecting them in the research design. The predominant factors considered were the research question and the purpose the research study.

Method	Definition	Theoretical Approach	Focus of Research Question	Decision
Ground Theory (GT) (Charmaz, 2001)	Systematic method of gathering, analysing, and synthesising qualitative data in order to construct theories about phenomena (Charmaz, cited in Smith, 2015).	Positivist and Interpretive Approach. Symbolic Interactionism (Blumer 1937) suggests that people are both self-aware and aware of others. Therefore they can adapt their behaviours and interactions to shape meaning.	How the individual experiences the phenomenon. What's going on?	Rejected: IPA has a theoretical commitment to the lived experience of specific individual in a specific situation. The interpretative aspect can utilise existing theoretical constructs to make sense of the individual's claims, concerns, and feelings, which distinguishes it from GT. The theoretical sampling required in grounded theory of simultaneous data gathering and analysis which informs categories and further data collection requires large participant numbers (Creswell, 2014).
Thematic Analysis (Baum, &Clarke, 2006)	An analytical method for identifying patterns in qualitative data (Baum, & Clarke, 2013)	Theoretical flexibility as it does not hold true to any particular theory of language or explanatory framework.	Utilised across many research questions except those which focus on language practice as that is the realm of discourse analysis	Rejected: IPA is a theoretically informed framework, i.e. ontological and epistemological underpinnings that frame the research process. IPA provided a more appropriate methodology as the assumptions that informed analysis, i.e. phenomenology, hermeneutics, and idiography capture the essence of the research question which was focused on personal meaning and lived experience (J. A. Smith, 2015).
Discourse Analysis	A set of methods and theories	Social Constructivist approach-	It is used to analyse	Rejected: DA dismisses the experience itself in giving

(DA)	for investigating language and the use of language in social contexts (Wetheral, et al., 2001). It aims to explain the meaning and social significance in texts.	view is that language provides a set of statements which construct objects and position subjects with the experience (Smith, 2009).	language in use therefore research questions are driven by what characterises the discursive worlds people live in and impact on their way of being? (Smith, 2009)	preference to language as it mediates and constructs understanding of reality (Starks, & Trinidad, 2007). IPA was appropriate as the qualitative method of choice as it is primarily concerned with trying to understand the world from the point of view of the participant's lived experience, as directed by the research question.
Interpretative Phenomenological Analysis (IPA)	A methodology which is underpinned by an ontological (critical realism) and epistemological (interpretative) position that influences how the research is conducted.	Phenomenology; Hermeneutics; Idiography. IPA focuses on exploring the lived experience of individuals to unearth an understanding of the phenomena through an individual's experience.	Address questions which explore people's lived experience and perspectives of a phenomenon.	Accepted: the goal of the research is to gain access to and understanding of how people experience training in mental health service. Also, to explore how it impacts on their perception of self, client and clinical practice.

Table 3.1: Research Methods Reviewed

3.4 Research Methods

The current study aims to explore, understand, and learn from the various ways people experience Trauma Informed Relational Care training and how it impacts their sense of self, relationship with client, and their clinical practice 12 months post training. IPA is considered an appropriate framework for exploring this as it focuses on subjective experience to reveal both what is known and unknown to the participant via the interpretative process. As such, it seeks to illuminate and outline how people have made meaning from the experience of training and how such meanings manifest themselves within the context of their everyday life.

3.4.1 Semi-structured Interviews

The IPA data collection method requires participants to offer rich, in-depth, first-person accounts of their experiences. Semi-structured one-to-one interviews are particularly useful for in-depth discussion as they enable the researcher to respond authentically and with curiosity within the interview process. Smith et al (2009) assert that the “unexpected turns” in an interview can often yield the most valuable information. Nonetheless, other methods of inquiry were considered including email dialogues (Turner, Barlow & Ilbery, 2002), and diaries (Smith et al., 2015). While, focus groups were also considered for this research, it was held that the internal discourse of the multi-disciplinary team and the perception of power imbalances between roles would not facilitate an open and honest reflection on individual experiences.

3.4.2 Sampling

3.4.2.1 Method of Sampling

This study utilised a purposive homogenous method of sampling. This entailed identifying participants who have experienced a particular event and for whom the research question has personal relevance and significance (Pietkiewicz et al., 2014). The sampling was therefore based on theoretical and practical considerations such as exposure to Trauma Informed Relational Care Training in June 2017 as well as the more pragmatic concerns of accessing participants (Eatough & Smith, 2008). The participants for this study were identified as clinician’s working in the adult mental health setting who had participated in trauma informed relational care training.

3.4.2.2 Sample Size

Eight participants completed a semi-structured interview for this study. This aligns with the idiographic focus of IPA which encourages a small homogenous group and enables

a detailed case-by-case analysis of participant experiences of the phenomena in question.

Professional doctorate IPA studies generally comprise between four and ten interviews, dependent on the aim and context of the research (Smith et al., 2012). In the UK, Turpin et al., (1997) recommend that six to eight interviews is appropriate for clinical psychology doctorate level, since this permits the similarities and differences between individuals to be examined and any common features to be established. Given the theoretical principles of IPA (phenomenology, hermeneutics and idiography), there is an emphasis on the depth rather than breath of study (Larkin & Thompson, 2011)

3.4.2.3 Inclusion and Exclusion Criteria

As the topic under investigation obtained to a specified experience and timeframe these were used to define the boundaries of the relevant sample. The inclusion criteria comprised any clinician (social worker, CMHN, CNS, CP, OT, SLT, or support worker) working in a multi-disciplinary adult mental health team who had participated in a 2-day Trauma Informed Relational Care Workshop. The participants were recruited from one training session in June 2017 in order to minimise variation between participant between training and practice. Moreover, individuals who had previously participated in the training were excluded to ensure homogeneity of sample and interpretative consistency (Pietkiewicz et. al, 2014).

3.5 Participants

3.5.1 Recruitment

The potential participants were recruited from one Community Healthcare Organisation (CHO). The researcher had attended the training and was familiar with the various multi-disciplinary (MDT) teams who attended the training in June 2017. The initial phase of recruitment involved the researcher making contact via telephone with the Clinical Nurse Manager (CNM) of each sector, and seeking permission to attend the MDT meeting to give a presentation on the research. The researcher provided information sheet (Appendix A) on the day of presentation and requested individuals to volunteer in person on the day or by telephone contact. The researcher also attended a network group meeting arranged by clinicians interested in the area after the training.

The cohort of study participants was recruited between June and October 2018. During this time eight participants were interviewed. Five of these interviews were conducted face-to face and recorded on a Dictaphone, while the remaining three were conducted

by telephone loudspeaker and recorded on Dictaphone. Informed written consent (Appendix B) was sought and given by all participants.

Verbal consent was sought and given for the interviews conducted over the phone and confirmed by written consent obtained via email thereafter. The researcher was aware that the recruitment phase was merely the starting point of the relationship with the participants and was open and clear in providing information and allaying any concerns.

3.5.2 Sample Characteristics

The participants consisted of seven females and one male aged between 25 and 60 years of age. Further demographic details are outlined in a Table 3.2 below. The gender imbalance in the participant sample is reflective of a profession in which over 75 per cent of the work force is currently female (HSE, 2016).

Table 3.2: Participant Demographic Information

Participant Number	Pseudonym	Gender	Age	Discipline	Years of Service	Interview time
P1	Emer	Female	30-40	Social Worker	13	59:07
P2	Fiona	Female	50-60	Psychiatrist	27	30:51
P3	Gabe	Male	40-50	Clinical Nurse Specialist (CNS)	25	46:39
P4	Sarah	Female	30-40	Staff Nurse	7	54:41
P5	Lucy	Female	30-40	Community Mental Health Nurse (CMHN)	10	45:10
P6	Rachel	Female	30-40	Community Mental Health Nurse (CMHN)	12	45:17
P7	Elaine	Female	30-40	Occupational Therapist (OT)	5	42:05
P8	Caren	Female	30-40	Staff Nurse	11	44:40

3.6 Procedure

3.6.1 Data collection

Potential participants who volunteered at the presentations were assigned a time and date for a follow-up phone call from the researcher. This afforded a further opportunity to discuss the purpose of the research, answer any questions, and schedule a convenient time and venue to conduct the interview.

Prior to data collection, participants were given another copy of the information leaflet, the opportunity to ask any other questions, and a written consent form to complete. The terms and obligations of confidentiality and right to withdraw at any point were verbally discussed with the participants. Permission to record the interview with a Dictaphone was sought at this point, followed by researcher assurances in respect of the anonymisation and storage of data according to GDPR. Following completion of the interviews each participant was verbally debriefed and also provided with a debriefing sheet (Appendix C). This afforded the opportunity for participants to express any outstanding concerns, and provided contact details for further support or questions about the study.

3.6.1 Interview Schedule

The semi-structured interviews were guided by an interview schedule (Appendix D) and comprised several themes and open-ended questions to prompt the respondent as needed. The schedule was developed using an iterative process which incorporated relevant research, supervision, and personal reflection. The interview was piloted on a subset of the final participant pool (n=2) which provided an opportunity for the researcher to become comfortable with the flow of the interview process, make amendments to the themes, and critically review the data in relation to the research question. Just one amendment was made to the final interview schedule; an additional theme was added in terms of the 'potential negative consequences of model'. This created the opportunity to introduce balance to the discussion and address potential social desirability aspects.

The primary role of the researcher during interviews was to encourage the participant to tell their story by means of a curious, empathetic, and exploratory approach. The open and flexible disposition adopted throughout the interview enabled the researcher to both

respond to any unexpected or novel topics which arose, and to elicit richer meaning and an exploration of the issues.

All interviews were recorded using a Dictaphone, transcribed verbatim, and anonymised. The interviews ranged in duration between 30 and 59 minutes (mean duration 40 minutes).

The hermeneutic perspective of IPA holds that neutrality does not exist. With this mind, the researcher engaged in reflexive practice during the interview, noting any personal internal responses to the participant, along with any observable changes in body language. This in-the-moment reflection was later yoked to the relevant research memos and reflective notes made during the interview process and analysis.

3.7 Data Analysis

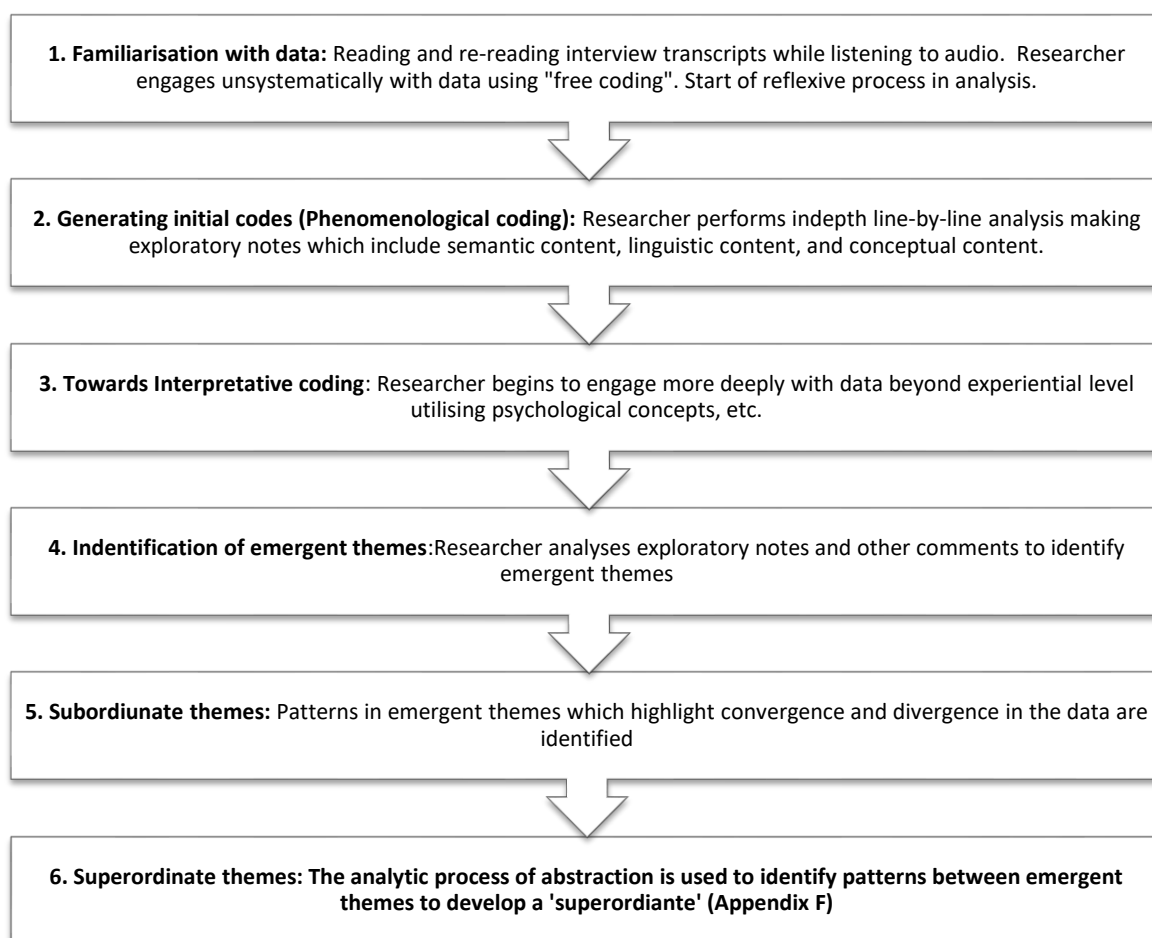
Following transcription and anonymisation of data, all interviews were prepared for IPA analysis as outlined by Smith and colleagues (2012). During the study, the original step-by-step guidelines were further enhanced with strategies from Larkin and Thompson (2012). Larkin and Thompson (2012) suggest “free coding” as the initial engagement with data. This approach entailed an unsystematic engagement with the transcript and jotting notes on emotional reaction to participant, metaphors that come to mind, and psychological concepts. This brought the reflexive process to life in analysis.

Building on the “free-coding” phase a more in-depth line-by-line analysis was undertaken on a clean copy to form the basis of the core-analysis. This involved formatting the interviews on Microsoft Word into three columns: the left column for emergent themes; the central column for the original transcript; and the right column for exploratory notes (Smith et al., 2012). The exploratory notes involved a close reading of the transcript and annotations arising from the semantic content, language content, and conceptual features. An example of this layout is available in Appendix E. Such comments were differentiated by use of plain text for descriptive comments, italicised text for language, and underlined text for conceptual comments (Smith et. al., 2012).

The IPA process of analysis is complex, iterative, and creative. The methodology requires the researcher to engage with the data over an extended period of time in order to ensure that thematic saturation is achieved. As such, the dynamic approach

necessitated a deep and reflective commitment to the data through transcription, multiple readings, and listening to the interview. Simultaneously reading and listening to the interview allowed the perspective to shift from interviewer to analyst in the transition from a purely descriptive phenomenology of the experience to a hermeneutic stance (Huff, Smith & Jesiek, 2015). Likewise, time with and away from the data also allowed for a productive reflective space. The stages of analysis outlined below are adapted from Smith, Flowers and Larkin (2012).

Figure 3.1: Stages of Interpretative Phenomenological Analysis



3.8 Reflexivity

Given the many layers of reflective activity making up the everyday experiences the researcher seeks to elucidate via interview, reflexivity is intrinsic to the phenomenological and hermeneutic principles of IPA.

3.8.1 Researcher Positionality

The nature of phenomenology assumes that researcher maintains a position of open enquiry towards the phenomenon under scrutiny whilst remaining alert to their own preconceptions and bias. The researcher as a model absorbed student (Holmes, 2012), novice clinician, and/or colleague of the participants, must therefore balance the multiple lens which frame the research process and interpretation of the data. The goal of the dynamic researcher then is to continuously reflect on their position within the research process in efforts to transcend personal presumptions, biases, representations, and schemas.

In attempts to excavate any aspect of the researchers experience that could potentially influence the study, the researcher therefore engaged in reflective journaling, supervision, and research workshops (Appendix G). In fact, this was fundamental from the outset since the researcher spent considerable time re-evaluating the theoretical models underpinning mental health practices in light of their role as a Trainee Clinical Psychologist. The researcher was particularly mindful of this during the interview process and sought to ensure that no bias was evident in the questions or manner of questioning, and to maintain the focus an active curiosity of the participant's position. As such, the researcher was able to bring "attentive reflection on the pre-reflective" aspect of the participants experiences (Smith, 2009). This was evident as the participant explored their changing perspective from a pre-training and post-training perspective.

3.8.1 Reflective Box

I struggled with the analysis. The fear of confirmatory bias that I was alerted to in the literature review surfaced again as I grappled with coding the transcripts. The question haunted me- Am I looking for evidence in the transcripts that supports my own assumptions and bias? If so, it would negate the very essence of the idiographic in IPA. The journaling process allowed me to acknowledge my fears and was helpful during this doubt-filled time. However, journaling did not provide the answers. I had to seek guidance from my supervisor whose response "TRUST IN THE DATA" did very little to assuage my concerns. Until, I returned to the data and let it tell its tale.

The participants, Gabe and Fiona were outliers, in that they provided a dissident voice of the model to counter other pro-voiced participant. As I immersed myself in these dissident accounts I could honour how they made sense of the subject matter, integrate it into their own reality of clinical practice and see TIC within a bigger societal context. Pillow (2003) speaks of “reflexivity as recognition of the other” (p.184). As I struggled to make sense of the data I came to understand the meaning of “let them speak for themselves” (Trinh, 1991) or as my supervisor advised to “trust in the data”.

3.9 Research Trustworthiness and Credibility

The assessment of the quality and validity in qualitative research has been fully-documented by Lucy Yardley (2000) and adopted by Smith and colleagues as four broad principles upon which IPA can be assessed. The researcher therefore was diligent in the utilisation of: 1) sensitivity to context; 2) commitment and rigour; 3) coherence and transparency; and 4) impact and importance. As criteria for ascertaining trustworthiness of research such principles enforce a more pluralistic stance than an over-simplistic and prescriptive checklist.

3.9.1 Sensitivity to Context

In working closely with the existing literature to understand how developmental trauma and attachment theory can provide an overarching framework for promoting change to the clinician, their perspective of clients, and ways of working, the researcher demonstrated sensitivity to context on several levels within the study.

This was further illustrated by the researcher’s engagement with the theoretical concepts of IPA prior to data collection, having sufficient knowledge and expertise to devise the most revealing questions, and approaching the participant in an empathetic manner. Researcher familiarity with a number of participants, as well as a clear understanding of the diverse theoretical frameworks in which MDT operates (i.e. medical model versus biopsychosocial model) also supported a deeper level of exploration within the interview. Moreover, sensitivity to the context further assisted the researcher to elicit a deeper level of understanding and abstraction of the narration, (Shinebourne & Smith, 2010), discourse (de Visser & Smith, 2006) and rationality (Smith, Flowers, & Larkin, 2012). The researcher was able to demonstrate sensitivity to

context through the depth of analysis and interpretation achieved in moving from the literal meaning found in content of utterances to the implied meanings subsumed beneath the content and meaning presented by more hidden conceptual findings (Kacprzak, 2017). This was evident in the write-up in terms of the transparency of presenting the decisionality of the superordinate themes and supported with verbatim accounts provided by participants.

3.9.2 Commitment and Rigour

At all times, the researcher remained consciously committed to the epistemological principles of qualitative research by adhering to the idiographic and experiential elements of the phenomenon. This rigour was most evident in the framing of the research question and selection of the purposive homogenous sample (Kacprzak, 2017). The integral role of the participant was recognised from initial engagement to debriefing, with the researcher giving the utmost attention to the verbal and non-verbal cues during the course of the interview and consciously noting/exploring all non-verbal communication throughout.

The researcher was mindful of the need for rigour throughout the process, particularly during the subsequent analysis phase wherein consistent and equal attention to detail is imperative. Researcher diligence and commitment was supported and maintained by attending a number of academic workshops on qualitative research design and analysis. Moreover, the many critical discussions conducted with both field and academic supervisors further reinforced the researcher's ongoing commitment and assiduity throughout the lifespan of the study.

3.9.3 Coherence and Transparency

The researcher attempted to maintain coherence throughout the process of research by ensuring that the theoretical principles of IPA (phenomenology, hermeneutics and idiography) were cornerstones within each aspect of decision-making, from the initial phrasing of the research questions, through sample criteria, data collection, and analysis. During the write-up process the researcher captured the experiential domain of each of the participants whilst accounting for the double hermeneutics in the findings. The iterative process of data analysis and report-writing contributed to the coherent argument throughout the piece. Transparency was achieved through the detailed description of the research process, including justification for all decisions

made within the research, such as the interview schedule, sample, interview process, and analysis. A clear audit trail was provided from the initial analysis through emergent themes, superordinate themes, and illustrative and/or direct quotes. Continuous reflective journaling documented the researcher's personal journey throughout the process and ensured bias, personal opinion and motivations were identified and brought out into the open. Such transparency allowed the researcher to write more critically in relation to the interpretive aspects and was a useful tool in write-up.

3.9.4 Impact and Importance

It is hoped the current research provides insight into how clinicians experience themselves, the clients, and their work in the adult mental health setting, when provided with a different framework of understanding. However, the cognitive mechanisms through which such change occurs are neither obvious nor easily accessible. In fact, "IPA aspires to theoretical translatability" (Kacprzak, 2017, p.57) through which readers may evaluate research in light of both theoretical and empirical knowledge. This study provides an alternative experience for clinicians of understanding clients and clinical practice. It explores the realms of possibility wherein a clinician's perception of a client is framed within the adult mental health setting.

3.11 Ethical Considerations

Ethical consent for this study was obtained from the Teaching Hospitals Research Ethics Committee pertaining to the community health organisation from which all participants were recruited (Appendix H).

3.11.1 Informed Consent

As previously discussed, both verbal and written informed consent was sought and obtained from each participant. All consents were confirmed prior to the commencement of the interview process. The details of participation were verbally outlined, an information sheet provided, and opportunity for questions afforded to each participant.

The process of ongoing consent and the right to withdraw without consequence during and after the interview was highlighted, and participant opportunities to contact the researcher thereafter to withdraw consent/participation was also emphasised. All General Data Protection Regulations (GDPR) concerns were addressed by means of a process of informed consent, anonymisation, and controlled access to data and storage.

3.11.2 Confidentiality and Anonymity

All participants were guaranteed absolute confidentiality and anonymity. The researcher analysed and assigned pseudonyms as the interviews were transcribed, and maintained exclusive access to the coding sheet documenting such participants pseudonyms. Moreover, all potentially identifying information such as profession and locality was removed from the transcript. The limits of confidentiality were fully discussed with each participant. Following each interview the digital audio files were uploaded onto a password-protected laptop and each audio file password-protected. In addition, each transcribed interview was also password-protected, and with the exception of supervisory audit, viewed only by the researcher

3.11.3 Potential Distress

Given that the participants were being asked to reflect on and divulge their own attachment history, clients, and clinical relationships with the AMHS and MDT, the researcher was cognisant of the potential for distress both during and after the interview process. The researcher was therefore vigilant throughout the process, responding to verbal and non-verbal cues within the interaction indicating any undue discomfort. At the conclusion of the interview the researcher debriefed each participant and gave them a debriefing sheet (which contained detailed contact information for employee support, the research supervisor, and the researcher, should they wish to discuss any concerns relating to the content of the interview or the manner in which it had been carried out.

3.11 Conclusion

The chapter above outlines the ontological and epistemological grounds upon which the methodology was selected. It provides full detail of the methods, sampling, procedures, and analysis used to ensure the replicability and trustworthiness of the study.

Chapter Four: Results

4.1 Introduction

Following a period of extensive, iterative engagement with the interview data, moving from whole to part and back again through transcribing, reading, analysing, collating and verifying, several themes emerged from the eight interviews. The themes were conceptualised as a process of change or metamorphosis which each participant experienced as they partook in training and began to make sense of that training in practice over the following 12 months. This chapter will discuss this process of metamorphosis in detail. The process emerged as the optimal frame for understanding the sense making of each participant in response to the research question, which set out to explore the lived experience of clinicians who attended a two-day Trauma Informed Relational Care training. The themes will be supported by illustrative quotes from the interviews to capture the essence of participants' experiences. Interpretative comments accompany these quotes to provide insight into how the researcher made sense of the participants' experiences as framed by the research question.

4.2 Overview of Research Findings

The research data yielded a rich collection of accounts that interwove a narrative of change for each participant. As this change was a dynamic process that was dependent on the completion of one stage before moving onto the next, it was thought that a traditional table of superordinate themes would not be able to sufficiently relay the relationship between themes. Therefore, a schematic representation of the process which captured the superordinate and subordinate themes arising from analysis of the interviews was developed. Diagram 4.1 below illustrates the research findings drawn from the data in an interconnecting process of change or metamorphosis. The active, gradual and individually varying nature¹ of change is evident in participant narratives. The descriptor 'metamorphosis' is used as it captures the spirit of the emerging clinician transforming in light of the new understanding and awareness borne by the training. Fiona remarked: "*Personally, I wish I had it [the training] years ago*".

¹ Idea of 'varying nature of change' is discussed in a reflection box later in this chapter.

Figure 4.1 Schematic Representation of Superordinate Themes:

Metamorphosis: Process of Change

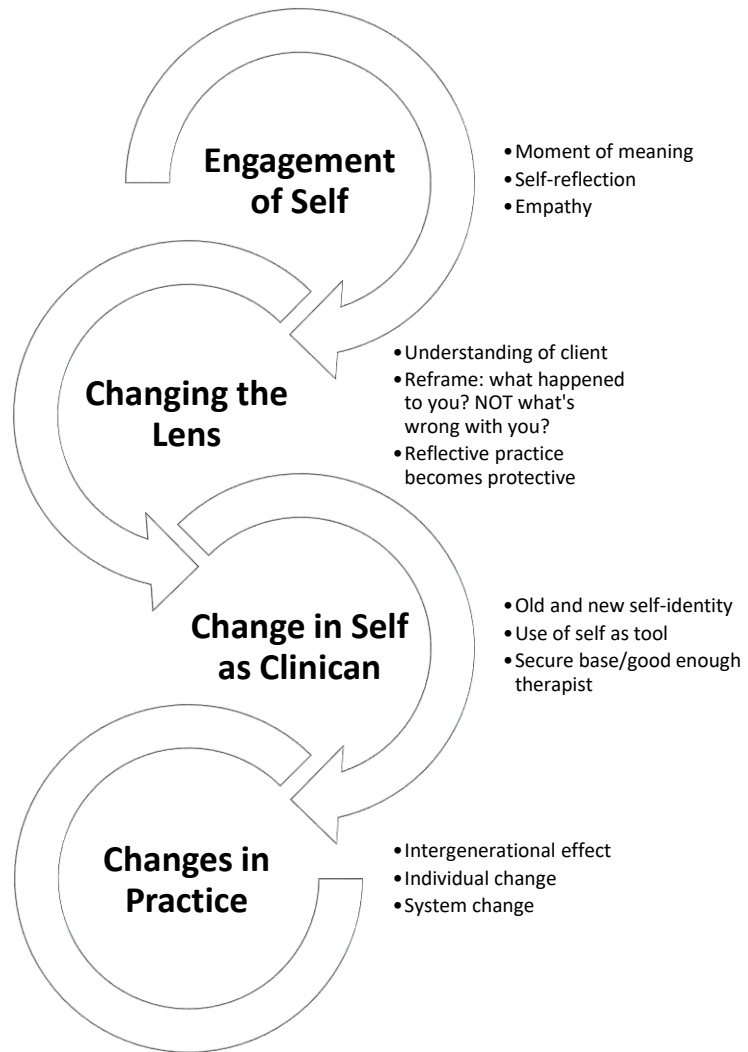
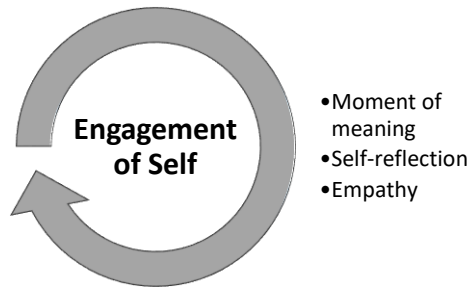


Figure 4.2 Stage 1 of Metamorphosis



4.3 Engagement of Self

The engagement of the self was the start of a process of change described by each of the participants. They responded to the exploration of their training experience with a rich description of how they engaged with the training on multiple levels: emotionally, viscerally and cognitively. This led to rich accounts of how the training experience

initiated change from the inside out.

4.3.1 Moment of meaning

Each participant expressed a defining moment within the experience in which their subjective, emotional self was engaged by the training material. The experiential aspect of training seemed to spark participants' visceral and emotional responses, which prompted an engagement of their subjective experience. Each participant used evocative language to describe their engagement with early moments of the training material.

Emer: *“haunting”*; Fiona: *“profound”*; Gabe: *“sadness in the suffering”*; Sarah: *“feeling of sadness... it hit home”*; Lucy: *“really profound... it struck a chord with me”*; Rachel: *“startingly interesting”*; Caren: *“it was so blatantly there, you felt this... that’s just horrific”*; Elaine: *“It was quite upsetting”*.

For each clinician, this moment of emotional connection was based on personal views and poignant reflections. Gabe spoke about the *“sadness in suffering”*, referring to the unseen impact of neglect in early caregiving relationships which can have lifelong negative consequences.

“If someone has a broken leg, you see it, but the invisible trauma and suffering particularly in young people... that can be perpetuated in one way or another throughout their lives”.

This clinician's realisation that early trauma begets later trauma captures the core wretchedness of developmental trauma as well as the vulnerability of infancy and childhood. Further, due to its 'invisible' nature, both Gabe and the world might miss

this trauma and so potentially cause more harm. This participant later reflects on the impact that an understanding of this trauma and its relationship to attachment would have for the world if it was known on a societal level, saying: *“It’s quite idealistic; it might even stop a few wars along the way”*.

The care-giver response was activated for four of the clinicians. Participants’ deeply felt response to the training material modelled the void of attachment loss and the potential impact of developmental trauma.

Elaine: *“I wanted to give him a cuddle, to kind of soothe him and put him at ease when he was distressed”*; Emer: *“my instinct was to soothe John”*.

For Lucy and Sarah, the care-giver response was activated towards their own child. They both took time to reflect and so become aware of the role they play in their own children’s lives.

Lucy: *“I came home after those training days and I was just looking at her and thought my god, they are so vulnerable”*.

Sarah: *“When I went home there were extra hugs and kisses... I can give love to my child because I am able and I have the skills”*.

This response indicated the activation of a deep-felt connection to the meaning of the training within the clinicians. This connection to the training material was strengthened by the activation of an intuitive understanding of the material presented, which as Caren described a *“gut thing”*, a ‘knowing’ of the impact of abuse and developmental trauma, emotionally if not theoretically.

Caren: *“It just kind of reaffirmed for me, it is what you know”*.

Rachel: *“it was really true we had the stuff already, we just had to not be frightened”*.

It was in these moments of emotional engagement that the clinicians began to understand how this training could be applied in their own lives and clinical practice. Having ‘felt’ the emotional connection through experiential learning and acknowledged the real-life application to both personal and professional life, clinicians were motivated to engage in the training.

Emer: *“I was fortunate I never had any childhood illness that would take me away from my mum... I suppose that got me thinking about creche and childcare now, parental illness, mental health”*.

For four of the clinicians, the leap of integrating objective didactic teaching with subjective experience to make meaningful connections between the self, the theory and the client occurred automatically within the training.

Lucy: *“I think you sit there, and I was watching some of the videos and you bring it back to patients or our own friends... what happened for people growing up. So, I think it does impact”*.

Sarah: *“I suppose when working with people you have to take all of that into account... there may have been trauma”*.

For Gabe, who had experience with the theoretical material which focused on attachment theory, the training did not yield any revelatory insight. He said: *“It’s nothing radically new, it’s going back 60/70 year old theorists”*. Given Gabe’s professional field (psychotherapy), his familiarity, self-engagement and ease with attachment theory is evident. Yet at the same time, he can empathise with his colleagues’ responses to this training:

“I can imagine for maybe someone who wasn’t completely trained or up to date then it would be earthshattering in some respects”.

4.3.2 Self-Reflection

The initial emotional engagement with the training material paved the way for a self-reflective space which allowed the participants to reflect on their own attachment experiences. A common thread throughout the interviews was that participants returned to their own experiences of attachment within their families. The participants also use reflections on their own experience to identify ways in which they relate to their clients throughout this theme.

During Caren’s interview, she referred to her experience of care-giving from her grandmother, who was not her primary care giver, but who took care of her while her mother was at work. It was this attachment and the impact of that which dominated the narrative.

“We were never slapped or anything like that, but it was just hardness that is not there now”.

Caren captures the impact of emotional unavailability while also minimising it by saying that at least she and her siblings were not “*slapped*”. This quote is reflective of a reluctance to engage in dialogue about early childhood experiences and proliferates a common myth about what constitutes abuse/neglect in society and services. This reluctance to talk about early childhood experiences is further highlighted by Caren later in the interview:

“People here don’t want to talk about their past, they will often shut down if you start talking to them about it”.

Elaine described her family system as a way of understanding how she functions in relation to other people: “*I come from a big family so there was a lot of us there to try to appease*”. She makes sense of her way of being in the world by relating it to her experience of her mother.

“I’m affectionate, but I wouldn’t be soft, I’d be very hard stones and I would see that in my mother as well”.

There is conflict in how Elaine sees herself as both ‘affectionate’ and ‘hard stones’. Elaine goes on to qualify her ‘hard stones’ description by saying; “*We wouldn’t be very affectionate with my mother*”. This could be interpreted as Elaine learning to minimise emotional need and expression and potentially the role of emotional feeling and expression within relationships. Elaine’s internal working model seems to impact on how she how she makes sense of client’s experiences.

“With the lady in mind I didn’t delve back into her history, but there wasn’t any evidence of abuse... if anything she was over mollycoddled... counting too much on others”.

Elaine’s internal working model of ‘*hard stones*’ i.e. learning to minimise her own emotional needs from others, seems to have impacted on her ability to empathise and see beyond the behaviour of her client. Elaine seems to view her client as overly reliant on others. This highlights the importance of having a reflective space within clinical practice to minimise the impact of self on the client. In contrast to Caren, Elaine’s

ability to recognise the shared experience of attachment between herself and the client is reduced.

There was an acknowledgement from Rachel that holding a mirror to her own early experiences was “*unnerving*”, “*uncomfortable*” and difficult. She described the difficulty in staying with that reflective space, saying: “*I’d say my own instinct is to think about it and then don’t think about it*”. This line was delivered with a nervous laugh and a sweeping hand gesture which indicated her desire to move on.

On further exploration, Rachel deepened her own reflections on self in relation to a client, saying: “*I think it reminds you of how you are human and how your experiences can be so similar to theirs*”. It was within this reflective space that the participant was able to mentalise about herself in relation to the client and so find a connection.

Other participants differed in how they expressed their self-reflections. In Gabe’s interview, the slow and deliberate use of language was striking to the interviewer.

“It made me very aware and conscientious about relationships I had in the past where you are vulnerable in development”.

Gabe used depersonalising language and referred to himself in the third person – “*you are vulnerable*” – which acted as a way of deflecting the impact of reflection on his earliest attachment. This potentially demonstrates his lack of ease with integrating the new material (pre-verbal attachment relationships) from the training when relating it to him.

As Gabe’s narrative moved towards past experiences of self-reflection he became more comfortable in discussing past experiences using ‘I’ and divulging of information.

“Not so often as I get older but certainly in my early days I would have fallen into the trap of repeating a type of attachment mode that would be my own stuff rather than the clients”.

Lucy took an intergenerational, reflective stance towards her own experience and that of her mother. “*My mother wouldn’t have had as great a mother as I had, and I think that made her want to be a better mother*”. Within this reflection, Lucy captures hope and potential for change. She rejects a fatalistic view of early childhood experiences and embraces empowerment, voice and choice.

“There are patients that can change but don’t know how... but you have also people that who don’t want to, and you must respect that to”.

Lucy utilised the reflective space of her own attachment relationship to create space to mentalise about clients. She described a growing sense of understanding and how that altered her perception of the client and their needs.

“Building confidence, helping them realise, yeah you can change, it is bloody hard, but you can do it. And just because you weren’t parented properly, and you haven’t been a parent before, but we were all children and we know what it’s like to be a child. Oh yeah, it makes me, um, an awful lot more patient with patients”.

Fiona reflected on her role as parent, which allowed her to draw on personal experiences and bring them into practice. There is a sense of balance and perspective as she reflected on what supported her ability to be a care-giver.

“You reflect on what you did well, and you didn’t do well... and it raises an awareness in me that supports were very important”.

As Fiona reflects on her own earlier experiences as care-giver, she acknowledges the challenges of being a care-giver as well as the protective factor of support. She further uses this reflection to begin mentalising about clients within adult mental health services.

“made me focus on the challenges for parents with mental health difficulties when you think it is automatic... being aware of what’s going on at home”.

4.3.3 Empathy

A common element of change that ran through all the interviews was a deepening sense of empathy with the client. The engagement with the self-reflective process prompted the clinicians to start to recognise the shared experiences they have with clients in the service.

Lucy: *“We were all children once and we know what it’s like to be a child. Oh yeah, it makes me an awful lot more patient with clients...”*

Rachel: *“And the upbringing that you have or the family you are in which is out of your control... I do think it puts you all on the same footing”.*

Not only can the participants begin to mentalise about their client’s mental and emotional states, but they can also build a ‘felt sense’ of the client’s experience. Emer spoke movingly about the impact of this deepening empathy on her understanding of the client.

“And I don’t think that she has ever had that experience of being appropriately soothed when she needed it, so she has a very superficial understanding of emotional support and care”.

Emer is integrating her ‘felt’ response of attachment loss with the theoretical knowledge of attachment to frame a new understanding of the client which is non-judgemental. She was able to ‘see it’ and ‘feel it’ from the client’s perspective, which changed her way of being with that client, saying: *“If I don’t have this awareness of her, I’m meeting her and I’m not understanding her as a person”.* This experience of deepening empathy humanises the client and changes the focus towards a relational way of being with her.

Sarah recognises the change in her experience of empathy. She not only understands what it means to be empathic, but her empathy moves her towards an emotionally shared experience and one in which she is willing to be there with her client.

“So, although I can say ‘yeah, I’m empathetic’, I have to go that deeper level and relive their experiences when they are talking about it and be there with them”.

Five of the participants acknowledged the humanity in the life situation of clients that attend the service. They recognised that people did not choose this life; rather, it was often chosen for them by the circumstances and families into which they were born.

Rachel: *“it reminds you of how you are all human and how your experiences can be similar to theirs, and how we are all the same... and how a lot of it is out of your control”.*

This reduces the ‘othering’ of the client in which their mental illness is seen as a ‘choice’, ‘fault’ or ‘blame’. The client’s mental illness is not constructed as an internal

pathology but a consequence of experience. The growing understanding of the suffering of others helps to build compassion.

Lucy: *“you know what they never had a chance because we knew their mothers, and this was probably the second or third generation in the filing cabinet”*.

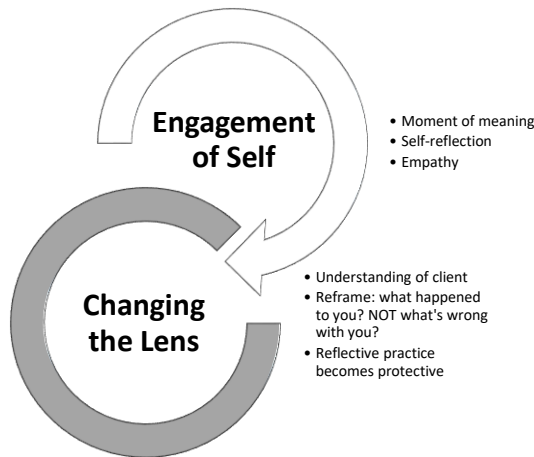
There is a real sense of sadness and vulnerability in how Lucy views the impact of mental illness on the family system. She uses language to juxtapose the sadness of the consequences of intergenerational impact of ACEs and the mundanity in which clients end up ‘in the filing cabinet’. There is both a literal and metaphorical meaning to this phrase. The literal meaning relates to the fact that multiple generations of this family have been attending this mental health service and they each have a clinical file in the filing cabinet. On a metaphorical level, Lucy recognises the generational impact that ACEs and trauma have on a family and the perpetuation of difficulties. There is a sadness and acknowledgement that babies can be born into a life of difficulty.

Elaine offers a contrasting experience of her reduced capacity to relate to the client when risk is introduced to the therapeutic relationship. When Elaine takes on the teacher role there is a shift in power dynamic from empathy based collaborative relationship to a paternalistic relationship where Elaine holds control and responsibility for the outcome.

“I kind of see myself as a teacher at times saying ‘oh you need to do this and do that’... being a little more authoritarian. You know, at the end of the day if there are safety concerns about the daughter we have to enforce that”.

Elaine’s sense of risk and threat had shut down her ability to mentalise about the client, instead invoking the paternalistic role of the service. She recognised the impact of this relational change on how the client perceived their care, saying: *“She felt threatened and at risk, so she withdrew from our support”*. This block in empathy acted to rupture the relationship and entrenched positions: *“we were doing what was ethically right... even though she wasn’t agreeing with it”*.

Figure 4.3 Stage 2 of Metamorphosis



4.4 Changing the Lens

The second stage of change that emerged centred on how the clinicians conceptualised the client. Each participant utilised a narrative of change in relation how they understood the lifespan implications of adverse childhood experiences and developmental trauma as they returned to the service. This paradigm shift resulted in the clinicians reframing how they

mentalised about their clients as well as how they understood their current mental illness in relation to their past. The clinicians also described how this reframing acted as a protective factor as it provided them with space to reflect as well as a framework to contain their concerns.

4.4.1 Understanding of client

In gaining a new understanding of the impact of ACEs on client development and presentation, Lucy began to reformulate her thoughts about how a client's life experiences impacted her presentation. This reflection built up Lucy's capacity to mentalise about the client.

“It has made me realise well if this woman grew up in a domestic violence home or drug/alcohol home and she wasn't engaged with and she wasn't cared for... She was reared but not nurtured. It makes you understand where she is coming from and be less judgemental... you understand a bit more why she is behaving like this”.

Lucy uses the words “reared but not nurtured” as a way of describing deficits in the experience of her clients childhood. She clarifies her understanding of this phrase by offering “in certain houses... babies were to be seen and not heard”. This differs from

today's understanding of the importance of relational interaction to the development of a socially and emotionally healthy child.

Lucy uses trauma theory and attachment understanding to mentalise about the client and understand her behaviour in the context of her experience. She realises that the client's past experiences continue to affect who she is in the present. The knock-on effect of this new-found understanding of the client is a growing compassion and non-judgemental stance that improves therapeutic alliance: *"You are more open and accepting... whereas now I will say what was it like for them?"*

Gabe spoke about different levels of client understanding that were presented in the training; that is, trauma, attachment, neuroscience, as well as how the understanding would influence his work with clients. *"I could say the work on brain plasticity stuff, neuronal development. It would impact me on the importance and urgency on how that early formation can be reflected in their current presentation"*. He talks about sharpening the lens of client understanding, particularly in relation to behaviour that could be understood in the context of ACEs and neuroscience: *"And trying to understand a person's presentation in the context of ACEs so that you can try to empathise more with them"*.

Sarah found that trauma theory supported her to see a person with a past, impacted by that past, rather than an individual in a vacuum of mental health services. Irrational behaviour can be rationalised when understood in the context of the training.

"After the training it makes you more aware of looking at ACEs, trauma how it affects them [the client] in their own lives".

Sarah was starting to view the client within the context of their entire lifespan and not just who she sees today.

Rachel talked about the impact that the theoretical understanding of trauma and attachment had in terms of working with her clients.

"it makes sense that they had difficult childhood or had ACEs then they have either mental health problems, behavioural problems or social problems as a result, it's kind of I don't click into it as quickly".

There are some clients for whom this framework of understanding clicks automatically, where ACEs are known and reported in the file. For others, whose ACEs are not recorded or who are new to the service enquiring about ACEs is not automatic for her.

4.4.2 Reframing: What happened to you? NOT What is wrong with you?

Along with this growing understanding of trauma and attachment theory around why and how the client might present in the services, participants described the way in which their focus on the client also changed. Many of the clinicians reported that this focus had changed from asking *what's wrong with you?* to *what happened to you?*

Caren discussed the differences she sees between her understanding of clients and those of the Multidisciplinary Team (MDT) in the service in which she works:

"I don't think they have a great understanding in the MDT to be honest... I think they think what's wrong with the person... if they have a history of CSA [child sex abuse] they would be referred to specialist treatment service".

Caren went on to further discuss how this attitude towards clients can possibly exclude them from the mental health service. The client would be referred to the specialist service and removed from their waiting list. She found the medical understanding of clients to be too limiting: *"there is not just one explanation for why people are"*. The awareness she has developed through training has increased Caren's confidence to support the client relationally and to support her better understanding of the client: *"More awareness and sort of just trying to figure it out with the client more when I would have just passed it over"*.

Fiona described her changing focus when working with clients, from a medical model that viewed mental illness as an internal construct to a trauma-informed model whereby the context is viewed as a precipitant.

"I would be questioning the setting more than what is exactly in front of you. Not ignoring what is in front of you but also being aware of what's going on around the individual".

Fiona was starting to view the client within the context of their entire lifespan. She asked contextualising questions, hoping to find evidence that would support her understanding of the client she sees in front of her:

“What is going on in the environment when people were growing up? What is the nature of their relationship with parents or who their carer was? And what the context of that was.”

Rachel also talked about a changing focus of understanding the client through reframing questions about their experiences to cast light on current difficulties.

“I do think when you give time and sit down and listen to, and ask those ACEs questions, try and find out why they are behaving like this?... they might realise well this happened in my childhood and that’s why I fight or push everyone away”.

Not only is Rachel hopeful that asking the ‘what happened to you?’ question will support her understanding, but also that it will start a therapeutic process with the client and so build understanding about them.

Lucy succinctly captured the ways in which the training changed her view of the client; a movement from a predominant medical view of mental illness as an internalised difficulty, to the trauma-informed model that embraces the biopsychosocial aspect of human development.

“What happened to you? I think that’s important, it’s not how can we fix you but how can we help you fix yourself. Um, because medication is not going to change that, you know”.

Lucy’s growing understanding of the client’s distress through a trauma lens enables her to view herself in partnership with the client. Instead of a paternalistic relationship in which the clinician knows best, Lucy is able to work in collaboration with the client, supporting them to ‘fix yourself’.

Gabe considered the medical model understanding of a person as he tried to define how he situates his professional approach to the client: *“The medical model of the mental health system now, it is about diagnostic stuff... And trying to understand maybe early experience in that context that it may not actually explain”.* Gabe recognised the limitations of the current clinical model in the services, yet he was cautious in committing to any one model as the panacea.

“I work interactively, so the attachment stuff is important, but I don’t like to completely align with it. I think it becomes potentially counterproductive”.

Gabe later reflected on the mental health system at large and aired concerns about how models can be utilised for different purposes at the expense of both clinician and model:

“One aspect I think that is relevant and that is a political aspect and that is the skills base regarding disciplines working with clients... I think we need to be careful how this very heavy stuff informs the clinical practice discipline”.

4.4.3 Reflective practice becomes protective

Reflective practice was vital for supporting this paradigm shift of understanding for the participants. The self-reflection that began in training continued as the participants moved into the clinical space they inhabited with the clients. Reflective practice becomes protective for the clinician and the client. In that it allows the clinician to separate themselves from the experiences of clients, to take a reflective step back and increase their mentalising capacity of the client. This supports the clinician to understand what is going on for the client and themselves in the therapeutic interactions creating a deeper therapeutic alliance.

Lucy captured the ways in which of her new understanding of the client through the trauma lens enabled her to reframe her thinking and language about the client.

“You can go in there and you can say; ‘Oh for God sake they are to try or you can go in there and ask, why aren’t they trying?’ How can we make this better with them?”

This reframing had a positive impact on the ways in which Lucy worked within the service and managed her own emotional wellbeing in balance with the demands of the work. *“Of course, you get frustrated, but it does make me reflect on my practice a lot more to say how can we make this better?”* The increased reflective practice provided a space for Lucy to mentalise about the client and so increase tolerate her own frustration around the client’s progress.

Emer found that the space to think about her own value system reinforced the congruence between personal and professional practice. Staying true to herself enabled her to stay connected to the client in a meaningful way.

“It helps me keep my values as to why I got in the job and keeps me emotionally aware of what’s going on for people. I think I get less frustrated when I take in that framework and whether it’s one person or a family unit. So, it automatically changes my practice”.

This quote demonstrates mutuality between Emer’s thoughts and feelings about the client. These thoughts and feelings are inspired by the trauma informed relational care framework, which taps into her core beliefs and assumptions about how people are in the world. The integration of personal beliefs, professional principles and clinical practice act as a containing and protective factor for Emer within the mental health service.

Sarah reflected on how the training impacted her personally and professionally through knowledge (theoretical framework), understanding (empathy) and the mechanism of being in relation to others.

“It has helped me as a person to become more understanding, to have the perspective of looking at the different things... It has broadened my perspective as a clinician working with people... It’s an awareness of myself to share and listen with others”.

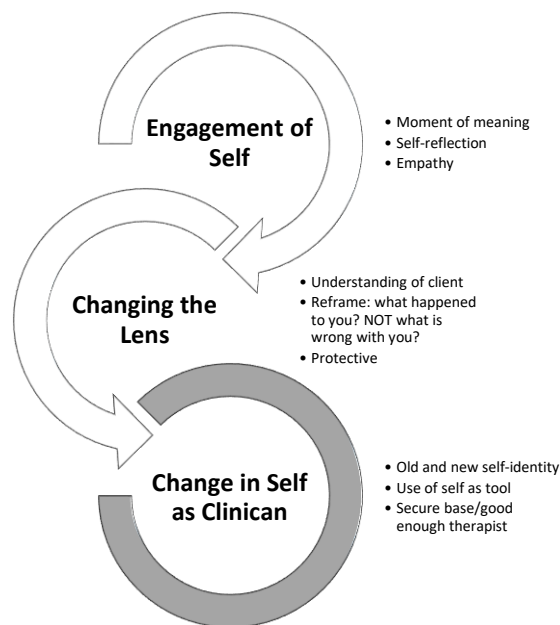
This quote suggests a change in conceptual perspective for Sarah in terms of how she frames her understanding of herself and others. Sarah appeared to have integrated the training into her way of being in the world, and described it as having permeated her personal life and professional work. There is a sense of congruence between who she is as a clinician and as a person in her day to day life.

Gabe described the reflective space of the training as a reminder to contemplate how he sees himself in relation to the client, offering him ‘fresh eyes’ through which to view the theoretical framework and so create a better understanding of his role with the client.

“We are not robots, we are too complicated for that, so you can’t become too idealistic about it. Was it, Klein that talked about the good enough mother?”

Working within the framework was protective for Gabe as he recognised that no-one is ideal, just as no single model is omnipotent. Gabe invoked the ‘good enough’ therapist in terms of a ‘good enough’ model for working with clients, saying: *“I think it informs me not to be overly simplistic towards attachment issues because there also must be a level of intentionality and choices about modes of engagement we have to help the person to maybe develop better modes of engagement”*. Gabe engaged in critical and exploratory thinking about the theory in relation to the client and considered his position in relation to the theory.

Figure 4.4 Stage 3 of Metamorphosis



therapeutic role.

4.5 Change in Self as Clinician

The third stage of change is dynamically related to stage two, as the paradigm shift in understanding the client started to impact on how the clinician viewed themselves in relation to their clients. Each participant gave an insight in their interviews about the changes experienced within the self, how that impacted on their identity and how they perceived their

4.5.1 Old and new self-identity

A distinct narrative ran through six transcripts of ‘me before training’ and ‘me after training’. This narrative belied an over-reliance on the identity of self within the discipline. Fiona: *“As psychiatrist you are taken up with so many pieces of information”*. Emer: *“My professional side would kick in and say what can we do?”*. Emer recognises the barrier that putting on the ‘professional hat’ brings between her and the client.

Emer: *“And I think if we ever just push our professional hat aside and just sit in the moment of the emotions that person is experiencing we can feel them more probably without going into ‘well this needs to be done’”*.

Emer recognised that the veil of professionalism and the ‘doing’ mode can support detachment from the client and diminish the relational empathy. She tried to make sense of how to operate within the relational perspective without losing a sense of efficacy within her disciplinary role. Emer seemed to have experienced an initial conflict as to whether the ‘doing’ and the ‘relating’ could work together. Later in the interview, Emer spoke about how this conflict was resolved:

“I see people for their experiences and see all their lives and not just what brought them here today. You must get the person’s story from their perspective”.

Being able to see and understand the client as a person, within the context of a family system, and framing their mental health difficulties within their life experience changed how Emer related to the client: *“it keeps me emotionally aware of what’s going on for people”*.

In contrast, Gabe embraced his own identity within his professional identity. There seemed to be a congruence in how Gabe viewed his private self and his profession self.

“Therapy works in that it is so relational based and all the research would back that up... I can’t hide behind things, professional veneer”.

Gabe’s profession is embedded in his use of self within the therapeutic relationship. He recognised the importance of utilising the self in relation to the client: *“you are bringing some of yourself inevitably”*.

As the participants reflected on the training and themselves within the interviews, a sense of moving from unconscious to conscious knowing of self emerged. Rachel chided her former self for being *“so naïve... And looking back and cringing on what I thought I knew that I didn’t”*. She described her way of working as being *“all about doing, doing, doing and fixing”*. The repetition of the word ‘doing’ begets an understanding of the clinician and client in an unequal power dynamic in which the clinician has the answers.

Rachel's transformation occurred when her confidence and trust in herself as a clinician emerged through the training process: *"The training really made me feel like I already had the skills and knowledge and maybe it was framing for us... giving us more knowledge"*. Her therapeutic skills were validated and her confidence to be with the client grew: *"You don't have to run and fix it, you're not ignoring it but you're acknowledging it"*. She appeared to feel trust and value in her own relational ability to support the client through distress.

Fiona's new awareness of the biopsychosocial impact of trauma on clients was reflected in a change of attitude to work: *"the awareness piece of being aware of what's going on at home... making me more motivated to see patients"*. This change in her understanding of the client manifested as an internal shift in how she felt about her role in relation to the client. *"I would take more ownership... and I want to make sure they get the right intervention"*. There is a sense of responsibility in how Fiona views herself in relation to the client.

In contrast, Elaine remained stanch to her professional identify throughout the interview. *"I always have my OT hat on, there are so many other factors around it that are beyond your remit or control and you can't do everything"*. The impact of working within the model was limited given that Elaine viewed her clinical discipline and the model as mutually exclusive.

4.5.2 Using self as tool

Seven of the participants spoke about how they used themselves within the therapeutic relationship to support the client to build mentalisation or coping skills. Lucy described using pieces from her own life experience in her interactions with some of her clients to support them in their recovery.

"There are times when parents struggle. I think for patients to hear I can struggle, I need to get out and have a walk. Sometimes I feel like my toddler is doing my head in and you have to be normal about it".

Lucy used her life experiences as opportunities to normalise feelings, reassure the client and model coping skills. *"Sometimes I think sharing a bit of you with them, am, it does make it better"*.

Emer also talked about how she uses herself within the therapeutic relationship: *“kind of modelling to her how to be with her son... how to listen and respond to her son”*. She described using her emotional ability to respond to her client as a way of modelling how she can in turn respond to her son. By demonstrating relational skills in practice, that is listening, mentalising about others and responding, the clinician hoped to build a skillset within the client. *“Getting her to see her son as that child who needs to learn the skills to soothe himself”*.

Gabe’s experience of using the self within the therapeutic relationship was imperative in his work as a psychotherapist. *“In my work the clinician becoming the substitute attachment figure is vitally important”*. However, he goes beyond the theoretical constructs of attachment to the heart of relational being:

“You are bringing some of yourself inevitably... your ability to engage with people on a warm level. You can’t actually learn that from a text book”.

Gabe acknowledged that the power of the therapeutic relationship lies in the innate ability of the clinician to be and use the self with the client.

Rachel’s growing confidence in her relational abilities saw a shift in how she worked with clients. *“We had the stuff already, you just had to not be frightened, not be judgemental and be happy to sit with someone... just be with them”*. Rachel’s focus on the relationship and trust in herself as a tool to support and contain the client in distress instead of distancing herself from the client in doing is highlighted here.

Caren spoke about her use of self, using her own emotional response to the client to help guide support and the intervention.

“She was really struggling... you have to be gentle and I didn’t broach it for a while. It wasn’t a plan, but it was knowing she wouldn’t respond well... I gave her reassurance”.

Caren described being attuned to the client’s emotional needs and directing her intervention based on this feedback rather than having a prescriptive plan. This ‘knowing’ is not an objective fact but a felt sense between the clinician and the client.

Rachel also spoke about ‘knowing’ and the different type of relational experience that trusting in the felt sense provides: *“be happy to sit with someone and support them and just be with them. And it wasn’t until I actually did it, that I understood what it meant”*.

4.5.3 Secure base/good enough therapist

Sarah captured the essence of the work of creating a secure base with the client, demonstrating consistency and care without looking for anything in return. The patience and time devoted to the client was rewarded with trust from that client:

“I wanted her to be alive... So, there was an awful lot of missed calls and texts to show I was there... When she saw that I was consistent, and you know checking in and offering my support. That was when she warmed to me and said ‘ok’. And that was when we started up the whole ‘OK, we got you’”.

The relationship between Sarah and her client developed to the point of having a language to describe the connection: ‘OK, we got you’. The security of the therapeutic relationship has enabled the client to flourish to the point where Sarah described the movement from the safe haven of this relationship to discharge: *“OK, I’m here if you need me but you are OK”*. The imagery that encapsulates this section of interview was that of a mother bird encouraging her young out of the nest. The language is motherly and reassuring in tone.

Emer expressed surprise at the continued attendance of a client to their sessions. *“She is looking at me funny for some of the things we are talking about... She keeps coming back, she does still want to come back... and we are talking about the same things over again”*. Emer seemed initially puzzled by the return of this client week in week out to sessions. As she further explored this relationship, she began to unearth what it is that keeps the client coming back.

“I suppose the piece that brings her back is that she is being listened to, the serve and return... I don’t think she has ever had a space where she has spoken about her emotions”.

Emer provided this client with a reliable and safe space which that client can return to at her own will.

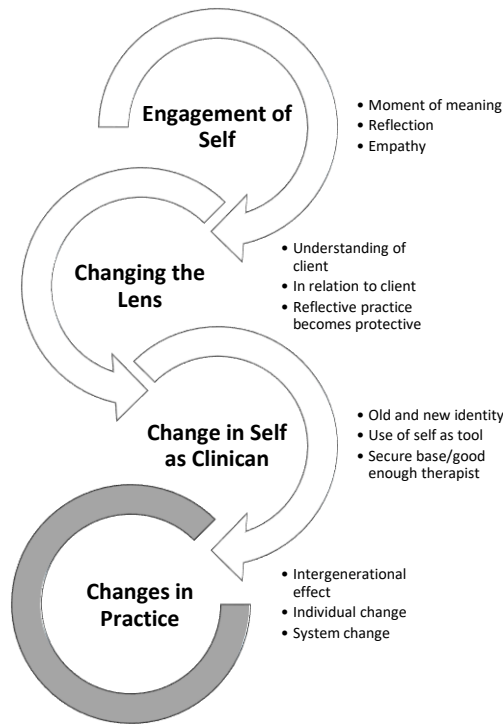
Caren described trust and safety as key elements for building a strong therapeutic alliance. *“She was telling me things that she wasn’t telling anyone else, so it was a safe place for her. The relationship was important”*. She also described her role within that relationship as being someone who offered *“a support, reassuring”*, as someone to hold the uncertainty during a distressing time.

Rachel described the impact the training had on her perception of what it is to be a good clinician. *“I had such a better understanding about attachment and about being good enough and doing things good enough... understanding what was vital”*. She had previously spoken in the interview about the need to be ‘doing’ with clients. The ‘understanding about attachment’ in the therapeutic relationship meant that being with the client became the ‘vital’ piece. *“I was able to feel comfortable and be very encouraging of her to talk to me about it. And that it was OK, and I don’t judge her”*. The ‘good enough’ therapist is the one who can ‘sit with’ and help contain the emotions.

Reflective Box

It was through Elaine's interview that I first identified the varying level of progress in the process of change. Elaine seemed to get 'stuck' in the process of change that involved self as clinician. Moments in her life could account for the stalling of progression in change. For example, in stage one, while reflecting on her own attachment, Elaine spoke about being both "*affectionate*" and "*hard stones*". This internal working model can later be identified as limiting her capacity to mentalise and reach a position of empathy for one client who she identified as "*mollycoddled*". Further, in stage three of change, Elaine clung to her professional identity. I have asked myself why? What does her narrative tell me about her? My conclusion at this point draws on two levels of understanding; firstly, Elaine may be working within her proximal zone of development. Elaine's needs for development may require further guidance and encouragement in intermental learning between expert and clinician. Therefore, Elaine got 'stuck' as the work environment did not provide scaffolding experiences to integrate understanding into clinical practice. Secondly, Elaine may hold a fear of letting 'herself', the '*affectionate*' side into her work identity as it may "*blur*" understanding for her as to how she is in work and how she is in world. There does not seem to be congruence between Elaine's two senses of identity. This no doubt would impact on how she can accommodate changes in her practice.

Figure 4.5 Stage 4 of Metamorphosis



4.6 Changes in Practice

The final stage of change was concerned with how the clinicians implemented this paradigm shift in their work practices. All participants noted a change in clinical practice either on an individual or a systemic level. This will be explored in more detail as each participant's experiences, both triumphs and trials, are given voice and meaning is made through interpretation. It is clear that an intergenerational impact of ACEs and developmental trauma had a profound effect on all of the

participants as a narrative of prevention and intervention pervaded each interview.

4.6.1 Intergenerational effect

The understanding of how intergenerational experiences influence clients who present to mental health services was an influencing factor for all eight of the clinicians, as they began to reframe their perceptions of their clients, their needs, the impact of their mental health, the interventions offered and care plans created. A sense of responsibility came with this knowledge and changed how clients' experiences and mental health were framed.

Rachel: *"I have this hugely valuable information and it effects generation after generation and people should have this [information]"*.

Elaine: *"The cycle is continuing for the next generation, which is kind of worrying"*.

Fiona: *"the transgenerational thing for me sort of, is what spoke out for me. Whatever about treating the underlying mental health concern which is your*

primary focus but also being aware that if you don't get it right you are potentially creating a transgenerational problem”.

The language used in this extract is laden with a sense of responsibility for and towards the clients and the perpetuation of problems to the next generation. There is a sense that Fiona has changed her view of clinical practice and of her role within the client's recovery. No longer is her role purely one of intervention, but there is also a growing role for prevention, which adds a sense of responsibility to the client and their family system.

Sarah also acknowledged an increased awareness of what the preventative element of supporting clients with ACEs could bring to those clients' own lives and that of their children.

“By them having an understanding that their ACEs, growing up can be prevented to passing onto their child by working together as a unit”.

Sarah continued in her reflection on this theme by describing work with one client as he became a new father. *“Helping him realise that he is his own person and he can be the good father he wants to be”.* Her understanding of trauma theory and attachment combined to create a moment of shared understanding with the client said: *“I don't have to be the man my dad was”.* Breaking the cycle of intergenerational abuse was framed as both intervention and prevention.

Lucy described how her understanding of the intergenerational impact of abuse on the clients of the service helped to strengthen and deepen her empathy with the client.

“Patients that grew up in domestic violence homes... we have to see beyond the, they are a nightmare, to well they never knew any different and do they have the skills”.

The deepening empathy allows Lucy to humanise the clients' experiences and not 'other' them through fault or blame: *“It makes you kind of understand at one level where she comes from and be less judgmental”.* There is a 'felt sense' of understanding between clinician and client.

Gabe takes a more philosophical approach to the intergenerational aspect of ACEs and the potential impact this understanding of people can have on the world.

“For me over the coming generations it might be something that is understood within general society... it could have quite revolutionary effects on society”.

Gabe theorised that if the general population had this understanding of trauma and attachment, that would have the potential to change how people relate to each other and therefore impact the world on a socio-emotional level: *“just having a more connected society where people can be more empathetic and understanding of what’s going on...”*. Again, this narrative suggests that this knowledge brings with it responsibility.

Caren found that the intergenerational impact of ACEs was evident in her service. The training offered an understanding of why mental illness had been perpetuated in families. *“We are in a small rural town and you can see the generations coming through the door”*. This intergenerational element causes Caren to question why mental health services have not been able to intervene in the cycle, and to ask whether the wrong approach has been taken. *“I don’t totally buy into the genetic... there is not just one explanation for why people are”*.

4.6.2 Individual change

Lucy also talked about the changes she has experienced regarding why and how she asks questions of clients about childhood and the potential of ACEs.

“I mean questions were always there about growing up and your childhood and whatever, but they were just questions that you asked on admission or assessment forms... but it is almost not to be afraid to ask those questions”

This quote describes a previous tokenistic process in which Lucy used to ask questions because she had to rather than because of a deep understanding of developmental implications of trauma. The difference in practice now being that she isn’t afraid of asking those questions and so can better support the client.

“The questions will be asked about developmental trauma. It changes the way we talk, it changes the way we look at treatment plans”.

Fiona addressed the change in her practice as she moved from a medical model, which pathologises to a biopsychosocial approach, which acknowledges context. This new framework supports Fiona to ‘see’ the ‘unseen’ of trauma and so give value to clients

who might ordinarily minimise their difficulties or disengage from services because of a lack of perceived care.

“It’s trying to promote more prevention strategies, knowing that early intervention, say young clients in their 20s with a history of mental health issues... I know a lot of second and third generation presentations... it does make you more empathetic and understanding and it makes you more able to advocate on their behalf to get the interventions that will make a difference”

Fiona highlighted the ways in which her practice has changed in relation to both women with postnatal depression and expectant mothers: *“women expecting a new baby... we have changed our practice... focus is on getting them support on interacting with their baby”*. Her focus has moved towards a relational intervention rather than a medical intervention alone. Fiona sees this new focus as key because it supports the mother’s mental health as well as preventing potential ACEs in the life of the baby: *“Looking at how you can minimise the impact of their mental health issues on the child”*.

Caren and Rachel described how their growing understanding of factors that influence clients’ relational ways of being helped them to be more empathetic and curious in terms of using the ‘Did Not Attend’ (DNA) policy.

Caren: *“I wasn’t so understanding with stuff like that. I was like, no they have DNAs twice now sure that’s it, I can’t keep giving them appointments... Now I’m more inclined to think ‘right, what’s going on with them that they have DNAed”*.

Rachel: *“I knew she had this in her history of being abandoned. And I really wanted to persevere and keep offering and keep offering”*.

Rachel repeats the phrase *“keep offering and keep offering”* as an indication of her commitment to the client. The ability of the two clinicians to mentalise about the client and hold a deeper empathy so as to utilise policy based on those clients’ needs is evident. This demonstrates an integration of learning in which evidence-based knowledge and an understanding of clients is incorporated into clinical decisions.

Lucy: *“I asked that patient what was her mother’s relationship like with her mother? And she said, ‘oh it was dreadful’, and I just said right you know did you ever consider why?”*

Sarah and Elaine discussed the ways in which the training influenced their practice from a discipline-specific angle. Sarah stated that her new-found understanding of trauma theory gave her confidence to change the clinical assessment process. *“I developed the new nursing assessment and made sure there was an ACEs question in there”*. Sarah recognised the importance of incorporating both a psychological and nursing perspective, as these viewpoints could influence further referrals: *“A person who might have ACEs we might have to look at physical things in the future, the heart”*.

Elaine found that integrating the training into her practice was not obvious or straight forward. *“Clarity is really important... there is a lot of role blurring and overlap...”* Elaine worked hard to ensure the changes she made to her practice were grounded in her professional discipline and not generally focused so that they could be interpreted as being part of any discipline. *“I suppose with OT we goal set a lot of the time... maybe we delve back into the past now”*.

Emer discussed her concerns over working with a client within the framework. *“I think she needs psychological input for herself... I wonder how much she is taking in, there is a lot more that needs to happen”*. Emer identifies a concern she holds for the client in terms of accessing the appropriate intervention for her mental health needs.

4.6.3 System change

Each participant worked in different disciplines and within MDTs that had varying levels of exposure to the trauma informed rational care training. Therefore the idiographic narratives of the participants highlighted triumphs and challenges² encountered while introducing the training the mental health system within which they worked. Fiona succinctly named the challenge of trying to practice within a model when colleagues operate from a different perspective.

² Challenges discussed in this section of the findings will be further expanded on in the discussion chapter.

“And to do it piecemeal isn’t wise as I think all the team need to do the training so that we are all on the same page as to why we are advocating for this. The ripple effects.”

Sarah and Caren also discussed the challenges of working within a team who don’t share the same understanding of client as well as how that impacted on their workload.

Sarah: “It’s just me on the team and it’s hard... Since our new consultant came the question of what’s wrong with you is primary, more the medical model... that doesn’t sit well with me personally”.

Sarah’s language indicates signs of loneliness and alienation from the team. She later went on to demonstrate her use of acceptance as a coping mechanism for the differing approaches of her colleagues: *“And that’s my way not everyone else”*. There is a sense that Sarah will continue to work with the model that is congruent with her view of people and understanding of clients, rather than the one which her other colleagues use.

Caren described a similar experience to Sarah in trying to integrate the training at a team or systemic level. *“I don’t think they have a great understanding in the MDT to be honest. I think everyone is like, ‘it’s wonderful, it’s needed’, but I’m not sure they get it really”*.

In contrast, Rachel found that the MDT responded in a positive manner, embracing the different opportunities of change in the system, particularly as they related to the prioritisation and referral of clients.

“Straight away the consultant asked me would I like to work with clients with children... Not that I am doing any specific intervention, but it would be my approach to the therapeutic relationship”.

The intergenerational effect of ACEs and attachment-informed practice became the platform on which change was introduced to the team through Rachel’s participation in training.

Lucy discussed how the team she works with has successfully integrated change to its working practices by changing the referral form and engaging in a shared model for understanding clients. She attributed this success to the fact that the majority of the team participated in training.

“We are all trained in it now, even our internal referral forms, that talk about the ACEs question and children... it changes the way we talk and the way we look at treatment plan”.

She also highlighted broader system aspects such as regulatory bodies, adding another level of consideration to using the model within the mental health system.

“With the new child protection guidelines and retrospective reporting as well, you know, we have to be more careful in what we ask and how we ask it as well... So it does change how the team works which is good”.

Fiona took a broader system approach and discussed the potential of the model to have a trans-agency impact. She identified the mental health system as a cog in the wheel of a broader societal responsibility.

“I think that’s trans-agency, I don’t think it’s just about medical, I think it’s schooling, early childhood schooling, I think it could make a big difference”.

Fiona highlighted the need for integration of approach at governmental level to effect change on a societal level. Tackling just one aspect such as mental health does not have a huge impact, whereas tackling the issues through multiple systems can create meaningful change. *“For me that’s the voice of psychiatry in Ireland, and they have a role in government and at managerial levels that they can bring about change”.*

Gabe warned about the potential to get “wrapped” up in a new model and not question the reliability of the data. He suggested that attachment *“is very seductive idea, and has a lot of good to offer”*. However, he went on to say: *“I don’t think one size fits all”*. Gabe has longest number of years served in adult mental health of the participants and, since past experiences influence our current assumptions, it may be his experience which recommends caution.

4.7 Chapter Summary

Clinicians who participated in the two-day Trauma Informed Relational Care training experienced a change in their perspectives of themselves, their clients and ultimately their clinical practice. The conceptualisation of their experience as a process of metamorphosis was evident in all the narratives. The participants’ gave both divergent and convergent accounts of the stages which demonstrated that engagement with

change occurred as an idiographic process with some common features emerging such as moment of meaning, reflective practice and so on. The process of metamorphosis has been discussed in detail and illustrative examples provided in the form of direct quotations.

Gabe and Fiona offered valuable findings and contributions as their voices heralded a divergent account which identified trauma informed relational care within a broader context of understanding. Fiona highlighted the importance of multiple stakeholders working together such as education, Psychiatrists of Ireland and TUSLA for enduring change to occur. She recognised the limitations of change as they occur within the context of one mental health team. Gabe also highlighted the power and impact of external ‘politics’ on the potential for a model to change a system. These voices and findings act as a ‘outlier’ to other participant voices who seemed to gaze with a narrow focus on the impact and implications of TIC.

While all participants connected personally with the training and used both objective and subjective knowledge to change the lens through which they understood their clients, the ways in which this shift impacted clinical practice was dependent on the system within which each participant operated. The following chapter will discuss the findings in light of the previous literature.

4.8 Reflective Box

The data analysis phase was challenging as my experience of coding the data and identifying themes was a struggle, it was not as free flowing as the language in IPA suggests ‘emerging themes’. I fought with myself about how to be ‘true’ to the data. I struggled to understand how reflexivity could free me from this struggle. Until, I realised that reflexivity is about acknowledging the struggle so that insight is gained into how this knowledge is produced. Pillow (2003) called it “reflexivity of discomfort” (p.192). Not simply presenting the polished product of participants, subjectivity and self-reflection but to highlight where the self and the other converge and diverge creating a deeper level of insight and meaning to the lived experience.

Chapter 5: Discussion

5.1 Introduction

This chapter summarises and discusses the findings of the current research in relation to the literature and theories outlined in the literature review. The key results are therefore presented and evaluated in the context of existing research and the strengths and limitations of the current study discussed. This is followed by further elucidation of clinical practice implications, and consideration of education and policy implications. Future research recommendations are then discussed in relation to the identification of potential areas for developing the training experience. The chapter concludes with a critical reflection of the overall research process and a brief review of the overall study.

5.2 Summary of Findings

The study yielded rich and meaningful insights into the experiences of mental health clinicians' participation in trauma-informed relational care training and subsequent incorporation into their practice over a 12-month period. The research question focused on how the experience of the training had impacted on their perception of self, client, and clinical practice. Given the phenomenological underpinnings of this research, the aim was to systematically and reflectively explore the clinicians' experience of training by capturing their mental and affective responses. The interpretative framework of IPA, particularly the double hermeneutic predicate, enabled the researcher to make sense of both the convergent and divergent participant experiences. This, in turn, supported the researcher to draw on common features of a shared training experience through the idiographic lens of each participant. The analysis provided in Chapter Four acknowledges the potential influences of researcher subjectivity and "fore-ception" (Shinebourne, 2011). In so doing, the researcher has endeavoured to ringfence personal assumptions and beliefs reflexively in efforts to maximise the validity of the current research project. Moreover, the research question and IPA methodological fit elicits rich insights into the impact of TIRC training on the clinician's sense of self and clinical practice.

As outlined in the previous chapter, this research generated four superordinate themes which captured the process of change. What emerged from the participant narratives was akin to a metamorphosis wherein each participant reported experiencing a process of change that significantly altered their perception of self, client, and practice. This

metamorphosis was initiated during the training phase and continued to develop at varying levels for the clinicians, through working with clients in the mental health service over the following 12 months. The superordinate themes identified were *Engagement of Self*, *Changing the Lens*, *Change in Self as Clinician*, and *Change in Clinical Practice*.

5.3 Metamorphosis

The unique nature of each person's process of change was apparent through all stages of analysis. Each clinician brought their own set of assumptions, beliefs, and personal experiences which both impacted on their individual meaning making and determined the differing levels of importance they ascribed to the various aspects of the metamorphic process.

5.3.1 Engagement of Self

The training fostered a learning environment which supported the clinicians in focusing on their internal state, resulting in the first stage of change; *Engagement of Self*. This stage encompassed the subthemes of Moment of Meaning, Self-reflection, and Empathy which delineated how clinicians initiated an engagement in a process of learning and change. This was found to be initially based on subjective engagement, but subsequently supported by objective theoretical frameworks. This confirmed Mann and colleagues' (2009) proposition that a learning environment can either enhance or inhibit reflective thinking. It is evident that the reflective practice used within the training exerted considerable influence across all eight participants' experience, both within the training phase and in later practice as the clinicians began to retrain the lens through which they saw their clients. This, in turn, adjusted their view of themselves within the therapeutic relationship, and ultimately resulted in changes to their clinical practice.

In the current study, all eight participants reflected on aspects of their own attachments within the training and used this information to support understanding of clients in the mental health service. Further theoretical understanding of attachment theory and the impact on development supported engagement in the process of change. These findings align with Nguyen and colleagues' (2014) theory of reflective practice which identified five components which support clinicians to engage in deep learning and promote change. Nguyen et al (2014) suggest that reflective practice can only change

individuated ways of being, doing, and thinking within the interactive reciprocity of thoughts and actions (TA) and an underlying conceptual framework within the context of understanding how personal beliefs and assumptions relate to and inform the self.

During the initial stage of change, all eight clinicians reported a deepening sense of empathy compared to their previous experience. Five of the clinicians alluded to the “*humanness*” of clients and the enhanced recognition that many clients had suffered the (mis) “*fortune*” to be born into cycles of abuse gave rise to a general questioning around the attribution of ‘blame’, ‘choice’, and ‘fault’. This revitalised the clinicians’ awareness that clients do not choose mental illness, but that, for some, it is actually intrinsic to a developmental trajectory which was initiated in their infancy or childhood; a realisation which evoked a deeper empathy and compassion for clients. This narrative mirrors what Clark (2010) postulated as an integral model of empathy which combines subjective, interpersonal, and objective elements of empathy. Indeed, the clinicians were ultimately enabled to combine a felt sense of the client, an understanding of their experience within the therapeutic relationship, and the skills to frame this understanding within theory. This may account for the deepening empathy undergone by all clinicians in the study which directly impacted how the clinicians viewed themselves in relation to the client, with the client regarded as more similar than dissimilar to the clinician. The embedded “othering” of client as purported by Bloom and Farragher (2010) was therefore reduced. It is clear that when the client is understood within a lifespan context, the clinicians’ capacity to mentalise and empathise increases, thereby helping instantiate and maintain more mutual and collaborative relationships.

5.3.2 Changing the Lens

Participant narratives in this stage of change featured dialogue in respect of the changing understanding of client and how this helped them to reframe their thinking and curiosity about clients. This can best be understood in terms of Wallin’s (2007) account of a therapeutic shift from an embedded to a mentalising stance towards experience.

The superordinate and subordinate themes of *Change the Lens* highlighted the growing awareness and movement from a medical model to a trauma-informed relational care model for all participants. The medical model promotes embeddedness as described by

Wallin (2007) wherein mental illness is framed as ‘What’s *wrong* with you?’ Since the self is not held as distinct from the experience, psychic-equivalence must obtain in this case (Wallin, 2007). The atheoretical diagnostic (DSM) understanding of mental illness observed by four study participants formed the narrative within which the client was framed and an alternative understanding of the client was difficult to envision prior to training.

The subordinate theme, ‘Reframe: What *happened* to you? Not, What’s *wrong* with you?’ highlighted the clinician transition from embeddedness to a mentalising stance on client experiences. As Wallin (2007) suggests, in so doing, the clinician uses the ability to reflect on their own emotion and that of the client, and to respond so that both can make sense of these emotions. The trauma-informed relational care understanding of clients promoted the mentalising capacity of the clinicians by increasing understanding, reflection, and promoting their capacity to envision an alternative by asking ‘What *happened* to you?’ This speech-act in itself breaks the habituated stance of equating mental illness to a fatalistic pattern of behaviour. Changing the lens through which a client is understood creates potential for flexibility in how clinicians think, feel, and behave towards clients, and can ultimately change practice. The findings of this research were similar to the experiences captured by Chandler’s (2008) qualitative research on transitioning to TIC. This study concluded that modifying perspective, collaborative relationships, and prescribed educational resources were key outcomes of working within TIC model.

The superordinate theme of ‘Changing the Lens’ in the current study captures the experience of the participants as they underwent a paradigmatic shift in their understanding of the client in the context of developmental trauma theory and attachment theory. The clinicians began to integrate this understanding in a reframing of mental illness from a medical perspective to a biopsychosocial perspective. This was facilitated through a process of extended reflective practice which grew increasingly protective as they became accustomed to operating on a relational basis.

5.3.3 Change in Self as Clinician

Participant narratives in this section referred to the multiple ways their professional identity had been altered by the paradigmatic shift in understanding the client. The interrelated nature of the process was evident since each transitional stage was

connected to the previous learning. Brookfield (2017) suggested that reflective practice enables a person to explore the type of practitioner they are and to integrate new understandings of self and the conceptual framework in order to explore the practitioner-self. The emphasis on the relational aspect of treatment provided clinicians with the space to prioritise reflective practice when the focus adjusted from one of “fixing” to that of collaborative work.

The current findings are in stark contrast those of both Isobel and Edwards (2017) and Kirst et al. (2017) who concurred that staff experienced barriers to practice such as lack of clarity, consistency, and guidance about how to change clinical practice, a reluctance to explore trauma, and staff burnout. Conversely, the findings of the current study indicate that the clinicians in this Trauma-informed Relational Care training had identified mechanisms through attachment theory and relational care which formed the foundation of change in their clinical practice. The therapeutic alliance and the clinician’s role within this were further highlighted by the subordinate themes “Using self as tool” and “Good enough therapist/secure base”. Sweeney et al. (2018) noted the body of evidence which contends that the therapeutic relationship between client and clinician creates a positive outcome which could be considered comparable to therapy per se (Priebe, 2008, cited in Sweeney et al., 2016).

Holmes (2017) proposed that therapists who work within an attachment informed framework use meta-competencies influenced by the primary attachment interactional process such as rupture-repair, therapist as secure base, positive comments, and creative imagination. Several of the participants reported that their way of working with the client had changed to incorporate a number of these meta-competencies, particularly the inclusion of positive comments and creative imagination. Three of the participants spoke of drawing on their own experiences as a way of modelling and normalising experiences and using their own experience in a creative way to positively influence the client. One such participant (Emer) referred the “*serve and return*” as a key aspect in the relationship which ensured the client returned.

The clinicians’ narrative in this study indicated a significant shift in how they viewed themselves within the therapeutic alliance. Seven of the clinicians reported engaging in a meaningful way (using self as tool) with clients by harnessing aspects of their own experience to model and support emotional regulation. This supports Van der Kolk and

Perry's (2005) assertion that engaging in meaningful interactions can ameliorate the enduring and destructive impact of trauma on interpersonal relationships.

5.3.4 Change in Practice

Participants in the current study spoke about how their understanding of the intergenerational impact of ACEs altered their perception of the client and their own role within clinical practice. All eight participants identified multiple generations of families attending the mental health services and attributed ACEs as the perpetuating factor of mental illness.

The intergenerational cycle of ACEs has been the subject of numerous studies including that of Bellis et al. (2013) and Ben-David, Jonson-Reid, Drake & Kohl (2015). The narratives which addressed intergenerational ACEs demonstrated a sense of responsibility toward clients as the clinicians held this to be "*valuable*" information.

Robert and colleagues (2015) identified a correlation between a maternal history of abuse and offspring symptoms of depression. As such, they recommended the screening pregnant women and young mothers for ACEs. The findings of this study in the subordinate theme "Intergenerational effect" and "Individual change" emphasised how far clinician's awareness of the impact of parents on children in amending their clinical practice to include the identification of pregnant women as a priority group for care within the system. As one participant (Fiona) stated: "*women expecting a new baby... we have changed our practice... focus is on getting them support on interacting with their baby*". The knowledge of developmental trauma and the far-reaching negative consequences are challenging the mental health system to respond in a proactive manner which prioritises prevention as well as intervention.

The clinicians in the current study began to envision clinical practice in terms of prevention and intervention. The narrative around clinical practice increased focus on how the adult mental health services can promote prevention as well as intervention for mental illness. Attachment theory provided important clinician insights into the cycle of neglect, which, in turn, helped to identify mechanisms to support moves towards relational support rather than medical intervention alone.

Seven of the clinicians reported that their practice had been modified to decrease the threshold for referral for intervention for clients with children, and to respond to clients

with ACEs awareness as opposed to an exclusive focus on the acuteness of presentation (symptoms). This practice modification is supported by evidence in the Minnesota Study of Child Development as cited in Granqvist et al. (2017) which found that parents who received therapy at some point in their lives interrupted the cycle of abuse.

The clinicians were able to adapt their clinical practice within their own discipline to incorporate the core principles of trauma-informed care and trauma-informed relationships. However, a number of the clinicians encountered certain systemic challenges when trying to integrate the training into MDT practices.

These included resistance to moving from the medical model of mental illness to holistic biopsychosocial model. The clinician narratives also pointed out that the clinical lead usually decided on the model adopted in the MDT. The challenges identified in this study align with the barriers to implementation of TIC in the UK as discussed by Sweeney et al. (2016) and Sweeney, Filson and colleagues (2018).

For some clinicians, the lack of supervision and guidance around implementing TIC was seen as another obstacle. The dialogue centred particularly on the need for supervision when grappling with the question of precisely when to refer clients to a specialist trauma-specific intervention. These findings again support those of Sweeney et al. (2016) who maintained that the majority of barriers in implementing TIC related to the lack of a supportive organisational culture.

5.4 Strengths and Limitations

This section addresses the strengths and limitations of the current study by considering the goodness of fit between the research question and methodology employed. Various aspects of the methodology will be examined including researcher positionality, sampling method, sample size, analysis, and so on.

The use of IPA in this research study is arguably a research strength since it allows for the exploration of complex interrelationships within phenomena. To this end, the researcher engages deeply with the phenomenological experiences of participants in an interpretative role which gives voice and meaning to anticipated and unexpected experiences. The present researcher achieved this by adopting a phenomenological attitude using philosophical, theoretical, literary, personal, and interpretative lenses.

This elicited rich findings which extended beyond the descriptive into a creative interpretation identifiable within the positionality of the researcher.

The participants in this study were unique in their individual characteristics, personal experiences, engagement in interview, and professional discipline. The professions of the mental health clinicians varied from psychiatrist, staff nurses, psychotherapist, occupational therapist, social worker, and community mental health nurse. Such variance in clinical discipline and experience and limited occupational homogeneity could be taken as a potential limitation. However, within the context of this study, the homogeneity of the group was actually determined by the clinical population (adult mental health) setting, the geographical area (same CHO area), and attendance of the same trauma-informed relational care training. Indeed, the divergence and convergence of participants' professional and personal experiences provided additional legitimate research avenues through which the researcher moved closer to the essential qualities of TIRC in the analysis.

A related limitation of the research could be identified as the gender imbalance (eight female to one male). Indeed the researcher tried to counter the gender imbalance by canvassing male clinicians who had attended the training; unfortunately, they declined to participate. In any event, such a distinct gender imbalance could arguable be attributed to the predominance of females in the healthcare services. However, similar gender biases have been noted in reviews of general nursing research (Polit & Beck, 2008). A related finding in the literature is that men tend to access counselling supports to a lesser degree than women (Englar-Carlsen, 2006). The incongruence of the culture of masculinity with talk therapy has been proposed as another gender issue (Englar-Carlsen, 2006) and there may also be an overlap between the requirements of the qualitative interview process with that of the talk therapy being at odds with the masculine gender role schema. Perhaps greater creativity and gender socialisation awareness needs to be considered when developing techniques which target and access the lived experience of male participants.

A further potential limitation of the study could relate to interviewing the participants at the single time point of twelve months following training. Had individuals been interviewed at a number of different time points, such as immediately after training, and/or at subsequent four month intervals, richer and deeper data could possibility have

been derived. Consecutive or multiple meetings with the participants would arguably have facilitated the development of greater rapport and greater trust, leading to richer narratives.

One of the main criticisms levied at the IPA method is the lack of standardisation in analysis. The researcher aimed to address issues of standardisation by using the Smith et al. (2009) stages of analysis as clearly outlined in the methodology, as well as establishing transparency throughout analysis with the interpretation tracing a clear trail back to the original data. Every transcript provides supporting evidence of the descriptive, linguistic, and conceptual analysis along with a research journal which annotated the researcher's reflexive process. Given the interpretative and subjective nature of IPA analysis, supervision was used to reflect on the grounds of interpretation.

As an idiographic study, it is given that the findings cannot be generalised, produce a theory, or offer a definitive cause-and-effect understanding of the phenomenon.

Nonetheless, they do provide telling insights into how these particular participants were impacted by training in terms to understanding of client and self in relation to client and clinical practice.

As such, it augments existing literature to give programmes and policy developers a new lens with which to question and conceptualise the needs of clinicians in relation to trauma-informed care and the mechanisms through which to provide it.

5.5 Implications for Clinical Practice

A number of studies (Isobel & Edwards, 2017; Kirst et al., 2017; Sweeney et al., 2016) which have examined the operationalisation of TIC in mental health services, have critiqued the lack of clarity about practice change, a lack of commitment to trauma inquiry, and staff burnout as potential barriers to implementation. Bath (2017) also maintained that the TIC approach often displaced other useful approaches such as attachment-informed practices.

The current study adopted a Trauma-informed **Relational** Care Model which used attachment theory as a mechanism for understanding the client in context and afforded a relational focus as the foundation for effecting change in clinical practice. The mechanisms of attachment such as rupture-repair, serve and return, active listening, partial contingency mirroring and empathetic engagement could be integrated into

clinician's current skillset. This would develop the clinician's skills in building strong therapeutic alliance which is the cornerstone of clinical practice.

What was evident from the findings in this research is that a piecemeal approach to introducing trauma-informed relational care had the potential to create challenges within the system. This was all too apparent for clinicians who work in MDT which operate within the medical model as they were attempting to integrate aspects of trauma-informed relational care into elements of their practice while working under a clinical lead who was predominantly guided by the medical model. Given the small scale of this research it is challenging to envisage the transfer of training to practice. However, each participant noted the importance of them being a 'champion' for Trauma informed care on the team. Perhaps, identifying a 'TIC Champion' on MDT and this person being supported by a Network group of other 'TIC champions' would allow a reflective space for support and development in this area.

A key means of supporting clinical practice of clinicians would be the introduction and use of standardised and evidence-based assessments of trauma history and symptoms. Six clinicians acknowledge that prior to training they did not enquire about early life experiences of ACEs and when they did, it was merely tokenistic and did not impact their care plan. All clinicians reported that since completing the training, they had changed their assessment practice. One had specifically designed an assessment to include an intentional enquiry about ACEs and this information was understood in the context of current presentation. It was also used to inform next steps of referral (as needed). However this method of assessment is somewhat ad hoc and the needs of the client would be better served by an evidence-based ACEs assessment. Again introducing a universal standardised trauma measure across all services would be stretch given the size of this research. However, what is evident from the findings is that those who participated in the training did increase their understanding of the impact of early trauma on current presentations to the mental health service. This increased awareness and understanding is changing the assessment practices for those who did participate. Further research is warranted into exploring how these changes impact clinical practice and the experience for clients.

As Green (2006) reported the impact of short term in-service training on clinical care is limited due to the once-off nature of this training and the lack of meaning evaluation

from client and clinician perspective. There is a significant gap in what is known about effective treatment and what is provided as routine care in clinical practice. At organisational level the route from considering the adoption of a new routine to successfully implementation is non-linear and littered with many setbacks and unanticipated challenges along the way (Proctor et al., 2009). There has been an increasing emphasis on the importance of improving fit between mental health intervention development and service systems (Proctor et al., 2009). Therefore, in considering the progression of Trauma-informed relational care it has to be considered how this model fits within existing service systems. The evolving field of implementation science means that an effective evidence base has to be established and then consideration is given to how that can be effectively translated into routine use. There is a significant difference between dissemination and implementation. TIRC training concentrated on the distribution of information to a clinical practice audience via a 2-day workshop. Implementation would need to consider what strategies are utilised to introduce efficacious clinical practice. This would require further testing and evidence-based practice.

5.6 Implications for Education

Given the participant narratives in this study and the research, the serious issue of trauma in mental health service users is arguably an unmet need. Mental health professionals play a key role in supporting people with trauma who engage in services, and to this end, it is vital that mental health services adopt a person-centred and inclusive outlook which is explicit in its philosophy of care. Trauma-informed care education focuses on minimising the potential for re-traumatisation within services by valuing safety, trustworthiness, collaboration, choice, and partnership (Sweeney et al., 2016).

It is recommended that along with clinicians, all ancillary staff, including security, reception, and administrative staff, participate in relevant training to ensure that the culture and environment of the entire service, and not just that of clinical practice, is incorporated. A trauma-informed care service is more than the sum of its parts.

This study highlights the transformational process which the clinicians underwent during training and in the 12-month aftermath. Their narratives attested to how the clinicians developed an alternative perspective on how to talk about and conceptualise

recovery and therapeutic engagement. A key message of education in mental health services would be the recognition of the prevalence, signs, and impact of trauma on the adult service user or having a trauma lens. This allows the clinician to enquire, “What *happened* to you?” as opposed to “What is *wrong* with you?” Embedding such training within mental health services has the potential to be transformative and give rise to changes in professional practice and service provision which directly benefit service users.

The clinician narratives confirmed that trauma-informed relational care training provided them with the ‘lens’ to reframe clients’ behaviour, a changing view of self and client, and enhanced skills and confidence in their clinical practice. It is critical that staff feel empowered rather than burdened by such training. Therefore this training was not prescriptive but rather supported the clinician to value and integrate their existing skills with new knowledge through the process of reflective practice. One important recommendation is to provide trauma-informed care education in a manner that emphasises flexibility of response, skill and confidence enhancement, and allows for staff ownership.

Finally, it is evident that professionals within mental health services could play a key role in raising trauma-informed awareness across services through multi-agency contact. In addition, the growing need of trauma-informed care could encourage undergraduate education and professional training programmes in universities and accredited colleges to offer curricula which specifically prepares students to work in trauma-informed care practices.

5.7 Implications for Policy

Existing research on ACEs (Bellis et al., 2015; Felitti et al., 1998; Rossiter et al., 2015) confirms that ACEs are endemic in the lives of the people who attend and use mental health services (Kessler, 2010). As Rossiter et al. (2015) reported in their study, over 70 per cent of the 129 participants attending a single mental health service in Ireland had one or more ACEs.

Jorm et al. (2018) reported that in spite of the increased investment in mental health, prevalence rates in mental illness had not decreased. He suggested that a preventative approach targeting big risk factors to mental health could potentially reduce the treatment gap. As discussed in literature review, ACEs are a significant risk factor for

mental illness. Jorm et al. (2018) further purported that mental health professionals trained in Trauma-informed Care have a major role to play in raising awareness about the risk of ACEs, in identifying ACEs, avoiding re-traumatisation of clients, providing preventative care by identifying families in mental health services who may be at risk, and by offering supports.

As such, integrating trauma-informed relational care as a core aspect of policy in service development could have a direct impact on the experience of clients in the service and also represent a long-term focus of addressing a mental health prevention strategy.

In the current study the preventative potential of trauma-informed relational care was highlighted for all eight participants, with many clinicians adjusting the threshold for referral to one-to-one support based on the identification of ACEs or the potential for the perpetuation of ACEs within families through mental illness of parent, namely, PND or other serious mental illness. Breaking the intergenerational cycle within mental health services became a clear motivating factor for clinicians and fostered an enhanced sense of investment in clients and motivation to advocate for clients.

While individual clinicians may engage clients using trauma-informed methods, such efforts will ultimately be ineffectual without a system-wide change. The potential to integrate trauma-informed relational care with the recovery model, which was advocated in *A Vision for Change* (2006), is feasible. Both recovery and trauma-informed care are person-centred, value-shared decision-making, and collaborative work, which seek to prioritise empowerment and choice for clients. Trauma-informed Relational Care brings an additional level of understanding in terms of trauma perspective, in educating clinicians about the impact of trauma, preventing the propagation of trauma in services, highlighting the need for safety, prioritising healing through relationship, potentially serving as prevention, and an providing an intervention-focused service. The preventative aspect lies in the recognition of intergenerational impact of ACEs such as parental mental illness, substance abuse, and domestic violence and the therapeutic and social supports which could be provided. The shift in policy towards adopting trauma-informed relational care principles could also potentially augment the commitment to reducing suicidality espoused in such

policies such as Connecting for Life: Ireland's National Strategy to Reduce Suicide 2015-2020 (DOH, 2015)

5.8 Implications for Future Research

Evidence has shown that it takes 10 to 15 years for new healthcare innovations to become fully assimilated into routine clinical practice (Proctor et al., 2009). This protracted process can be supported by properly training staff, conducting evaluations, and promoting ownership at all levels. Moreover, continuing to develop trauma-informed care through in-service research, developing assessment tools, and gaining an understanding of TIC from all perspectives is fundamental to development.

Given the range of differing MDT participation levels, a number of different experiences and challenges were identified by participants in terms of how trauma-informed relational care training was received within their multi-disciplinary team (MDT). Therefore, capturing the experience of an entire multi-disciplinary team trained in trauma-informed relational care would provide interesting insight into how a system responds from the same philosophical perspective as well as how that impacts how the team conceptualises the client, mental illness, recovery, language around the client, and treatment and practice in MDT. If explored through focus groups this could potentially capture the parallel process of MDT within the group format.

Another area for research development is the exploration of the schematic of metamorphosis through grounded theory, particularly in relation to the process of change instigated in trauma-informed relational care model of training. While the current study provides a lived experience of the process, it would be interesting to determine the potential to develop a theory of change which emerges from experience. Such a sample population would be based on adult mental health clinicians who participate in the TIRC training model, and the iterative and emic process of questioning and refining within grounded theory would enable researchers to dig deeply and refine the experiences of the participants in an emergent theorisation.

The use of longitudinal approaches to narrative data when conducting research with this participant group is arguably worthwhile. Given that the experience of training instigated a process of change for these participants which was evident 12 months post-training, it would be interesting to observe whether individuals continue to sustain TIC

in their clinical practices and which practices and behaviours help or hinder this process.

The deepening relationship between the researcher and the participant could also educe a richer understanding of the private and professional individual as well as the system.

The voice of the mental health service user within this field of enquiry is conspicuously absent. As the core principles of TIC include mutuality, empowerment, and partnership, one essential future step in research would be to access the lived experience of services user within a trauma-informed relational care model of mental health services. This would yield yet another perspective of the phenomena. It could also provide the mental health clinician with meaningful insights into how the care they provide is experienced and whether it is properly trauma-informed. Another potential outcome of the service user research would be to harness the service user's voice, as well as that of staff and evidence-based practice to co-design programmes and services within a trauma-informed care model.

In terms of how research could enhance the TIRC training experience, the findings from this study could be used to develop a 'Participant Experience Evaluation'. As such, the results of this current research could be used to devise questionnaires with Likert scale responses, concerning the participants' experience during training; with such questions as; "Was there a moment in the training in which you emotionally connected with the material?" The data would be transformed using linear regression analysis to create classifications of experience. These classifications would further refine the 'Participant Experience Evaluation'.

5.9 Critical Reflection

One of the key strengths of IPA is the centrality of the researcher and the transparent recognition of their role throughout the research process from design, to conducting interviews and analysis, and write-up. Double hermeneutics is the mechanism of interpretation in which the researcher's life experiences, personal values, assumptions, and expectations are used to allow meaning to emerge from the data. In light of this, it is necessary to discuss my own positionality as the researcher with attention given to self-reflection as both the participants and I navigated the research process.

My interest in the area of trauma-informed relational care has evolved over a period of ten years and was driven by both personal and professional experiences. I have an intuitively- and experientially-driven interest in the areas of attachment theory and trauma-informed care. I completed the two day trauma-informed relational care training in June 2017 along with the participants in this study. The training left an indelible mark on me. It spoke to my experience as a mother in no doubt concerning the pre-eminence of relationships in understanding human development and my experience as a trainee psychologist who in the previous six months had met eleven clients, nine of whom had experienced trauma. I began to wonder about the experiences of other clinicians within the training and what the impact on *them* might be.

At some level, my initial preconceptions assumed that clinicians from other disciplines than psychology would not fully appreciate the significance of this model. I assumed that they would be so entrenched in their own biomedical model of the client that the sheer simplicity of a *relationship* might not be enough to impress them. On reflection, I realise I was actually “othering” my colleagues and positioning psychology as the only discipline which intrinsically valued the client-therapist relationship. I am now more than happy to admit that I had underestimated the value which other disciplines such as nursing and psychiatry place on the therapeutic relationship.

Indeed, as I engaged in the very first interview it became immediately apparent that the client was held in high regard and that each participant was motivated to understand and support the client.

As I began the recruitment process for the interviews by attending multi-disciplinary team meetings, I encountered some hesitancy to volunteer for participation in the research among staff. I was unsure why this might be and considered that perhaps people were too busy, not attracted to the idea of an interview, or felt it was too much of a draw on their time. The possibilities were endless and trying to understand the recruitment problem did little to solve it. Having previously worked in the CHO area, I therefore decided to tackle participant reluctance head-on within the recruitment session. It transpired the main reason for not volunteering was that people thought they would be asked direct questions about the content of the training, and given it had taken place 12 months previously, they were anxious about the need to study. I reassured them it was not an assessment of knowledge but rather an exploration of how they

experienced the training and the impact it had on them. This allayed fears and I received four voluntary participants on that day.

As I reflected on this experience, two important things were brought to mind. Firstly, I had assumed that the clinicians understood the language of research, such as ‘qualitative methodology’, ‘semi-structured interview’, ‘interpretative phenomenological interpretation’, and ‘analysis’. I was so immersed in the world of research that I did not stop to think what I was asking of the clinicians. Secondly, in asking them to trust me, I had couched the whole participation process in inaccessible, and arguably hierarchical, language. I was struck by the parallel between this and what clinicians ask of clients every day; to participate and trust in a process that is unclear. For me, the main learning is that research and clinical work both require safety and trust to build in every moment of contact with clear and accurate communication.

The data analysis phase was also challenging as I struggled to hear the idiographic voice of participants. I feared that I was drawn to those parts of the transcripts which confirmed my own world view of the training. I brought this concern to supervision as it was impacting on the analysis. During supervision I was challenged to think about the impact of differing outcomes of the findings. Would it impact on how I viewed the model? Was I too invested in the model? Following this session, I began to journal my experiences of analysing each transcript.

This created a space to debrief and reflect on concerns I had about analysis. Then, I encountered Gabe’s transcript. Gabe provided a narrative of cautiousness and questioning about the model in his experience of clinical practice. Having witnessed Gabe’s cautiousness and holding true to my interpretation of his meaning making, I returned to the previous transcripts. I embraced the phenomenological attitude and let go of the fear of doing it wrongly. The voice of each participant flowed, thereby enabling me to capture the divergent and convergent experiences of each participant, leading to what I trust is the very essence of the phenomenon.

5.10 Study Conclusion

At time of writing, there has still been no systematic trauma-informed response by mental health services in Ireland. While a comprehensive review of the literature found that clients attending mental health services are more likely to have experienced ACEs or trauma in their lifetime, the research concluded that trauma history was rarely

explored. This has resulted in a failure to understand the presenting problems and to refer clients for the appropriate intervention.

The aim of this study was to explore clinicians' responses to a locally-devised trauma-informed relational care training. Through semi-structured interview, the participants shared the various ways they made sense of the training and integrated their learning into a more insightful understanding of the client and relational clinical practice.

As the study evolved it became apparent that the process of change required the clinician to become subjectively and emotionally involved with the training material in order for meaningful engagement to take place. This 'felt sense' was the foundation upon which the objective information was integrated into understanding the client. The deepening empathy and compassion felt towards the client was rooted in the realisation that they were more similar than dissimilar which reduced the embedded "othering" of clients. Critical to this shift was the movement of clinicians from deep-rooted practice towards a mentalising stance of the client. This recognised the importance of context and perspective when trying to understand the client and maintain a positive interrogation of "What *happened* to you?" rather than the more pejorative "What's *wrong* with you?" Such a revitalised perspective supported the clinician to reassess the value of the relational aspect of care and to prioritise the therapeutic relationship.

In conclusion, a critical summary of the research process was conducted along with a review of the strengths and limitations of the study. The findings were evaluated in terms of their implications for clinical practice, policy, and education, and recommendations for research identified and discussed.

References

- Aas, M., Henry, C., Andreassen, O. A., Bellivier, F., Melle, I., & Etain, B. (2016). The role of childhood trauma in bipolar disorders. *International journal of bipolar disorders*, 4(1), 2.
- Abuse, S. (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach.
- Ainsworth, M. S. (1989). Attachments beyond infancy. *American psychologist*, 44(4), 709.
- & Bateman, A. (2008). *Mentalizing in Clinical Practice*. Washington DC: American Psychiatric Press.
- Anderson, J. (2016). A simple guide to avoid receiving a diagnosis of 'personality disorder'. *Clinical Psychology Forum* (279).
- American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text rev.). Washington, DC: Author.
- Bailey, T., Alvarez-Jimenez, M., Garcia-Sanchez, A. M., Hulbert, C., Barlow, E., & Bendall, S. (2018). Childhood trauma is associated with severity of hallucinations and delusions in psychotic disorders: a systematic review and meta-analysis. *Schizophrenia bulletin*.
- Bariola, E., Hughes, E.K., & Gullone, E. (2012). Relationships between parent and child emotion regulation strategy use: A brief report. *Journal of Child and Family Studies*, 1-6.
- Bateman, J., Henderson, C., & Kezelman, C. (2013). Trauma-informed care and practice: Towards a cultural shift in policy reform across mental health and human services in Australia. *Mental Health Coordinating Council*.
- Bath, H. (2017). The Trouble with Trauma. *Scottish Journal of Residential Child Care*, 16(1).
- Becker-Blease, K. A. (2017). As the world becomes trauma-informed, work to do: Taylor & Francis.
- Bellis, M., Ashton, K., Hughes, K., Ford, K., Bishop, J., & Paranjothy, S. (2015). Adverse childhood experiences and their impact on health-harming behaviours in the Welsh adult population. *Public Health Wales*, 36, 1-36.
- Bellis, M. A., Lowey, H., Leckenby, N., Hughes, K., & Harrison, D. (2013). Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. *Journal of Public Health*, 36(1), 81-91.
- Ben-David, V., Jonson-Reid, M., Drake, B., & Kohl, P. L. (2015). The association between childhood maltreatment experiences and the onset of maltreatment perpetration in young adulthood controlling for proximal and distal risk factors. *Child abuse & neglect*, 46, 132-141.
- Bevir, M., & Rhodes, R. A. (2002). Interpretive theory
- Biggerstaff, D., & Thompson, A. R. (2008). Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative research in psychology*, 5(3), 214-224.
- Bloom, S. L., & Farragher, B. (2010). *Destroying sanctuary: The crisis in human service delivery systems*: Oxford University Press.
- Bolton, G. (2017). *Reflective Practice: Writing and Professional Development*. London: Sage Publications.

- Bohart, A.C., Elliot, R., Greenberg, L.S., & Watson, J.C. (2002). Empathy. In J. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp.89-108). New York, NY: Oxford University Press.
- Borg, M., & Kristiansen, K. (2004). Recovery-oriented professionals: Helping relationships in mental health services. *Journal of mental health, 13*(5), 493-505.
- Bowlby, J. (1988). Developmental psychiatry comes of age. *The American journal of psychiatry, 145*(1), 1.
- Brookfield, S.D. (2017). *Becoming a critically reflective teacher*. John Wiley & Sons.
- Bronfenbrenner, U. (2005). Ecological systems theory (1992). Jessica Kingsley Publishers
- Burke, E., Danquah, A., & Berry, K. (2015). A Qualitative exploration of the use of attachment theory in adult psychological therapy. *Clinical Psychology and Psychotherapy, 23*, 142-154.
- Butler, L. D., Critelli, F. M., & Rinfrette, E. S. (2011). Trauma-informed care and mental health. *Directions in Psychiatry, 31*(3), 197-212.
- Chandler, G. (2008). From traditional inpatient to trauma informed treatment: Transferring control from staff to patient. *Journal of American Nurses Association, 14*, 363-373.
- Chambers, M., Gallagher, A., Borschmann, R., Gillard, S., Turner, K., & Kantaris, X. (2014). The experiences of detained mental health service users: issues of dignity in care. *BMC medical ethics, 15*(1), 50.
- Chiesa, M., Larsen-Paya, M., Martino, M., & Trinchieri, M. (2016). The relationship between childhood adversity, psychiatric disorder and clinical severity: results from a multi-centre study. *Psychoanalytic Psychotherapy, 30*(1), 79-95.
- Choi, N. G., DiNitto, D. M., Marti, C. N., & Segal, S. P. (2017). Adverse childhood experiences and suicide attempts among those with mental and substance use disorders. *Child abuse & neglect, 69*, 252-262.
- Clark, A. J. (2010). Empathy: An integral model in the counseling process. *Journal of Counseling & Development, 88*(3), 348-356.
- Cloitre, M., Stolbach, B. C., Herman, J. L., Kolk, B. v. d., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of traumatic stress, 22*(5), 399-408.
- Courtois, C. A., & Ford, J. D. (2009). *Treating complex traumatic stress disorders: An evidence-based guide*: Guilford Press.
- Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training, 41*(4), 412_425.
- Costanzo, M.S. (2016). Ill or Injured: Shifting the emphasis to trauma in mental health diagnosis and treatment. *Psychiatric Rehabilitation Journal, 39*(4), 368-370.
- Coyle, L., Hanna, D., Dyer, K., Read, J., Curran, D., & Shannon, C. (2019). Does trauma related training have a relationship with, or impact on, mental health professionals frequency of asking about, or detection of, trauma history? A systematic review. *Psychological Trauma: Theory, Research, Practice and Policy*. <http://dx.doi.org/10.1037/tra0000434>.
- Danquah, A. N., & Berry, K. (Eds.). (2013). *Attachment theory in adult mental health: A guide to clinical practice*. Routledge.

- DH. (2003). Mainstreaming gender and women's mental health: Implementation guidance, Department of Health, London.
- Dozier, M., Manni, M., Gordon, M. K., Peloso, E., Gunnar, M. R., Stovall-McClough, K. C., ... & Levine, S. (2006). Foster children's diurnal production of cortisol: An exploratory study. *Child maltreatment, 11*(2), 189-197.
- Eisenberg, N., & Morris, A.S. (2002). Children's emotion-related regulation, cited In R. Kail (ed), *Advances in Child Development and Behaviour, (30)*, 190-229
- Emde, R. (2009). Facilitating reflective supervision in an early child development centre. *Infant Mental Health Journal, 30*(6), 664-672.
- Englar-Carlson, M. (2006). Masculine norms and the therapy process. *In the room with men: A casebook of therapeutic change*, 13-47.
- Eatough, V., & Smith, J. A. (2008). Interpretative phenomenological analysis. *The Sage handbook of qualitative research in psychology, 179*, 194.
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine, 14*(4), 245-258.
- Felitti, V.J., & Anda R.F. (2009). The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders, and sexual behaviours: Implication for healthcare. In R. Lanius, & E. Vermetten (Eds). *The Hidden Epidemic: The impact of early life trauma on health and disease*. Cambridge University Press.
- Felitti, V.J., Anda, R.F., Nordenberg, D. Williamson, D.F., Spitz, A.M., Edwards, V. Koss, M.P. & Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experience (ACE) study. *American Journal of Preventative Medicine, 15*(4), pp.245-258
- Fonagy, P., & Allison, E. (2014). The role of mentalising and epistemic trust in the therapeutic relationship. *Psychotherapy, 51*(3), 372-380.
- Fuller-Thompson, E., Baird, S.L., Dhondia, R., Brennenstuhl, S. (2015). The association between adverse childhood experiences (ACEs) and suicide attempts in a population-based study. *Child Care Health Developments, 42*, p.725-734.
- Furlong, P., & Marsh, D. (2010). A skin not a sweater: Ontology and epistemology in political science (pp. 184-211): Palgrave Macmillan.
- Frueh, B. C., Cusack, K. J., Grubaugh, A. L., Sauvageot, J. A., & Wells, C. (2006). Clinicians' perspectives on cognitive-behavioral treatment for PTSD among persons with severe mental illness. *Psychiatric Services, 57*(7), 1027-1031.
- Garbarino, J. (2015). *Listening to killers: Lessons learned from my twenty years as a psychological expert witness in murder cases*. University of California Press.
- Granqvist, P., Sroufe, L. A., Dozier, M., Hesse, E., Steele, M., van Ijzendoorn, M., ... & Steele, H. (2017). Disorganized attachment in infancy: a review of the phenomenon and its implications for clinicians and policy-makers. *Attachment & human development, 19*(6), 534-558.
- Gregorowski, C., & Seedat, S. (2013). Addressing childhood trauma in a developmental context. *Journal of Child & Adolescent Mental Health, 25*(2), 105-118.
- Green, D. (2006) "CPD: Why bother?". In L. Golding & I Gray (EDs.) Continuous Professional Development for Clinical Psychologists; A practical handbook (pp7-19). Oxford: BPS Blackwell Publishing.

- Hanson, R. F., & Lang, J. (2016). A critical look at trauma-informed care among agencies and systems serving maltreated youth and their families. *Child maltreatment, 21*(2), 95-100.
- Harris, M., & Falot, R. D. (2001). Envisioning a trauma-informed service system: A vital paradigm shift. *New directions for mental health services, 2001*(89), 3-22.
- Hepworth, I., & McGowan, L. (2013). Do mental health professionals enquire about childhood sexual abuse during routine mental health assessment in acute mental health settings? A substantive literature review. *Journal of Psychiatric and Mental Health Nursing, 20*(6), 473-483.
- Holmes, J. (2011). Attachment in the consulting room: towards a theory of therapeutic change, *European Journal of Psychotherapy & Counselling, 13*(2), 97-114. Doi: 10.1080/13642537.2011.570013
- Holmes, J. (2014). *The search for the secure base: Attachment theory and psychotherapy*. Routledge.
- Holmes, J. (2015). Attachment theory in clinical practice: A personal account. *British Journal of Psychotherapy, 31*(2), 208-228.
- Holmes, J., & Slade, Arietta. (2017). *Attachment in Therapeutic Practice*. Sage.
- Holmes, J. (2017). Attachment, psychoanalysis, and the search for 21st Century psychotherapy practice. *Psychoanalytic Inquiry, 37*(5), 309-318.
- Hooker, C.I., Verosky, S.C., Germaine, L.T., Kniht, R.T., & D'Esposito, M. (2008). Mnetallising about emotions and its relationship to empathy. *SCAN,3*, 204-217.
- Hopper, E., L Bassuk, E., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal, 3*(1).
- Horwitz, A. V., Widom, C. S., McLaughlin, J., & White, H. R. (2001). The impact of childhood abuse and neglect on adult mental health: A prospective study. *Journal of health and social behavior, 184*-201.
- Hsieh, H.-F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative health research, 15*(9), 1277-1288.
- Huff, J. L., Walther, J., Jesiek, B. K., Zoltowski, C. B., & Oakes, W. C. (2015, October). Qualitative research on psychological experience: A starting point for using interpretative phenomenological analysis. In *Frontiers in Education Conference (FIE), 2015 IEEE* (pp. 1-4).
- Isobel, S., & Edwards, C. (2017). Using trauma informed care as a nursing model of care in an acute inpatient mental health unit: A practice development process. *International journal of mental health nursing, 26*(1), 88-94.
- Johnson, Dan. (2018). What should we do about Trauma? The Psychologist, British Psychological Society.
- Jorm, A. F., & Mulder, R. T. (2018). Prevention of mental disorders requires action on adverse childhood experiences. *Australian & New Zealand Journal of Psychiatry, 52*(4), 316-319.
- Kacprzak, K. (2017). From bad through good to excellent Interpretative Phenomenological Analysis (IPA) studies—presenting set of criteria to evaluate IPA papers and to provide high-quality future research.
- Kessler, R. C., McLaughlin, K. A., Green, J. G., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., . . . Angermeyer, M. (2010). Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. *The British Journal of Psychiatry, 197*(5), 378-385.

- Kirst, M., Avery, A., Matheson, F., & Stergiopoulos, V. (2017). Provider and consumer perceptions of trauma informed practices and services for substance use and mental health problems. *International Journal of Mental Health Addiction*, 15, 514-528.
- Knight, C. (2015). Trauma-informed social work practice: Practice considerations and challenges. *Clinical Social Work Journal*, (43), p.25-37).
- Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological Analysis. *Qualitative Research in Psychology* (3), 102-120.
- Larkin, M., & Thompson, A. (2012). Interpretative phenomenological analysis. *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*, 99-116.
- Liebermann, A.F., Padron, E., Van Horn, P., & Harris, W. (2005). Angels in the Nursery: The intergenerational transmission of benevolent parental influences. *Infant Mental Health Journal*, 26, 504-520.
- Liotti, G., & Gilbert, P. (2011). Mentalising, motivation and social mentalities: Theoretical considerations and implications for psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 84, 9-25.
- Ludy-Dobson, C. & Perry, B. (2011). The role of healthy relational interactions in buffering the impact of childhood trauma. Cited in L.C. Terr. (2011). *Working with children to heal interpersonal trauma: The Power of Play*. Guilford Press, London.
- Luyten, P., & Fonagy, P. (2015). The Neurobiology of Mentalizing. *Personality Disorders: Theory, Research, and Treatment*, 6(4), 366-379.
- Maniglio, R. (2013). Prevalence of child sexual abuse among adults and youths with bipolar disorder: a systematic review. *Clinical psychology review*, 33(4), 561-573.
- Mann, K., Gordon, J., & MacLeod, A. (2009). Reflection and reflective practice in health professions education: a systematic review. *Advances in health sciences education* 14(4), 595.
- Mauritz, M., Goossens, P., Draijer, N. and Van Achterberg, T. 2013. Prevalence of interpersonal trauma exposure and trauma related disorders in severe mental illness”, *European Journal of Psychotraumatology*, Vol. 4, available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC3621904/
- McGee, H., Garavan, R., Byrne, J., O'higgins, M., & Conroy, R. M. (2010). Secular trends in child and adult sexual violence-one decreasing and the other increasing: a population survey in Ireland. *European journal of public health*, 21(1), 98-103.
- McNeish, D., & Scott, S. (2008). Meeting the Needs of Survivors of Abuse: Overview of Evaluation Findings. *London: DMSS Research and Consultancy*.
- Mental Health Commission. (2017). *Mental Health Commission Strategic Plan 2016-2018, V2. MHCIRL*.
- Mihelicova, M., Brown, M., & Shuman, V. (2018). Trauma-Informed Care for Individuals with Serious Mental Illness: An Avenue for Community Psychology's Involvement in Community Mental Health. *American journal of community psychology*, 61(1-2), 141-152.
- Milne, D., James, I & Skeikh, A. (2006). "Evaluating CPD: A practical framework, illustrated with clinical supervision. In L. Golding & I Gray (EDs.) *Continuous Professional Development for Clinical Psychologists; A practical handbook* (pp. 149-173). Oxford: BPS Blackwell Publishing.

- Moloney, B., Cameron, I., Baker, A., Feeney, J. Korner, A., Kornhaber, R., ...& mCIEAN, I. (2018). Implementing a trauma informed model of care in a community acute mental health team. *Issues in Mental Health Nursing*, 1-7.
- Muskett, C. (2013). Trauma Informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing*.
- Nelson, C.A., Zeanah, C.H., & Fox, N.A. (2019). How early experiences shape human development: The case of psychosocial deprivation. *Neural Plasticity*. doi.org/10.10155/2019/1676285.
- Nguyen, Q.D., Fernandez, N., Karsenti, T., & Charlin, B. (2014). What is reflection? A conceptual analysis of major definitions and a proposal of a five-component model. *Medical Education*, 48, 1176-1189.
- Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy*, 48(1), p.98-102.
- Padilla, R. J. (2011). Personality disorders in child sexual abuse victims. *Actas Esp Psiquiatr*, 39(2), 131-139.
- Palfry, N., Reay, R., Aplin, V., Cubis, J.C., McAndrew, V., Riordan, D., & Raphael, B. (2018). Achieving service change through the implementation of a Trauma Informed Care training program within a mental health service. *Community Mental Health Journal*, 1-9.
- Paterson, B. (2014). "Mainstreaming Trauma", paper presented at the Psychological Trauma-Informed Care Conference, Stirling University, Stirling, 4 June, available at: www.stir.ac.uk/media/schools/nursing/documents/Trauma14-Paterson-mainstreaming-trauma-workshop.pdf
- Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*, 20(1), 7-14.
- Pillow, W. (2003) Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research, *International Journal of Qualitative Studies in Education*, 16:2, 175-196, DOI: 10.1080/0951839032000060635
- Polit, D. F., & Beck, C. T. (2008). Is there gender bias in nursing research?. *Research in nursing & health*, 31(5), 417-427.
- Proctor, E., Landsverk, J., Aarons, G., Chambers, D., Gilsson, O. & Mittiman, B. (2009). Implementation research in mental health services: an emerging science with conceptual, methodological and training challenge. *Administration and Policy in Mental Health*, 36(2), 7-19.
- Putnam, K. T., Harris, W. W., & Putnam, F. W. (2013). Synergistic childhood adversities and complex adult psychopathology. *Journal of traumatic stress*, 26(4), 435-442.
- Read, J., Fosse, R., Moskowitz, A. & Perry, B. (2014). The traumagenic neurodevelopment model of psychosis revisited, *Neuropsychiatry*, 4(1), 65-79.
- Reeves, E. (2015). A synthesis of the literature on trauma-informed care. *Issues in Mental Health Nursing*, 26(9), 698-709
- Reuben, A., Moffitt, T.E., Belsky, D.W., Harrington, H., Hogan, S., Schroder, F., Hogan, S., Ramrakha, S., & Poulton, R. (2016). Lest we forget: comparing retrospective and prospective assessments of adverse childhood experiences in the prediction of adult health. *Journal of Child Psychology and Psychiatry*, 57(10), 1103-1112. DOI: 101111/JCPP.12621

- Roberts, A. L., Chen, Y., Slopen, N., McLaughlin, K. A., Koenen, K. C., & Austin, S. B. (2015). Maternal experience of abuse in childhood and depressive symptoms in adolescent and adult offspring: a 21-YEAR longitudinal study. *Depression and anxiety*, 32(10), 709-719.
- Rossiter, A., Byrne, F., Wota, A. P., Nisar, Z., Ofuafor, T., Murray, I., . . . Hallahan, B. (2015). Childhood trauma levels in individuals attending adult mental health services: An evaluation of clinical records and structured measurement of childhood trauma. *Child abuse & neglect*, 44, 36-45.
- Schon, D.A. (1987). *Educating the reflective practitioner*. San Francisco, CA: Jossey-Bass.
- Schore, A.N. (2012). *The science of the art of psychotherapy*. New York: W.W. Norton & Company.
- Seeman, T., McEwan, B., Rowe, J., & Singer, B. (2001). Allostatic load as a marker of cumulative biological risk. *Proceedings of the National Academy of Sciences*, 98; 4770-4775.
- Shankoff, J.P. (2012). Leveraging the biology of adversity to address the roots of disparities in health and development. *Proceedings of the National Academy of Sciences in the United States of America*, 109 (Suppl.2), 17302-17307.
- Shinebourne, P. (2011). The Theoretical Underpinnings of Interpretative Phenomenological Analysis (IPA). *Existential Analysis: Journal of the Society for Existential Analysis*, 22(1).
- Sieff, D.F. (2015). *Understanding and Healing Emotional Trauma; Conversations with pioneering clinicians and researchers*. East Sussex: Routledge.
- Siegel, D. D. (2007). *The Mindful Brain and attainment in the cultivation of well-being*.
- Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: theory, method and research*: London: SAGE Publications.
- Smith, J. A. (2015). *Qualitative psychology: A practical guide to research methods*: Sage.
- Smith, J.A. (2018). Participants and researchers searching for meaning: Conceptual developments for IPA. *Qualitative Research in Psychology*. DOI:10.1080/1147808872018
- Starks, H., & Brown Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative health research*, 17(10), 1372-1380.
- Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: what is it and how can we further its development? *Mental Health Review Journal*, 21(3), 174-192.
- Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018, a). A paradigm shift: relationships in trauma-informed mental health services. *BJPsych advances*, 24(5), 319-333.
- Sweeney, A., Clement, S., Gribble, K., Jackson, E., Carr, S., Catty, J., & Gillard, S. (2018). A systematic review of qualitative studies of adults experiences of being assessed for psychological therapies. *Health Expectations*, 1-16.
- Terr, L. (1991). Childhood traumas. *American Journal of Psychiatry*, (149), 169-176.
- Tuffour, I. (2017). A critical overview of interpretative phenomenological analysis: a contemporary qualitative research approach. *Journal of Healthcare Communications*, 2(4), 52.

- Turner, A., Barlow, J., & Ilbery, B. (2002). Play hurt, live hurt: Living with and managing osteoarthritis from the perspective of ex-professional footballers. *Journal of health psychology, 7*(3), 285-301.
- Turpin, G., Barley, V., Beail, N., Seaire, J., Slade, P., Smith, J. A., & Walsh, S. (1997). Standards for research projects and theses involving qualitative methods: suggested guidelines for trainees and courses. In *Clinical Psychology Forum* (pp. 3-7). DIVISION OF CLINICAL PSYCHOLOGY OF THE BRITISH PSYCHOL SOC.
- Van Der Kilk, B. (2015). *The body knows the score: Brain, mind, and body in the healing of trauma*. Penguin Books, London.
- Wallin, D. J. (2007). *Attachment in psychotherapy*. Guilford press.
- Wagstaff, C., Jeong, H., Nolan, M., Wilson, T., Tweedlie, J., Phillips, E., ... & Holland, F. (2014). The accordion and the deep bowl of spaghetti: Eight researchers' experiences of using IPA as a methodology. *The qualitative report, 19*(24), 1-15.
- Widom, C. S., Czaja, S. J., & DuMont, K. A. (2015). Intergenerational transmission of child abuse and neglect: Real or detection bias?. *Science, 347*(6229), 1480-1485.
- Williams, J., Bucci, S., Berry, K., & Varese, F. (2018). Psychological mediators of the association between childhood adversities and psychosis: A systematic review. *Clinical psychology review*.
- Wota, A., Byrne, C., Murray, I., Ofuafor, T., Nisar, Z., Neuner, F., & Hallahan, B. (2014). An examination of childhood trauma in individuals attending an adult mental health service. *Irish Journal of Psychological Medicine, 31*(4), 259-270.
- Yalom, I. D. (1980). *Existential psychotherapy* (Vol. 1). New York: Basic Books.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and health, 15*(2), 215-228.
- Yeats, W. B., Finneran, R. J., & Harper, G. M. (1989). *The Collected Works of WB Yeats: The Poems (revised)* (Vol. 1). Macmillan.
- Zaki, J. (2014). Empathy: A motivated account. *Psychological Bulletin, 140*(6), 1608-1647.
- Zeman, J., Cassano, M., Perry-Parrish, C., & Stegall, S. (2006). *Journal of Developmental & Behavioural Paediatrics, 27*(2), 155-168.

Website Reference

[https://nswmentalhealthcommission.com.au/sites/default/files/141002%20Living%20Well%20-%20A%20Strategic%20Plan%20\(1\).pdf](https://nswmentalhealthcommission.com.au/sites/default/files/141002%20Living%20Well%20-%20A%20Strategic%20Plan%20(1).pdf)

<https://healthmanager.ie/2016/11/majority-of-hse-employees-are-women/#>

Appendices

Appendix A: Research information sheet



Feidhmeannacht na Seirbhíse Sláinte
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INFORMATION SHEET

Study Title: An exploration of the impact of a 2-day Trauma Informed Relational Care workshop on Adult Mental Health (AMH) clinician's understanding of self, client and practice

Who Am I?

I am Paula Hurley. I am doing a PHD in Clinical Psychology in the University of Limerick. As part of this course, I am doing a research project looking at people who work in adult mental health setting and their experiences of attending a 2-day developmental trauma workshop.

What Do I Want to Do?

I am looking at speaking with a number of people who attended this 2-day developmental trauma workshop in June 2017. I would like to hear how this training may have impacted you, your view of clients attending adult mental health services and your clinical practice.

I hope to capture a wide range of experiences from differing disciplines within the adult mental health setting to fully understand the impact this training has on self and practice. Your participation would provide valuable feedback on this training and its relevance to adult mental health setting. By looking at this, adult mental health services may have a pathway for developing a trauma informed services that may be better able to support staff and clients on engagement with services.

What Does Participation Involve?

Participation in this study requires you to meet me for an interview.

Interview: I would arrange a 1:1 meeting with me. In this meeting I would ask a number of questions. The interview would last between 45 and 60 minutes, but if you need a break or want to stop at any time that is alright. We can also meet more than once if you would like to discuss it over more than one meeting.

How to Contact Me?

If you would like to take part in the study please speak contact me via email or telephone.

My details are below:

Researcher: Paula Hurley; Academic Supervisor: Dr Barry Coughlan

Email: 0469157@studentmail.ul.ie OR 087 2144289

Appendix B: Written consent form



Feidhmeannacht na Seirbhíse Sláinte
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CONSENT FORM



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Please read the following sentences and place a in each box if you agree with the sentence.

I _____ (INSERT NAME) agree to participate in an interview.	<input type="checkbox"/>
I have read the Information Sheet and have had sufficient time to consider whether I would like to take part	<input type="checkbox"/>
I understand the nature and purpose of the exercise	<input type="checkbox"/>
I have had an opportunity to ask any questions that I have and that these have been answered	<input type="checkbox"/>
I understand that the interview will be recorded on a Dictaphone and consent to this	<input type="checkbox"/>
I know that I can decide to stop participating at any point during the interview and I can do so without fear of any penalty	<input type="checkbox"/>
I understand that all information in relation to my participation will be anonymised and stored in line with the Data Protection Act (2003)	<input type="checkbox"/>
I understand that all information regarding taking part will be kept strictly confidential unless the researcher is concerned that I am at risk of harm to myself or others	<input type="checkbox"/>
I understand that Under the Freedom of Information Act (2014), I can have access to any information stored about me, if requested	<input type="checkbox"/>

I understand that I may withdraw from the study at any point, for any reason, without any penalty	
---	--

Signed

Date

Witnessed by

Date

Appendix C: Written debriefing sheet



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DEBRIEFING SHEET



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Thank you very much for taking part in the study. Your participation has been useful in looking at your experiences of attending the 2-day Trauma informed relational care workshop and the impact on you, your view of client and clinical practice. You may have questions that you would like to ask me after you leave this room. If you would like to meet again to have another chat about anything that you feel this has brought up please get in touch and I will arrange to meet you again.

If you have any queries about your own contribution or data, or the project overall, please do not hesitate to contact me (0469157@studentmail.ul.ie). Data you provided will be held for a minimum of ten years in line with the Freedom of Information Act (2014) and Data Protection Act (2003).

If you have been distressed in any way by taking part in this study you can contact the Employee Assistance and Counselling Programme. Thank you again for taking the time to participate.

Researcher: Paula Hurley; **Supervisor:** Dr Barry Coughlam;

Email: 0461957@studentmail.ul.ie; Email:

Confidential Contact Information if Distressed Following Participation:

Employee Assistance and Counselling Programme (EACS) can be accessed via your line manager or on an individual basis at:

www.hse.ie/eng/staff/workplacehthwellbeing/stfsuprts/eacounsel/

Appendix D: Semi-structured interview schedule



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Interview Schedule



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Setting: Interviews will hopefully occur in clinic rooms in Ravenscourt Day Hospital, St. Finbarr's Hospital, Douglas Road, Cork and Blackrock Hall, Mahon, Cork.

Duration: 30 to 60 minutes per interview

Stage 1 – Introduction and Rapport Development

Explanation of study and goals, signing of consent forms. Describe the process that will occur: this is an exploratory interview and that there are no right or wrong answers, that I am interested in hearing people's opinions on the questions that are asked. A verbal reminder will be given that both: (i) the discussion is being recorded, and (ii) that participants can withdraw their consent to participation at any time (both of these are highlighted on the consent form). Confidentiality will be repeated here, ensuring participants that any data collected will be anonymised, transcribed and only the researcher and supervisors will read the transcripts.

Stage 2 – Explore participant's perceptions about their experience of attending the Developmental trauma workshop and its impact on their perception of self.

Tell me a little bit about your experience of attending the DT training?

Prompts of materials used during the training such as 'Baby John' video, 'still face experiment' will be used as memory retrieval cues.

As you bracket the professional self from the personal self, what kind of emotional experiences did you have in response to seeing the different video materials e.g. 'Baby John'?

'We all have an attachment history'- what was it like for you to reflect on your own attachment history?

Has it impacted your view of self in relation to the clients?

Stage 3 – Explore participant’s perceptions around their view of clients

- Has learning about and experiencing the impact of early attachment, reflecting on your own attachment impacted your view of clients within the adult mental health service?
- If so how? If not, explore with participant.
- What aspects of the training have been helpful/unhelpful to develop your understanding of clients within AMH service?
- Has it impacted your ability to empathise with the clients? How?
- How has it helped to improve your quality of your relationship with the client?

Stage 4 – Explore participants’ perspectives on how the DT has impacted their clinical practice.

- Have you noticed any change in your clinical practice since attending the DT training i.e. how you understand/formulate client’s mental health?
- Can you talk to me about some of the differences you notice? How has it impacted your clinical practice?
- What are the areas that you feel you need further support to develop understanding/skills?
- Any other reflections you would like to share about the DT and its impact on you and your clinical practice?

Stage 5

Thank the participants for their contribution.

- Agree to pass on results if they desire them.
- Give debriefing sheet and provide verbal debrief – anything outstanding / unresolved. Remind of supports available post-interview (as per debriefing sheet)
- Give participants an opportunity to ask any questions or make any comments that they may have

- Tell participants that if any of them feel the need to talk to somebody in the aftermath of the interview there are psychological services available to them on an anonymous and confidential basis (this is stated in the debriefing sheet and the contact details is highlighted within same)
- Tell participants that the researcher is willing to meet them again in a week's time if they feel this would be helpful

Appendix E: Example of IPA analysis process

B: Descriptive
 Black: linguistic
 Green: Conceptual

Emergent Themes	Original Transcript	Exploratory Notes
<p>PS:1</p> <p><i>fundamental</i> <i>fundamental</i> <i>fundamental</i> Mental illness - who's to blame? Choice? Fault?</p> <p>Compassion building</p> <p>A new self- surprised by self</p>	<p>Interview L_5</p> <p>Interviewer (I): What was your experience of the training?</p> <p>Participant (P): I think it really made you realise the impact of parenting on children, I suppose when I saw the ghost in the nursery and the ACES study it really does make you realise that some people never got a chance really. You know, I found it really profound. It really struck a chord with me, I know now that Any was sitting beside me and throwing her eyes to heaven (laugh), but I did I really, really did. There were times when I was just emotional during it as well, and I don't think that is just having your own children, I think you know, it really it makes you realise it's so important.</p>	<p>What is the impact of parenting? What did she think it was?</p> <p>Naming parts of training that resonate-why resonate?</p> <p>Realisation that people didn't have chance/choice? Was there a thinking prior to now of blame/choice/fault?</p> <p>Strong descriptive 'profound'. Hit at a fundamental level within her- maybe intuitive knowing</p> <p>Different reactions within training- dismissive v's engaged</p> <p>Surprised by own emotional reaction- trying to understand it for herself as mother, not enough...</p> <p>Why the need to compare self to others? Is there a right/wrong way to react?</p> <p>What's so important? - parenting relationship of child - is non exposure to abuse enough?</p>

2:1 d

Helping to understand the 'stuckness'

Compassion/ building empathy "it's not their fault"

Medical model v's biopsychosocial model

Growing reflective function- Integrating Knowledge and practice

I: what was it that triggered the emotional response in you?

P: I don't know is it because there are certain patients you would be looking at and you think geekers we are not making any progress. it's all going back to your childhood, and why can't we make progress and we are referring onto psychology and everything. I suppose there were one or two patients in my head and I just in my own head, you know what they never had a chance because we knew their mothers, and this was probably the second or third generation of family members in the filing cabinet

Because there was a patient or two I could relate it to and say they are not actually making this decision, they just

Lack of progress in treatment- not understanding reason for 'stuckness'. Sense of frustration with use of language.

Does this mean that it is more difficult to treat?

Questioning professional practice? What does that say about current models? → Is it working?

Participant's personal reflection on working with clients

Use of pause to reflect own thought process, perhaps sadness

Not client's fault. Is this the awakening of compassion/ building of empathy? Is this the point of movement from medical to biopsychosocial model? Change of thinking and language around client?

Client's context impacting factor- intergenerational problems

ACEs perpetuating ACEs perpetuating mental illness - cycle → sadness

Learning and integration of training with clients- growing understanding of psychological perspective of client: Reflective function

They are "not actually" why the decision.

↳ what does this say about how behavior was formed previously?

↳ How did this impact her relationship with client

realisation that moves empathy/sympathy → empathy/relate

Commented [PH1]: On reading my heart sank to the pit of my stomach- almost heartbreak for the client (the child within). Is that how participant felt?

- Is there an impact on the clinician? vicarious trauma

- Was this relationship seen before?

↳ How does that change how client is conceptual

Appendix F: Identifying superordinate and subordinate themes



Appendix G: Reflective journal extract

07/06/2018

I had my first meeting with an MDT today. There were only two volunteers out of a potential nine. I did not foresee recruitment being such a challenge. I wonder what is the barrier to recruitment... Am I presenting the research in an accessible manner? Am I clear on what it is I am asking of them? Are clinician's time poor? Is the face to face interview off putting for some people?

Potential solutions:

Offer telephone interviews to overcome the time factor.

Invite concerns to be addressed in open forum or privately.

Look at language I am using in research presentation- is it plain?

Try to target men in recruitment to get gender balance

25/06/2018

I met with another MDT group for recruitment today. I knew a lot of people at this meeting which gave me confidence to address barriers to participation. A few individuals thought I was going to ask them about the content of the training which caused them a bit of alarm given the training took place 12 months ago. They thought they had to study before coming to the interview. I reassured them that I was interested in their experience of the training (not the content) and its impact on themselves and their practice since the training. I also reassured them I would provide prompts within the interview of training topics if they so desired. And I had success- four volunteers from this recruitment session.

Huge lesson, I assumed that the MDT group would understand that it was their experience of the training I was interested in and not their theoretical knowledge. I must not have been clear on this aspect. Note to self- have essential bullet points on power point. Reduce the language to plain English, no research terminology.

25/08/2018

I am struggling with the analysis. I have this fear of confirmatory bias, that I am looking for evidence in the transcripts that supports my own assumptions and bias. This negates the very essence of the idiographic in IPA. I need to consult with my supervisor and send on an extract of analysis to get feedback. The journaling process is allowing me to acknowledge my fears and is helpful in this doubt-filled time.

Appendix H: Ethical consent form



Coláiste na hOllscoile Corcaigh, Éire
University College Cork, Ireland

COISTE EITICE UM THAIGHDE CLINIÚIL
Clinical Research Ethics Committee

Lancaster Hall,
6 Little Hanover Street,
Cork,
Ireland.

ECM 4 (u) 10/04/18 & ECM 3 (pp) 05/06/18

22nd May 2018

Dr Mairead Carolan
Senior Clinical Psychologist
North Cork Adult Mental Health Service
St Stephen's Hospital
Glanmire
Co Cork

Re: An exploration of the impact of a 2-day developmental trauma workshop on adult mental health (AMH) clinician's understanding of self, client and practice.

Dear Dr Carolan

The Chairman approved the following:

- > Cover Letter dated 8th May 2018
- > CV for Chief Investigator
- > Invitation Letter Version 1
- > Participant Information Leaflet Version 2
- > Consent Form for Focus Group Version 1.

Full approval is now granted to carry out the above study.

The date of this letter is the date of authorization of the study.

Please keep a copy of this signed approval letter in your study master file for audit purposes.

You should note that ethical approval will lapse if you do not adhere to the following conditions:

1. Submission of an Annual Progress Report/Annual Renewal Survey (due annually from the date of this approval letter)
2. Report unexpected adverse events, serious adverse events or any event that may affect ethical acceptability of the study
3. Submit any change to study documentation (minor or major) to CREC for review and approval. Amendments must be submitted on an amendment application form and revised study documents must clearly highlight the changes and contain a new version number and date. Amendments cannot be implemented without written approval from CREC.
4. Notify CREC of discontinuation of the study
5. Submit an End of Trial Declaration Form and Final Study Report/Study Synopsis when the study has been completed.

Yours sincerely

Professor Michael G Molloy
Chairman
Clinical Research Ethics Committee
of the Cork Teaching Hospitals