# “RUNNING IN THE RAIN”:

# EXPLORING PSYCHOLOGICAL RESILIENCE AND TRAUMA MANAGEMENT IN CHALLENGING, AND POTENTIALLY TRAUMATIC, ENVIRONMENTS

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# ABSTRACT

The purpose of this thesis was to explore the experiences of people that operate in challenging, potentially traumatic, environments, and offer an informed opinion as to whether the trauma management model known as 'TRiM' provides an effective approach to support a wider community of risk facing roles and professions (e.g., medical professionals, lawyers, fire and rescue service personnel). Three empirical studies were designed, conducted, and analysed using a mixed methodology approach to investigate the experiences of those that choose to put themselves in potential harm's way for the benefit of others and to test TRiM's suitability for use outside the UK military, which the model was originally designed for. Each study aimed to build on the findings of the previous study in order to provide consistency and relevance.

To begin the research, Study 1, covered in Chapter 2, aimed to investigate the experiences of individuals ($n$ = 7) that worked, or had worked, in a variety of psychologically and / or physically challenging environments with a commonality that each of them had suffered some form of *potentially* traumatic experience during their role or profession. Semi-structured interviews were conducted to explore how they made sense of and managed their experiences (Aim 1 of the thesis). The findings of Study 1 revealed that those that faired best following their potentially traumatic experience (PTE) were the participants that had suitable resources at hand and, as such, felt prepared for working in challenging environments, utilising the necessary skills and knowledge associated with operating with related risk of potential physical and / or psychological harm.

Study 2, covered in Chapter 3, was a longitudinal, quantitative study that had two key aims; firstly, to gauge the benefits of implementing a TRiM programme within a division of UK's Fire and Rescue Services ($n$ = 44*)* (Aim 2 of the thesis) and secondly to provide comparative data between a group that had received TRiM training vs. a control group (Aim 3). The study, involving Shropshire Fire and Rescue Service, employed a series of on-line

questionnaires measuring stress, resilience, general wellbeing, social support and presenteeism, at four specific time points over a twelve-month period. The findings indicated no significant changes in any variable over time.

Study 3, covered in Chapter 4, involved a series of focus group discussions with experienced TRiM specialists ($n$ = 11) who offered informed knowledge and experience to help further deliberate the perceived efficacy of TRiM across 'real-world' settings (Aim 4 of the thesis). The results of study 3 highlighted the perceived benefits and drawbacks with TRiM but most importantly provided informed data on considerations for implementing biopsychosocial support, such as TRiM, most effectively in risk facing organisations or professions.

In summary, through using a mixed-methodology approach, this thesis offers an original and significant contribution to the field of applied performance psychology by increasing the knowledge and understanding of biopsychosocial support as well as providing evidenced based recommendations for the successful implementation of non-clinical interventions, such as TRiM, for risk facing individuals and organisations, in order for them to perform effectively in challenging and potentially traumatic environments. Importantly, this thesis also highlights a number of areas or ideas for future research to further increase understanding of this complex and political field, such as alternative methods of data collection involving other qualifying organisations or populations that may provide greater flexibility, numbers and experiences for study.

# GLOSSARY

| | |
|---|---|
| AG: | Adversarial Growth |
| ANS: | Autonomic Nervous System |
| BDA: | Before, During & After (TRiM questioning technique) |
| CBT: | Cognitive Behavioural Therapy |
| CNS: | Central Nervous System |
| CPD: | Continued Professional Development |
| CPT: | Challenging & Potentially Traumatic [Environments] |
| DSM (5): | Diagnostic and Statistical Manual of Mental Disorders (5th edition) |
| DTA: | Deductive Thematic Analysis |
| EMDR: | Eye Movement Desensitisation & Reprocessing |
| FG: | Focus Group |
| GD: | General Dimension |
| GP: | General Practitioner |
| HOT: | High Order Theme |
| HR: | Human Resources |
| HRV: | Heart Rate Variability |
| HSE: | Health & Safety Executive |
| ITA: | Inductive Thematic Analysis |
| LOT: | Low Order Theme |
| OH: | Occupational Health |
| PFA: | Psychological First Aid |
| PMA: | Positive Mental Attitude |
| PNS: | Parasympathetic Nervous System |
| PTE: | Potentially Traumatic Experience |

| | |
|---|---|
| PTG: | Post Traumatic Growth |
| PTSD: | Post Traumatic Stress Disorder |
| RNLI: | Royal National Lifeboat Institute |
| SID: | Supporting Information Document |
| SNS: | Sympathetic Nervous System |
| SFRS: | Shropshire Fire & Rescue Service |
| TFCBT: | Trauma Focused Cognitive Behavioural Therapy |
| TRiM: | Trauma Risk Management |
| UK: | United Kingdom |
| UPN: | Unique Participant Number |

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# STRUCTURE OF THE THESIS

This brief opening section provides an outline structure and overview of this thesis, which represents a body of work offering original contribution to the field of applied performance psychology on the management of potentially traumatic experiences in challenging environments, using a mixed methodological approach. This three-study approach, using an exploratory and sequential design (Creswell & Plano Clark, 2011), firstly collected qualitative data on the thesis subject matter in order to inform and focus further quantitative data collection. The data gained from the first two studies were, in turn, used to further inform and focus a final qualitative study ensuring *completeness* and *enhancement* of all data collected within the thesis, in line with Bryman's findings (2006).

The thesis is presented in five chapters and incorporates the three unique research studies. It should be stated that as each study contained in Chapters Two, Three and Four of the thesis were written as separate empirical studies, there will be a degree of repetition or overlying text found within the introduction sections of each.

Chapter One contains a comprehensive narrative review of associated existing contextual literature on TRiM. This includes an overview of TRiM and its component parts, such as biopsychosocial education, assessments of associated risk factors and TRiM personnel, as well as wider considerations such as the effects of psychological stress (acute, chronic and / or traumatic).

Chapter Two covers the first qualitative investigation that aimed to investigate the experiences of a number of individuals that worked, or had worked, in psychologically and / or physically challenging environments. The participants were purposively recruited from a wide-ranging group of civilian organisations, with only one currently serving in the military, but with a commonality that each of them had suffered some form of *potentially* traumatic

experience (PTE) during their role or profession. Semi-structured interviews were conducted to firstly explore how they made sense of and managed their experiences (Aim 1).

Chapter Three explains how data gained from Study 1 was used to inform and develop a bespoke questionnaire package to conduct a longitudinal, quantitative analysis of a UK Emergency Service (Shropshire Fire and Rescue Service) that routinely placed its personnel in potential harm's way, both physically and psychologically (Aim 2). Data on stress-related outcomes (e.g., resilience) and social factors (e.g., social support) were collected at four distinct timepoints over a twelve-month period to test the efficacy of TRiM and compare a group that received TRiM training and a control group (Aim 3).

Building on the findings of the first two studies, the third study, included in Chapter Four, comprises a qualitative study of four online (due to COVID 19 restrictions) Focus Group discussions involving individuals that represent a wide range of organisations that possess extensive experience of using TRiM. Inductive Thematic Analysis was used to generate key themes and general dimensions on the effectiveness of TRiM and recommendations for effective initial and long-term implementation (Aim 4).

Finally, Chapter Five incorporates the general discussion where all studies are critically considered, taking into account both the context of previous literature written on TRiM as well as the 'real-life' experiences of those that operate, or support those that operate, in challenging and potentially traumatic environments, offering recommendations and an objective opinion as to the suitability of TRiM in supporting a wider community.

# CHAPTER ONE:

# LITERATURE REVIEW

## 1.1 Introduction

In an ever changing and demanding world, many individuals operate efficiently and effectively within organisations, groupings or communities whilst facing seemingly increased modern-day pressures and stressors, affecting both work and home life (Shi et al., 2023). With the rise in dynamic working practises, fuelled by technological advances (La Torre et al., 2019), high levels of performance are often routinely expected, even when opportunities for people to take necessary rest and recouperation, a requirement for all human beings (Sapolsky, 2017), regularly become infringed and inadequate, often to the detriment of general health and wellbeing, and paradoxically, levels of performance, even in outwardly perceived benign settings (Wedgewood, 2022).

For those that choose to work in the most demanding roles or risk facing professions, such as, but not exclusively, the armed forces, the emergency services and healthcare professions, the overwhelming effects of elevated levels of stress can be even more pronounced to the extent of it causing actual psychological injury or illness (Paton, 2022). Consequences of an unbalanced approach to staff health and wellbeing or failing to deal with incidents fully can lead to mental, emotional, spiritual or even physical distress, often leading to affected functionality, lowered morale and poor efficiency and effectiveness in the workplace and at home (Lieberman, 2013). Furthermore, unrelieved short-term and / or long-term stress reactions can lead to increased anxiety, depression, burnout and even early mortality through deteriorated general health and / or suicide (Miller, 2021).

The prevention of such psychological injury or illness following exposure to extreme or prolonged stresses may not always be possible, depending on genetics, underlying conditions, previous experiences or background (i.e., ethnicity, poverty etc.) (Van de Kolk,

2014), but findings from an ever-growing body of research suggest that if psychological symptoms of increased stress, even potential trauma, are identified and addressed at an early stage then the more chronic forms of psychological disorders such as Depression or Post-Traumatic Stress Disorder (PTSD) and the potentially harmful responses they sometimes incite, may be prevented. Furthermore, emerging evidence from experts in the field of resilience such as Southwick and Charney (2018) and potential trauma (Bonanno, 2021) suggest focussed education aligned with practical approaches and practices in the re-development of personal management strategies may increase individual and collective resilience to maintain, even enhance, levels of performance under increased pressure or stress.

But the effects of elevated stress levels and / or psychological trauma are not only seen in such typically associated risk-oriented organisations such as the military. To illustrate this, a 2016 study by the World Mental Health Survey Consortium (WMHSC), which involved nearly 70, 000 adult respondents across 6 continents, suggested that over 70% of the global population will be affected by some form of traumatic event through their lives (Benjet, Bromet, Koenen et al., 2016). With the unprecedented increases in global mental health conditions being reported by the World Health Organisation (WHO) since the outbreak of COVID 19 (Tsamakis et al., 2021) across not only 'frontline' organisations but populations in general, psychosocial interventions, such as TRiM, could have a more significant role to play in supporting other cohorts.

In the modern world, many that profess to be highly performing organisations will regularly, albeit often unknowingly, place their staff in situations in which they may be exposed to increased even overwhelming pressure and stress (Weisinger & Pawliw-Fry, 2016), even potential trauma, through the accumulation of natural strain or through failings caused by mistakes, negligence, or lack of suitable protective protocol. In this context, and especially since the COVID 19 pandemic, it is not just the obvious organisations who

routinely operate in potentially injurious or adversarial environments, but other, less obvious groupings, can also experience overwhelming psychological pressures such as in business and industry, sport and education (Khan et al., 2020). All such groupings are expected to perform effectively, at the very least, whilst dealing with associated elevated levels of momentary or persistent pressure but are not, perhaps, viewed in the same 'risk-orientated' way and afforded the same support.

Important to note, some individuals may indeed cope sufficiently with increased stress levels (Van de Kolk, 2014), where others, often as a result of previous life experiences and / or lack of available resources, may not and, as a result, suffer psychological reactions to particular situations such as increased anxiety or even psychological breakdown (Turnbull, 2011). In turn, this may lead to the adoption of maladaptive coping strategies such as alcohol dependency or substance abuse to simply get by (Campbell, 2010).

From a pragmatic point of view, it sounds sensible that when operating within unpredictable and challenging environments that are potentially traumatic, there is some requirement for some form of resilience and trauma training to ensure that not only performance levels are maintained but also for the benefit of overall general health and well-being of the workforce. During, or following testing experiences, 'doing nothing' is always worth considering, as most humans prove resilient in the face of adversity and recover over time (Shalev, 2002), but this option can take time and can be painful, even debilitating. In his book, The End of Trauma, Bonanno (2021) suggests a more proactive approach is required in maintaining a flexible mindset, involving practicing optimism, confidence and a willingness to think about potential threats as challenges, which are key to maintaining resilience, overcoming adversity and performing effectively under pressure. Furthermore, Herman (1997) similarly suggests in his phase-based model that the four key stages of trauma recovery, are delineated and linked to person-centered outcomes: being safe and protected from harm, being able to

cope, processing and making sense of trauma, and living the life you choose. It is implied that neither suggestion is passive and both are progressive but do not necessarily require clinical intervention. A recent article in the journal Psychology Today supports these findings by suggesting that making sense of trauma cannot be overstated as part of the recovery process (Firestone, 2020).

In line with many of these points, NHS Scotland launched an initiative in 2017 known colloquially as 'Trauma Informed Practice' which aimed at normalising trauma as part of everyday life. The programme providers (NHS Scotland) hope that providing education and insight into the subject of psychological trauma, ordinary people, as well as risk-facing organisations, will benefit accordingly (Sweeney et at., 2018). Through raising general awareness around issues such as psychological health at home and in the workplace and by normalising reactions to potentially traumatic situations and helping, through biopsychosocio education, those people affected, it is hoped workable strategies are encouraged to not only deal with issues as they occur but also, where possible, inspire growth from the experience.

Similarly, UK Psychological Trauma Society (UKPTS) current guidelines (2021, pgs. 3-9), produced in association with the European Society for Traumatic Stress Studies (ESTSS), suggest that organisations that routinely place employees or staff in potential harm's way should; *"... take reasonable steps to promote psychological resilience and prepare staff for the possible impactof trauma exposure'.* From a duty of care perspective, UKPTS also; *'... believes that there are ethical, legal, economic and reputational reasons for trauma-exposed organisations to proactively protect the mental health of their staff as far as is reasonably practible".*

In line with such guidance, it seems sensible that application, or formulation, of an effective resilience and potential trauma management plan is both required by organisations that operate in challenging, potentially traumatic,environments, both from a legal and moral

obligation point of view as well as from a robust performance perspective. To emphasise the importance of this point, excessive stress and poor mental health, often associated with working in such challenging environments, are also recognised in UK as two of the most recurrent causes of sickness absence (Office of National Statistics, 2017).

Globally, a rise in the interest and awareness around the subject of mental health has also led to the subsequent increase in non-clinical interventions (Anderson et al., 2020) that proclaim to address these issues, such as Mental Health First Aid (MHFA) developed by Kitchener and Jorm (2001) and Psychological Debriefing (PD), such as Critical Incident Stress Management / Debriefing (CISM / CISD) programmes, developed by Mitchell and Everley through the 1970's and 1980's. There are, however, differing views as well as an understandable concern around provision of credible, short and / or long-term non-clinical models that can and safely address the needs of those that work in challenging and potentially traumatic environments, that can genuinely enable an individual or group to maintain functional resilience in the face of ongoing challenges and, at times, overwhelming hardship. For instance, a meta-analysis by the US Agency for Healthcare Research and Quality (Gartlehner et al., 2013) found that PD has a limited value and could be potentially harmful, yet a more recent study (Tamrakar et al., 2019) suggests PD was dismissed too quickly following questionable methodologies. NICE guidelines, however, suggest that PD sessions that focus on experiences during trauma should not be part of routine practice (Brooks et al., 2018; Wessely & Deahl, 2003).

**1.2 Trauma Risk Management (TRiM) – A brief overview:**

One of these non-clinical interventions is TRiM, which is well-known and popular within certain risk facing professions and is widely used across the UK armed forces and emergency services. As a peer delivered, cognitively based human resource management initiative, TRiM offers an effective option for the provision of wider psychological support for

individuals following exposure to Potentially Traumatic Experiences (PTE), which is both supported by UKPTS, and which importantly complies with the National Institute for Health and Care Excellence (NICE) guidelines (2018).

Advocates of TRiM may point out that it is a well-established, structured and proactive approach to potential trauma management, which include several studies pertaining to its effectiveness in reducing psychological injury such as PTSD (Jones et al., 2003). Critics, however, may cite inadequate independent empirical data to fully back its efficacy (Billings et al., 2022), especially in non-military settings. With a lack of such independent evidence some question whether the use or implementation of a TRiM programme is either suitable or whether it can legitimately support workforce's that operate in challenging environments, from managing the mildly stressful to maintaining general health and well-being in the most dynamic and challenging conditions imaginable.

In short, the purpose of TRiM is the early identification of symptoms of elevated stress levels through practical assessment and monitoring and the subsequent referral / signposting to specialist support, such as General Practitioners, psychological professionals or organisational occupational health, where required (Dunn et al., 2015). TRiM aims to raise awareness through trauma informing education (i.e., what are natural human reactions often associated potentially traumatic experiences), utilises an evaluated method of [peer] assessment and identifies provision of ongoing social support, whilst intending no harm to the individuals or groups concerned. As an example of its potential, Whybrow et al. (2015), suggest that the application of TRiM could reduce absenteeism, making it cost effective and furthermore attributing to the sustainability of institutions such as the NHS (2017).

TRiM can be delivered by non-clinically trained people, although in some cases trained medical professionals do use TRiM to deliver peer support in hospitals, for instance. Other well-known psychological interventions that do require professional medical training include

Trauma Focussed Cognitive Behavioural Therapy (TFCBT), developed by Cohen, Mannarino, and Deblinger on the back of Beck's construct of CBT in the 1970's and Eye Movement Desensitisation and Reprocessing (EMDR), devised by Shapiro in 1987, which are employed predominantly by professionally trained psychotherapists. It should be mentioned that some of these interventions or terms may be used or discussed within this thesis but there was never the intention to conduct any form of formal comparative study between any of them, including comparisons with TRiM, during this research.

As previously stated, to date, research on the effects of TRiM has been largely conducted within the armed forces (Frappell-Cooke at al., 2010; Greenberg et al., 2005). Apart from a small number of studies by UK Police such as by Watson and Andrews (2017), there is currently inadequate credible data regarding the use and effects of TRiM in other groups that operate in challenging environments, including the emergency services (Whybrow et al., 2015, Sharp et al., 2020). Furthermore, there is a dearth of both longitudinal and comparative studies providing data between those that receive TRiM (training and support) verses non-TRiM (training and support) within other workforces. Findings from the comparative study conducted by Watson and Andrews (2017), demonstrate the importance of such comparative studies in exploring the effectiveness of TRiM, in this case in reducing stigma associated with help seeking.

Therefore, taking the lack of credible data mentioned above, one key aim of this research programme was to consider and test TRiM from a critical point of view within the UK emergency services. The component parts of the TRiM Model have been well researched by King's College, London (KCL, 2015; Jones et al., 2017) and a blend of anecdotal and empirical evidence, would suggest it has a degree of proven efficacy within the military and other, largely hierarchical organisations. But is TRiM suitable for supporting those outside the military by increasing trauma awareness and effective resilience practices to mitigate overwhelming stress

and in doing so reduce associated stigma, thus improving overall general health and wellbeing and performance?

**1.3 Psychological (acute / chronic) stress:**

With the affore-mentioned increase in public awareness of *mental health*, the term '*stress'* has attracted increased interest not only because of its widely stated effects on human performance in the face of adversity but seemingly, according to NHS online latest guidance, on all manner of people in everyday life (NHS, 2023). Covid 19 has only amplified the significance and negative effects of increased psychological stress / distress further with the British Psychological Society highlighting in a recently published article; "particular risk factors – including fear" (BBC News, 2020).

New research in areas of psychology and neuroscience not only increase our understanding of what the term 'stress' actually is, what it does to us physiologically and how it effects the human brain (Neuroscience News, 2019), but it is extremely useful in providing people with the knowledge and skills to develop strategies to regulate its effect on our bodies and on our minds (Holman et al., 2018).

In short, and according to the US National Cancer Institute (2022), stress is the body's response to physical, mental and emotional pressure that causes chemical changes in the body that can raise blood pressure, heart rate and blood sugar level. The physiological process, per say, is not a bad thing, as is widely believed, as it is an evolutionary, natural reaction, designed as a survival or life-saving biological response to danger (Horton & Hanzelik, 2009) and can positively aid personal and organisational focus and readiness for action. However, if we as humans remain in a stressed, or aroused state for too long, a term known as chronic stress causing *distress*, not only is our general performance affected but we can become physically and psychologically ill (Sapolsky, 2004).

Rather ironically, and in a time of unparalleled technical innovation, many methodologies concerning the effective management of stress levels have been known about and practiced for many years, such as the benefits of effective diaphragmatic breathing (Rosenberg, 2017) and movement (Williams, 2021) but seem to have been forgotten in an increasingly busy world. But there are numerous other factors that are becoming possible with emerging technology such as the ability to accurately monitor Heart Rate Variability (HRV) which is a good measure of how an individual's autonomic nervous system is working. In short, HRV reflects the variation in time between heartbeats and a healthy heart does not beat at a constant rate (Porges, 2010). Importantly, HRV provides an insight to personal general health and fitness and can be positively, or negatively influenced by stress, sleep, activities and mood. By simply wearing an HRV monitor (on the wrist or around the chest area) an individual can, for instance, get short-term (<1-5 min) or longer term (24hr +) feedback on their HRV and can modify their activities accordingly (Hinde et al, 2021). However, and regardless of HRV technology, individuals with poorly modulated autonomic nervous systems are easily thrown off balance, both mentally and physically (Van de Kolk, 2014). Furthermore, such increased understanding of the idiosyncrasies of stress are now enabling humans to dynamically influence levels of stress without medical involvement. By applying the right positive mental attitude (PMA) and having the knowledge to identify stressors and available resources, humans can learn ways to maintain a balanced lifestyle through interoception (Porges, 2017) as well as functional skills associated with performing under pressure without unnecessary clinical interventions, such as medicines and psychotherapy, or detrimental practices, such as using drugs or excessive alcohol. Understanding within the field of psychological traumatic stress, also known as Psychotraumatology (Everly, 1992), similarly grows daily and is particularly important for those that regularly place themselves, or their staff, in highly stressful, potentially traumatic environments. Whilst operating in these challenging environments, having the

ability to effectively regulate elevated levels of arousal, such as stress, is vital, not only in the short term but also in the long term (Van Der Kolk, 2014).

In certain challenging work environments, such as those associated with the military or the emergency services, high levels of performance are often required where decision making, perceptual anticipation and meta-cognitive skills are fundamental (Cotterill, 2018). In these scenarios, psychological stress levels, which can cause potentially traumatic stress, are often managed or regulated through collective social support from colleagues, peers and leadership, which is also considered an important factor in encouraging proactive learning and growth (Pemberton, 2015) from their potentially traumatic experiences (Cacioppo et al., 2015). This support, often provided and required, whilst performing under multiple stressors (even on the battlefield), is most notably demonstrated through commitment to one another with cohesion being considered vital to high-level functioning (Murphy, 2005).

However, excessive potentially traumatic stressors or the risk of psychological injury is, again, not only limited to the military or emergency services. Innumerable individuals and organisations across the world routinely operate within highly challenging / potentially traumatic settings where risk from psychological injury is possible. Excessive or uncontrolled stress levels, in any environment where suitable human resources cannot be accessed all have potential to have devastating psychological effects. For instance, in a study carried out by the UK Office of National Statistics (ONS) between 2011 and 2015 it emerged that there were 139 completed suicides among teachers and other educational professionals and almost three quarters (73%) of these, or 102 suicides, were primary and nursery schoolteachers, which is 42% higher than the national average.

**1.4 Psychological (traumatic) stress:**

In short, traumatic stress occurs when acute stress becomes too great / overwhelming and the mind, brain and body can no-longer function effectively with what it is facing (Van de Kolk,

2014). Van de Kolk also suggests that trauma is not the actual event itself, rather it's an individual's response to it that determines the long-term effect.

Traumatic stress is also often referred to by lay people as "a person's normal reaction to an abnormal event" (Sher, 2004, pg. 2), but in many high-risk settings such as the emergency services, where people voluntarily put themselves in potential harm's way (physically and psychologically), what may be described as 'abnormal' to the general public may indeed be considered routine (Richins et al., 2020). That said, potentially traumatic events do not necessarily affect all people in the same way depending on their personal experiences, general health and psychological well-being, lifestyles and available resources such as trusted friends. Emotional responses to challenging events may include fear, anger or disgust and trigger the body's sympathetic nervous system (SNS), a natural physiological 'mobilising' reaction such as 'fight and flight', or in extreme circumstances 'immobilisation' featured in 'freezing' and dissociation, often when faced with perceived mortal danger (Levine, 2010). This may, in turn, affect human performance in terms of impaired cognitive skills and emotional imbalance (Hayes et al., 2012), which may impact on performance within high-performance or psychologically demanding roles.

The subject of psychological trauma is complex and political. The current academic definition of Traumatic Stress used by King's College London describes trauma as:

> "… *anything that is out of the ordinary range of daily events and is deeply distressing to someone. Many things can have this impact. It could be a fire, an accident, a robbery, an attack or being witness to a traumatic event such as death. It could be large scale, such as a major disaster involving many people, or a personal event involving yourself, friends or family members*."

Another definition of trauma, offered by Peter Levine, a leading figure in psychological trauma, provides a more flexible and arguably more useful definition, particularly in terms of this study, as "anything that overwhelms our ability to cope" (Haines, 2016, pg. 9). In using this less 'academic' but still credible definition, the researcher is afforded opportunity to explore options that may prevent or reduce potential overwhelm.

In short, traumatic events normally fall into three categories: deliberately man-made, natural disasters and everyday occurrences. In certain risk-oriented domains, however, all of these stressors may be an ever-present consideration where threat, horror or loss are either a possibility or constant expectation.

Trauma can indeed shatter a person's view of the world and self-held beliefs such as fairness, justice and invulnerability are often called in to question, often leading to spiritual crisis and / or profound re-evaluation of meaning (Maercker et al., 2013). Often, trauma affects individuals directly or vicariously, but such events can also have the power to impact the lives of others or team performance linked through proximity to events (i.e., witnesses or work colleagues) or meaningful relationships (Warren, 2006). However, the vast majority of people that experience potentially traumatic situations may suffer some form of natural short term / acute stress reactions (post-traumatic stress) during a period of normalisation and natural processing (Bonanno, 2004) but ultimately recover to some form of new normalcy. Contrary to some opinions, most people do not go on to sustain long term injury or develop post-traumatic stress disorder (PTSD) or Complex PTSD (McFetridge et al., 2017).

Furthermore, even the most extremely challenging situations do not always have an actual detrimental / traumatic effect on everyone (Regel & Joseph, 2010). Factors such as childhood experience (loved or not loved for instance), previous traumas (physical and / or psychological), outlook on life (belief), general health (physical and psychological) and the ability to regulate one's physiology or emotional stress response (although this is not always

possible in all circumstances) all play their part in developing someone's resilience to increased levels of stress or further potential trauma (Southwick & Charney, 2018). Bonanno (2010) suggests that humans are 'wired' to survive and often manage to withstand extremely aversive events, suggesting that not every-body manages well, but actually most do.

**1.5 Post Traumatic Growth (PTG) / Adversarial Growth (AG):**

Although some potentially traumatic experiences may result in actual psychological injury, or psychosomatic distress, evidence suggests that they can also lead to positive psychological changes as a result of the trauma survivor's struggle (Van Slyke, 2013). Recent studies suggest that 30-90% of people report some form of positive change following potentially traumatic experiences (Sawyer & Ayers, 2009). Research by Howells and Fletcher (2016) goes even further, suggesting individuals can develop positively, as a result of adversity, to a level beyond their pre-trauma functioning. This post traumatic or adversarial growth (PTG / AG) typically involves an increased appreciation for life, more meaningful relationships, an increased sense of personal strength, a change in priorities, and a richer existential and spiritual awareness (Tedeschi & Calhoun, 2004). Neenan (2018), suggests that as life itself can be at times traumatic, looking for potential value in adversity is vital for learning and growth in order to develop new responses to future life challenges.

Research around concepts such as Post Traumatic Growth (Baker et al., 2008, Zoellner and Maercker, 2006), Stress Related Growth (Park et al., 1996) and Adversarial Growth (Joseph & Linley, 2006) suggest that growth arises out of a person's struggle to deal with the shattered self (Janoff-Bulman, 1999) that occurs as a result of a potentially traumatic experience. However, according to the likes of Porges (2017), human recovery and growth only occurs once the individual is in a space of perceived safety (physically and / or psychologically safe). Therefore, in order to effectively process and progress from potentially traumatic scenarios and thrive in challenging situations, the research suggests an individual

must attain psychological stability in some form (Rothschild, 2010) or a place of perceived safety (Van der Kolk, 2014).

### 1.6 Potential trauma management / mitigation strategies:

Two recognised methods for dealing with potentially traumatic experiences are through self-regulation (Levine, 2010) and social support (Rees & Freeman, 2009). Having the ability to re-balance 'oneself' by self-regulating the human parasympathetic nervous system (PNS), practicing [bottom up] diaphragmatic breathing exercises, performing basic movement techniques (Williams, 2021) or engaging in [top down] mindfulness for instance, can build resilience through reinforcing personal efficacy, building confidence and restoring a sense of control (Clarke & Nicholson, 2010). Sapolsky (2017) supports this notion by suggesting that to make sense of our best and worst behaviours, automaticity, emotion and cognition must all be considered together. Thus, through applied biopsycho education, individuals can learn to recognise and manage levels of arousal and stress affecting thoughts, emotions and behaviour to find a 'safe space' and restore equilibrium (Levine, 2010) and hypothetically sustain in the moment and long-term performance.

In overcoming potentially traumatic experiences, social support (Rees & Freeman, 2009) from trusted colleagues, mentors, friends and family is considered fundamental, providing a psychological safe environment where an individual can normalise potential reactions to trauma by talking, listening and sharing experiences whilst being cared for and watched over (Turnbull, 2011). It is worth pointing out that in common, everyday life, people that do not have sufficient social interaction with others can easily become stressed, depressed and isolated (Rosenberg, 2017), even without any form of adversarial challenge. Social ecosystems, however, existing through trusted relationships or groups can critically provide a safe space for meaningful self-regulation. Porges (2017) refers to this neurobiology of the human need to feel psychologically safe, even with the absence of physically safety such as in

the challenging settings discussed, as the biological imperative as group or social engagement is considered vital for collective resilience and growth (Joseph & Linley, 2006).

In risk-oriented settings within the military for instance, where physical safety is not always possible, decision making, perceptual anticipation and meta-cognitive skills are fundamental (Cotterill, 2018), collective support from colleagues, peers and leadership is similarly considered vital in encouraging proactive learning and growth from their potentially traumatic experiences (Cacioppo et al., 2015). This support, often afforded whilst performing under multiple pressures (even on the battlefield), is most notably demonstrated through commitment to one another and cohesion is considered vital to high-level functioning (Murphy, 2005). Even in terms of dealing with potential trauma, social identity provides vital resources for recovery such as sense of belonging, sense of efficacy and trust (Muldoon et al., 2019).

From a human physiological and evolutionary perspective, the benefits of social support in overcoming stressful events have been highlighted by scientific research into the stress hormone oxytocin, which is produced in the hypothalamus and released through the pituitary gland in response to stress, prompts a desire for bonding through social support (Turner & Barker, 2014). Further research by Laura Kubzansky et al. (2012) from Harvard University has shown that when people are subjected to social stress, the release of oxytocin encourages a challenged mental state and improved recovery. Weisinger and Pawliw-Fry (2016) also suggest that the act of sharing pressure or distressful feelings reduces anxieties and stresses leading to improved performance. Even laughter with friends, has been recognised as having a huge impact on human well-being and recovery from setback and trauma, reducing adrenalin and cortisol production and releasing endorphins into the body in response to pain and stress to alleviate anxiety and depression (Burnett, 2018).

Although there is an increasing amount of research on trauma, there are relatively few models that aim to proactively help individuals prepare for, or dynamically deal with

challenging potentially traumatic events. TRiM, however, is one of the models that at least sets out to proactively, as well as reactively, address the significant challenges faced by individuals by incorporating some of the strategies raised above, such as self-regulation and social support, to keep people functioning effectively in most challenging scenarios.

## 1.7 TRiM in detail:

### 1.7.1 Background

The TRiM concept and model originated from two British army psychiatric nurses (Major Norman Jones and Captain Pete Roberts (both retired) in the early 1990s and was designed to help UK military personnel maintain functionality during war or peacekeeping operations through collective preparation and recovery (Greenberg et al., 2010). TRiM has been in use across the military since 1996 and across numerous other civilian and government organisations that routinely place their own people in potential harm's way for over twenty years. TRiM's relatively straight forward and structured approach has gained popularity amongst organisations that acknowledge that not all reactions to potentially traumatic events require clinical intervention (Richins et al., 2020). Some of these organisations, many of them using hierarchal management or leadership approaches, typically include the police, fire and rescue service, the ambulance service (including air ambulance) and the NHS, which has shown increased interest in TRiM since the onset of the COVID 19 pandemic (Flaherty & O'Neil, 2020). Anecdotal evidence currently suggests that other, less typical perhaps, organisations are now starting to see benefits of implementing peer supporting approaches, such as TRiM. Some of these organisations, or establishments, include teaching and education, law, social care and veterinary services, all of whom place their staff's wellbeing at potential risk either directly or vicariously.

TRiM was initially conceived as a trauma focussed early intervention and, as such, most often employed following an event locally assessed as being potentially traumatic

(Tehrani & Hesketh, 2018), i.e., reactively. As with other early interventions such as psychological debriefing (Dyregrov, 1989), TRiM was not specifically designed specifically to prevent the likes of PTSD, or manage levels of stress, but it does provide a structured approach during times of uncertainty, bringing people together to normalise responses to potentially traumatic events and facilitate team / organisational mutual learning and support in order to maintain levels of performance.

Since inception, TRiM has been utilised and further developed by the Royal Marines in collaboration with King's College, London. TRiM is now delivered in a military context as a proactive, peer delivered, cognitively based human resource management initiative for supporting individuals following exposure to potentially traumatic events and importantly adheres to the National Institute for Health and Care Excellence (NICE) guidelines (2016) as an approach that does no harm. Its purpose is the early identification of symptoms of stress through 'watchful waiting' (Jones et al., 2003) assessment and monitoring and the subsequent referral signposting to specialist support, such as General Practitioners or Occupational Health, where required (Dunn et al., 2015). Since its introduction, TRiM has culturally become embedded in many UK military units and is proposed responsible for the low rates of PTSD diagnosed in Royal Marines serving in Afghanistan in the mid 2000's (Frappell-Cooke et al., 2010). As an example of this, data collected prior to, during and post an operational deployment in 2007 showed a marked difference in cases of trauma related stress (in particular during the preparatory phase) between those who had received TRiM training (Royal Marines) and those who were TRiM 'naïve' (Coldstream Guards). The findings of the comparative study suggested that the use of TRiM may have assisted in increasing the psychological resilience of military personnel through the facilitation of social support (Frappell-Cooke et al., 2010). In this sense, it is taken that the psychological resilience gained allowed the soldiers, or marines, to consciously put themselves in potential harm's way believing that they possessed the

necessary resources, in terms of personal coping strategies and collective support, to deal with the potential consequences of what they were facing following the choices they had made (i.e., to serve and / or potentially die).

The TRiM Model now comprises three main parts: firstly, biopsychosocio education, secondly, a peer led assessment, using ten researched *Risk Factors* (see Table 1.1), which also incorporates ten *Indicators of Acute Stress* (Table 1.2) and thirdly, social support through colleagues / peers (which may include signposting to professional clinical services). It should be noted that both inventories of risk factors and indicators of acute stress were formulated from the clinical Diagnostic and Statistical Manual of Mental Disorders (DSM 5) and can be seen in Tables 1.1 and 1.2.

**Table 1.1**

**TRiM practitioners' list of risk factors for assessing the risk of developing later psychological disorders (Greenberg, 2011)**

| Date | | |
|---|---|---|
| No. | Risk Factor | Score |
| 1 | The person thought that they were out of control during the event | |
| 2 | The person thought that their life was threatened during the event | |
| 3 | The person blames others for some aspect(s) of the event | |
| 4 | The person expresses shame about their behaviour relating to the event | |
| 5 | The person experienced acute stress following the event* (see acute stress list – Table 2) | |
| 6 | The person has experienced substantial general stress since the event such as problems with work, home and health | |
| 7 | The person is having problems with day-to-day activities | |
| 8 | The person talks about problems relating to previous traumatic incidents | |
| 9 | The person has problems accessing social support (family, friends, organisational support) | |
| 10 | The person has been drinking alcohol excessively to cope with their distress | |
| | TOTAL (Max 20) | |

**Table 1.2**

**Indicators of acute stress which form the basis of risk assessment question 5**

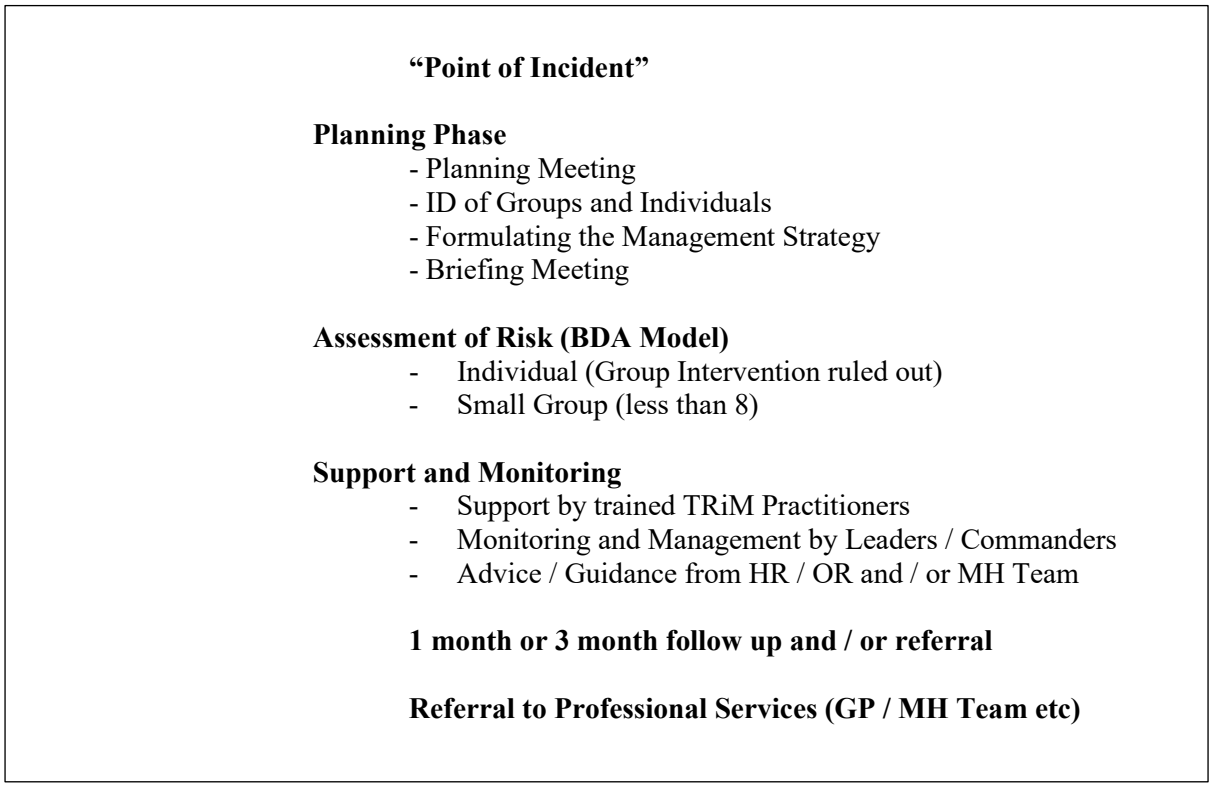
| | |
|---|---|
| 1 | They had upsetting thoughts or memories about the event come into the persons mind against their will |
| 2 | They had upsetting dreams about the event |
| 3 | They acted or felt as if the event was happening again |
| 4 | They felt upset about reminders of the event |
| 5 | They had bodily reactions, such as faster heartbeat, stomach churning, sweatiness, dizziness, when reminded of the event |
| 6 | They had difficulty falling or staying asleep |
| 7 | They experienced irritability or outbursts of anger |
| 8 | They had difficulty concentrating |
| 9 | They experienced heightened awareness of potential dangers to themselves or to others |
| 10 | They were jumpy or were startled at something unexpected |

### 1.7.2 TRiM planning timelines (see Figure 1.1)

Although an initial organisational response, or request, for TRiM support should start within 24 / 48 hours, the first TRiM assessment should not be carried out for at least 72 hours following a PTE to allow normal human reactions to stabilise sufficiently. In line with studies by Shalev (2002), which suggest there is a 4-month window of opportunity where most people recover from acute stress (normally within 6 or so weeks of a PTE; Jones & Roberts, 2009) to best address potential psychological injury, a subsequent (2nd) TRiM assessment is held one month after the initial assessment (at 72 hours) to see if there is any improvement, or not, in the wellness of the individual(s) concerned. If required, a third assessment is conducted at the three-month point. If an individual is still struggling at this point, or indeed at the 1-month point, then they may well be signposted to seek further professional assistance by the likes of a General Practitioner (GP) or occupational health / organisational psychological wellbeing.

**Figure 1.1**

**TRiM planning timeline**




### 1.7.3 TRiM biopsychosocial education

The TRiM education section aims to raise 'potential' trauma awareness by assisting trained practitioners to identify actual and potential psychological issues that may occur following challenging events. This key area of education covers themes such as explaining traumatic stress, traumatic stress reactions and responses, the role of avoidance and the effects of potentially traumatic experiences on thinking. Within this piece there should also be useful learning centered around how to help yourself (restoring balance) and how / where to look for additional support, if required. Credible TRiM providers would suggest it vitally important that managers and leaders at all levels of TRiM trained, risk facing organisations should have some basic biopsychosocial knowledge, as well as understanding of procedures involved in rolling out / integrating a TRiM programme and should consider attending a TRiM organisational

awareness course, as an example. It should be pointed out that any TRiM procedure is run separately to any formal investigations (important within certain organisations such as police or healthcare).

In short, TRiM training will provide practitioners the ability to:

- Develop a framework for managing adverse psychological consequences for staff exposed to potentially traumatic events
- Understand the nature of traumatic stress
- Plan and implement a common-sense approach to personnel management after a potentially traumatic event
- Understand the nature and process of a potential trauma risk assessment
- Avoid difficulties associated with CISD

Importantly, however, TRiM training will not:

- Turn personnel into counsellors or therapists
- Qualify personnel to become work and life stress managers or 'stress experts'
- Replace trainees own experience and intuition, rather the training aims to capitalise on these

### 1.7.4 TRiM risk factors (Incl. acute stress reactions) and TRiM assessment

Potentially traumatic events (PTEs), as previously mentioned, do not necessarily affect all people in the same way, depending on their personal experiences, general health and psychological well-being, lifestyles and available resources such as trusted friends or colleagues. Psychological trauma experts Regel and Joseph (2010) point out that reactions to even the most appalling events are often wide ranging and the majority of people actually recover over time without any form of medical or clinical intervention. Shalev also points out in his paper on *Acute stress reactions in adults* (2002) that as psychological trauma is seen in

a significant minority of those exposed … the term *traumatic events* should be replaced by *potentially* traumatic events (PTE).

Following a PTE some people do, however, suffer some form of natural acute stress reactions (post-traumatic stress) such as upsetting thoughts and intruding images, feelings of emotional numbness, troubled sleep, feeling on edge or being *jumpy* or strong feeling of guilt, anger, or shame, during a period of normalisation and natural processing (Bonanno, 2004). Although widely termed as psychological trauma, for some, the effects can also prove physically debilitating (Turnbull, 2010) and may require professional help.

In order to assess how someone is coping following a potentially traumatic incident, for instance, the TRiM model uses 10 risk factors to highlight areas of concern or risk shown in Table 1.1. These risk factors are deemed by many as a useful guideline for peers and colleagues to note or identify changes in individuals to judge how someone is dealing with significant events, either formally (as part of the TRiM risk assessment) or informally (in the staff room for instance, which although useful, is not considered a formal TRiM assessment). These factors are well researched and well documented in much literature regarding the effects of increased stress and potential trauma.

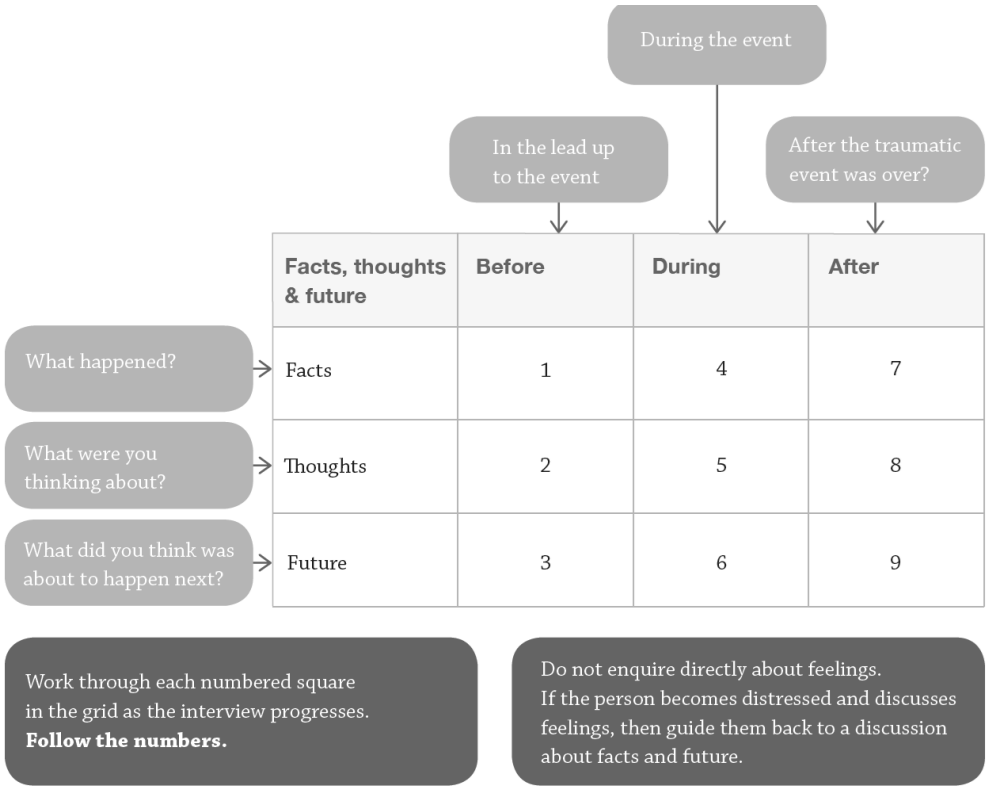
The TRiM assessments are most often conducted individually but with suitable planning and preparation can be conducted with groups of up to 8 people. During the assessments, TRiM practitioners use a 'Before, During & After' (BDA) template (see Figure 1.2) to help structure the assessment. The TRiM assessment (Table 1.1) uses a simple scoring strategy deciding whether a risk factor is present in the person being assessed by the TRiM Practitioner, recording a score of 2 if the risk factor is evident (for instance, the person being assessed thought that they were out of control during the event = 2). A score of 1 is given if the risk factor is deemed partially present (for instance, the person has experienced only a few acute risk factors (see Table 1.2) = 1) and a score of 0 is given when the risk factor is not

evident (for instance, the person did not think that their life was in danger = 0). Following the assessment, and normally once the TRiM Practitioner has time to reflect on the session, the scores will be added up. TRiM guidance suggests that a combined score of 10, or more, indicates a need to follow up more closely with 'watchful waiting' over the following days or weeks by colleagues and peers for instance. At the 1-month assessment point, it is hoped, and normally experienced, that the scores reduce, suggesting the person being assessed is showing improved or a lessening of stress reactions. If the scores remain similar or increases, there may be a suggestion of the requirement of a third assessment or for the individual to seek professional assistance.

One concern raised anecdotally by some users is that the TRiM model is often too prescriptive when delivered as the military (devised for military use), often overlooking the fact that other 'civilian' organisations, such as hospitals, have different and often complex organisational structures and limited resources at hand and simply overlaying a 'military model' doesn't always work effectively. In terms of using risk factors largely associated with a military population, some organisations have found that some risk factors are less useful, as they are regularly experienced as part of the role (paramedics for instance). To that end, some have chosen to add other risk factors to the list from their own informed experience and with guidance from their occupational health or psychological support departments such as witnessing fatalities during probationary periods (Fire & Rescue Services) or having feelings of being 'dissociated' (UK police).

**Figure 1.2**

**Before, During & After assessment questioning structure**




### 1.7.5 TRiM personnel

The TRiM programme is typically a peer delivered initiative by an appointed TRiM Team, which conventionally comprises a TRiM Lead or Coordinator, who acts as organisational TRiM representative, a TRiM Manager who is responsible for the TRiM administration and the TRiM Practitioners, who conduct the TRiM assessments. These posts are typically non-medically trained personnel but who have undergone specific TRiM training to allow them to understand the effects that PTEs can have on people and take appropriate action as required. It should be pointed out that all TRiM personnel, regardless of position, would have, at the very least, conducted TRiM training from a recognised TRiM provider.

These TRiM roles are most often fulfilled by individuals on a voluntary basis although some TRiM Leads and Managers roles are paid positions within some organisations. One of

the most important roles of the TRiM Leads and Managers is to monitor and ensure the general health and wellbeing of TRiM practitioners as well as those initially requiring support.

### 1.8 TRiM … So what?

Not all resilience programmes or models, such as TRiM, PTG / AG protect everyone from setback all the time, but such approaches often remind people that "we are able to manage our way through it" (Pemberton, 2015, pg. 3). TRiM is now regularly used by other organisations where people are routinely faced with potentially overwhelming situations (including potential trauma) such as the Royal National Lifeboat Institution (RNLI) and healthcare (https://www.walesdenery.org). Recent studies, such as those carried out by the RNLI (Lakey et al., 2018), suggest TRiM is a useful tool in the organisational management of personnel following traumatic incidents.

However, anecdotal evidence provided by members of a number of organisations that use TRiM, including the police and fire service, and reiterated by observational evidence gained from individuals interviewed in Study 1, suggests that TRiM, as a trauma management tool, is not always popular amongst workforces.

> *"… all they are there for is if someone wants a chat after something has happened. Think it's a bit dodgy in a way because all it takes is a loose mouth and someone will know someone else's business."* (Royal Navy Individual – Greenberg et al, 2011, pg. 187)

It is purported, evidenced above, that TRiM is often viewed with a degree of suspicion, as in most cases the TRiM process (risk assessment phase) is only employed reactively by management after a significant event, suggesting to some that "TRiM's being deployed therefore something must be wrong!".

However, anecdotal and literature evidence, not just in terms of TRiM, suggests that education in resilience and trauma management, both individually and organisationally, is required in fields of highly performing people / organisations and much of this evidence advocates a proactive approach rather than a reactive one (Van der Kolk, 2014). The TRiM model does set out to provide biopsychosocio education in terms of the signs and symptoms of increased stress or trauma (Brooks et al., 2018), but in most cases it is delivered reactively following an incident or PTE and does not always cover pre-emptive or proactive strategies to prepare for, manage or overcome some responses such as simple diaphragmatic breathing techniques (Nestor, 2020) or movement (Williams, 2021). To that end, it is perhaps questionable if the TRiM process provides adequate 'up-front' knowledge and experience to facilitate valuable proactive, adaptive and effective self-regulation to those that operate in challenging environments.

Another common reflection concerning TRiM is the perception that valuable social / peer support from colleagues, and managers, especially in line management or hierarchical organisations, may become tainted, rather than strengthened, as a result of intervention through the risk assessment process. Watson and Andrews (2017) point out in their comparative study within UK policing that both groups indicated that the greatest barriers to seeking help were a fear that it may harm their career and that their colleagues may have less confidence in them. Social or peer support, as previously explained, is considered vital in not only recovering from challenging times and potential trauma (Pemberton, 2015) but is also fundamental in maintaining overall resilience (Masten & Dougherty, 2010). In relation to these concerns, there could be a question of whether the peer support element of the TRiM process adequately facilitate adaptive recovery or can it actually hinder the process by officiating support? The TRiM model raises such peer support as a key function in dealing with potential trauma, especially in organisational settings but another question could ask if it goes far enough in

preparing peers to offer the best support possible? However, it is mused, and articulated in Study 1, that concerns around enabling truly effective peer support could be somewhat addressed through enhancing basic skills such as effective listening practices, utilising coaching approaches and perhaps considering ways to look after yourself, both psychologically and physically (Southwick & Charney, 2018).

As with all such psychosocial interventions, there are other concerns to consider too. In order for TRiM to be considered as a credible, collective asset by stakeholders (including workforce / leadership) there is also an understandable necessity for confidentiality, understanding and acceptance (Richins et al., 2020), which in turn often requires a degree of cultural change and the encouragement of organisational learning (Toft & Reynolds, 1997). At a time of social concern around issues regarding mental health there are also aired fears that some organisations are employing TRiM as a 'box ticking' exercise rather than having workforce wellbeing at heart. Importantly, Richin et al. (2020) points out that one of the strengths of TRiM over other early interventions may be its formalised but adaptable nature and delivery as well as the complementary aspiration of reducing associated stigma in help-seeking (Watson & Andrews, 2017), which often goes someway to addressing cultural change. This leads to the question of whether certain component parts of TRiM, such as the trauma informing education, could be used more effectively in building individual or organisational resilience, and driving necessary change, rather than waiting for the inevitable to happen and simply picking up the pieces?

Social distancing restrictions during the COVID 19 pandemic demonstrated that flexibility in approach to the delivery of psychological interventions, such as TRiM, needs to be jointly and sensibly re-considered by organisations, training providers and practitioners employing them. Taking Richin's findings into account, it is worth reiterating that TRiM's primary responsibility is to do no harm (Greenberg et al., 2008) and even though it is not

considered a clinical intervention, TRiM does involve human interactions of a potentially sensitive nature that require due diligence in supporting individuals safely and effectively. This means both in terms of supporting those seeking help to reintegrate into the workforce for instance (McNally et al., 2003) as well as a responsibility to those within participating organisations delivering the TRiM programmes.

There is also the question of whether TRiM is truly proactive as it is, most often, employed after the event has happened and as such whether it is a truly useful intervention for those knowingly and regularly work in all manner of challenging situations / environments. And so, even if TRiM does offer organisational support for some involving potential trauma (Whybrow et al., 2015), further investigation on TRiM's actual efficacy outside the military, where most research and trials have been conducted, may prove useful in determining its true potential in wider domains.

History tells us that even the most extremely challenging experiences do not always have an actual traumatic or detrimental effect on everyone (Regel & Joseph, 2010). Factors such as childhood experience (loved or not loved for instance), previous traumas physical and / or psychological), outlook on life (belief), general health and wellbeing (physical and psychological) and the ability to regulate one's physiology or stress response (although this is not always possible in all circumstances) all play their part in someone's resilience to increased levels of stress or further potential trauma (Southwick & Charney, 2018).

However, although there is significant, ongoing research on traumatic stress there appears to be relatively few models that actively aim to support individuals or organisations prepare for, perform and recover from operating effectively in challenging and potentially traumatic environments and dynamically reconstitutes and maintains that personal / organisational resilience. TRiM does offer a level of support for individuals and organisations

following potentially traumatic events, but openly states in its mission statement that the model (military version) was not designed for active stress management.

Bringing together the review above, maintaining effective performance levels, as well as ensuring legal, ethical and moral safeguards and increasing general health and wellbeing, it seems sensible that suitable education, training and ongoing support should be provided to those that routinely operate in challenging, potentially traumatic environments where at all possible. Although it is suggested that trauma cannot always be avoided or prevented (Brooks et al., 2018), it is hypothesised that in preventing a state of overwhelm in humans (i.e., the point that they can no longer cope, either physically or psychologically; Van de, Kolk, 2014), there is a chance to mitigate the effects of potential traumatic stressors and minimise the chance of someone becoming catastrophically traumatised and developing a disorder such as PTSD, for instance.

Therefore, this research set out to consider the usefulness of TRiM in a more general setting, rather than as solely an organisational tool, and explore whether elements of TRiM were suitable for more of a proactive, preventative and sustainability approach to maintaining individual / organisational functionality. To do this effectively the research aimed to consider TRiM not from a purely trauma focussed viewpoint but also with a perspective on health and wellbeing and resilience.

### 1.9 Scientific rationale

TRiM has been highlighted as having the potential to support many differing types of individuals and organisations that routinely operate in challenging and potentially traumatic environments. As its name suggests, TRiM is a predominantly trauma focused intervention, but in this thesis, it is proposed that TRiM could also be suitable for providing valuable, wider psychological support in terms of facilitating individual / organisational resilience and general health and well-being in the same risk-oriented groups and wider populations, and in line with

UKPTS Guidelines. The limitations of previous TRiM research will be somewhat addressed in the thesis with a focus on a mixed method approach (two qualitative and one quantitative study), as well as the inclusion of a longitudinal design over 12 months (in Study 2), which build a scientific rationale for the thesis.

TRiM has many supporters, but it also has a number of detractors (Regel, 2007) that suggest its evidence base may be insufficient to make it truly credible both in terms of meeting organisational and individual needs / requirements. Therefore, this research sought to test the expectation that TRiM does offer some form of effective support to a risk-facing populace, by conducting a series of focused and related studies. Thus, the thesis adds to scientific knowledge by exploring the influence of TRiM in novel populations in 'risky' roles in the general public.

It was felt that in order to contextualise this research in exploring the issue of effectively managing levels of elevated or potentially traumatic stress effectively in the real-world, it was first worth considering the experiences of people who have worked in a wide range of challenging environments in order to learn from their personal experiences with a view to inform future potential trauma management / mitigation. Specifically, the research question that guided this initial study (1) were: (1) how do individuals that work in challenging environments make sense and manage of their own potentially traumatic experiences. The individuals who took part in the research were recruited due to their profession or experience in working or operating in challenging, potentially traumatic, environments / organisations which were diverse and possibly unorthodox in terms of people's perceptions of what a challenging environment may be i.e., they were not all members of the armed forces.

Considering a lack of independent, empirical data concerning TRiM, it was felt that the research would also benefit from a quantitative study conducted over a prolonged period of time to test the actual benefits of TRiM being employed within an appropriate organisation. Therefore, in study 2, the research aimed to consider and compare the overall benefits of TRiM,

not just from a potential trauma management one, but also credible measures on general health and wellbeing, stress, social support, and resilience, as well as on presenteeism and / or absenteeism which were also considered useful and insightful data. So, Study 2 measures new variables that were informed by Study 1 and have not been extensively examined previously.

Finally, it was felt that there would be advantages to holding collective conversations with people with a 'real-world' knowledge of working with TRiM to highlight the perceived / actual benefits and / or shortfalls of implementing a TRiM programme (Study 3). In turn, recommendations for the implementation of TRiM in the future could be proposed.

### 1.10 Aims of the Thesis:

The aim of Study 1 was to explore the experiences of a number of individuals that worked, or had worked, in psychologically and / or physically challenging environments (Aim 1). Each of the participants had suffered some form of *potentially* traumatic experience (PTE) during their role or profession and the interviews were conducted in order to investigate how they made sense of and managed their experiences

Study 2 involved two key aims. The first (Aim 2) was to explore the bio-psycho-social benefits and overall wellbeing of a division of UK's emergency services, using the psychological measures previously mentioned (e.g., social support, resilience), following the implementation of a TRiM programme. Secondly, Study 2 aimed to provide comparative data between the two groups, namely Group 1 that had received TRiM training and the control group that did not (Aim 3).

The aim of Study 3 was to gather meaningful data from experienced TRiM professionals (a term that includes trained TRiM Practitioners, Managers and Coordinators / Leads) to investigate the perceived efficacy of the TRiM model / programme across a wide range of organisations that use, or have previously used, TRiM whilst routinely operating in challenging, and potentially traumatic, environments (Aim 4).

# CHAPTER TWO:

# STUDY 1: HOW DO INDIVIDUALS THAT WORK IN CHALLENGING ENVIRONMENTS MAKE SENSE OF, AND MANAGE, THEIR OWN POTENTIALLY TRAUMATIC EXPERIENCES?

## 2.1 Introduction

With an increase in public awareness of mental and emotional health, the term '*stress'* has attracted increasing global interest not only because of its effects on human performance in the face of adversity but on all manner of people in everyday life. New research in areas such as psychology and neuroscience are not only increasing our understanding of what stress actually is, what it does to us physiologically and how it effects the human brain, but is useful in allowing people to develop, or perhaps re-develop after years of inattention, strategies to regulate its effect on our bodies and on our minds (Holman et al., 2018). Rather ironically, and in a time of unparalleled technical innovation, many methodologies concerning the effective management of stress levels have been known about and practiced for many years, such as the benefits of effective diaphragmatic breathing (Rosenberg, 2017). But there are numerous other factors that are becoming possible with emerging technology such as accurately monitoring Heart Rate Variability (HRV).

It is now understood that stress, per say, is not necessarily a bad thing, rather it is a natural, physiological reaction designed to provide energising hormones to aid a biological response to danger (Horton & Hanzelik, 2009) boosting focus and readiness for action. However, if we as humans remain in a stressed state for too long, a term known as chronic stress, not only can our general performance be affected but we can become physically and psychologically ill (Sapolsky, 2004).

Furthermore, increased understanding of the idiosyncrasies of stress are now enabling humans to hypothetically influence levels of stress, or arousal, without clinical intervention.

With the right attitude, having the knowledge to identify stressors and available resources we can learn ways to maintain a balanced lifestyle and the functional skills associated with performing under pressure without clinical interventions, such as medicines and psychotherapy, or maladaptive practices, such as using drugs or alcohol.

Understanding within the field of psychological traumatic stress, also known as Psychotraumatology (Everly, 1992), similarly grows daily and is particularly important for those that regularly place themselves, or their staff, in highly stressful, potentially traumatic environments. Whilst operating in these challenging environments, having the ability to effectively regulate elevated levels of arousal, such as stress, is vital, not only in the short term but also in the long term (Van Der Kolk, 2014).

In certain challenging work environments, such as those associated with the military or the emergency services, high levels of performance are required where decision making, perceptual anticipation and meta-cognitive skills are fundamental (Cotterill, 2018). In these scenarios, psychological stress levels, which can cause potentially traumatic stress, are often managed or regulated through collective social support from colleagues, peers and leadership which is also considered an important factor in encouraging proactive learning and growth (Pemberton, 2015) from their potentially traumatic experiences (Cacioppo et al., 2015). This support, often provided and required, whilst performing under multiple stressors (even on the battlefield), is most notably demonstrated through commitment to one another with cohesion being considered vital to high-level functioning (Murphy, 2005).

However, excessive potentially traumatic stressors or the risk of psychological injury is not only limited to the military or emergency services. Innumerable individuals and organisations across the world routinely operate within highly challenging / potentially traumatic settings where risk from psychological injury is possible. Elevated or uncontrolled stress levels within business, industry, education and sport, for example, all have potential to

have devastating psychological effects. For instance, in a study carried out by the UK Office of National Statistics between 2011 and 2015 it emerged that "during the period 2011 and 2015 there were 139 suicides among teaching and educational professionals and almost three quarters (73%) of these, or 102 suicides, were for those recorded as primary and nursery schoolteachers (42% higher than the national average)" (Office of National Statistics, 2011-2015). The subject of psychological trauma is complex and political but a simple, flexible and useful definition of trauma, particularly in terms of this study, is offered by Peter Levine, a leading figure in psychological trauma, as anything that overwhelms our ability to cope (Haines, 2016).

That said, potentially traumatic events do not necessarily affect all people in the same way depending on their personal experiences, general health and psychological well-being, lifestyles and available resources such as trusted friends or colleagues. Psychological trauma experts Regel and Joseph (2010) point out that reactions to even the most appalling events are often wide ranging and the majority of people actually recover over time without any form of medical or clinical intervention. Shalev also points out in his paper on *Acute stress reactions in adults* (2002) that as mental trauma is seen in a significant minority of those exposed, perhaps the term traumatic events should be replaced by *potentially* traumatic events (PTE).

Following a potentially traumatic experience some people do, however, suffer some form of natural acute stress reactions (post-traumatic stress) such as upsetting thoughts and images, feelings of emotional numbness, troubled sleep, feeling on edge or being 'jumpy' or strong feeling of guilt, anger or shame, during a period of normalisation and natural processing (Bonanno, 2004). Although widely termed as psychological trauma, for some, the effects can also prove physically debilitating (Turnbull, 2010) as well as shattering a person's view of the world, and where self-held beliefs such as fairness, justice and invulnerability are sometimes

called in to question, often leading to spiritual crisis and profound re-evaluation of meaning (Maercker et al., 2013).

Even the most extremely challenging experiences do not always have an actual traumatic or detrimental effect on everyone (Regel & Joseph, 2010). Factors such as childhood experience (loved or not loved for instance), previous traumas physical and / or psychological, outlook on life (belief), general health and wellbeing (physical and psychological) and the ability to regulate one's physiology or stress response (although this is not always possible in all circumstances) all play their part in someone's resilience to increased levels of stress or further potential trauma (Southwick & Charney, 2018). Further, Bonanno (2010) suggested that humans are able to survive and often manage aversive events, while not everybody manages well, most are able to.

However, although there is significant, ongoing research on traumatic stress there appears to be relatively few models that actively aim to prepare individuals or organisations for operating effectively in challenging and potentially traumatic environments. One organisational approach to addressing such needs is covered within JESIP (Joint Emergency Service Interoperability Programme) which was formed in 2012 (www.jesip.org.uk) and which aims to promote wider understanding of the roles of each agency / emergency service when dealing with joint management of complex incidents. One of the roles of JESIP is raising awareness of shared risks which includes regular resilience and mental health training. TRiM, which interestingly features in the November 2020 edition (29) of the JESIP online newsletter, does offer a level of support for individuals and organisations following potentially traumatic events, but openly states in its mission statement that the model (military version) was not designed for active stress management.

Thus, it is sensible that suitable education, training and ongoing support should be provided to those that routinely operate in challenging, potentially traumatic environments

where at all possible. Although it is suggested that trauma cannot always be avoided or prevented (Brooks et al., 2018), it is hypothesised that in preventing a state of overwhelm in humans (i.e., the point that they can no longer cope, either physically or psychologically), there is a chance to mitigate the effects of potential traumatic stressors and minimise the chance of someone becoming catastrophically traumatised and developing a disorder such as PTSD.

Therefore, to address aim 1 of the thesis, and with a view to inform current and future potential trauma management / mitigation, this first of three studies set out to explore the personal experiences of a number of individuals that worked, or had worked, in a wide range of psychologically and / or physically challenging environments, where each of the participants had previously suffered some form of *potentially* traumatic experience during their role or profession. The plan was to firstly conduct a short pilot study involving two trial interviews with two appropriate volunteers. After a short evaluation, these pilot interviews were subsequently followed by a series of interviews with the research participants in order to investigate how they made sense of and managed (successfully or not) their challenging, and in some cases traumatic, experiences.

## 2.2 Methodology

### 2.2.1 Participants

The eight semi-structured interviews were conducted with participants identified through purposive sampling (Arber, 2001; Bryman, 2016) from existing contacts of the researcher and / or the Department of Sport and Exercise, Staffordshire University. All participants were volunteers, and all had experienced a significant event that was considered by the participant as potentially traumatic in nature.

To ensure anonymity and confidentiality, each participant was given a unique participant number (UPN) to use in all subsequent correspondence. Of the eight individuals interviewed, one (a female doctor (General Practitioner)) asked to withdraw from the study for

personal reasons. Even though this occurred after the interview had been transcribed and analysed, the researcher felt it important to honour the participant's wishes and remove the data from the study. A ninth participant (a female pilot), was also approached but after initially agreeing to participate in the study, dropped out after reading the information pack and before interviewing took place for personal reasons.

The final sample group of 7 interviewees for Study 1 comprised 3 females and 4 males with ages ranging from 27 to 64 and a mean age of 45. Ethnicity, social history and nationality were initially taken into account by the researcher, but it was felt that these issues had limited relevance in this particular study as potentially traumatic events can happen to anyone, from all backgrounds, and the inducive approach was chosen in particular because of its inclusivity and 'open mindedness' to all incoming data from all manner of people.

The researcher also decided that rather than select participants that would be naturally associated with working in challenging environments, such as members of the emergency services (police, paramedics, fire officers etc.) it was deemed important by the researcher to include *less typical* others, whose role reflected other parts of UK society who also faced or worked in psychologically and / or physically challenging environments covered in Table 2.1

**Table 2.1**

**Interview participants and Unique Participant Numbers (UPN)**

| | | |
|---|---|---|
| SUVM01 (aka Alice) | Business / Industry | A leading British entrepreneur (F) |
| SUTP02 (aka Ben) | The military (UK) | A serving UK Special Forces soldier (M) |
| SUZW03 (aka Chris) | Music | A former member of a successful music band (M) |
| SUCR04 | Medicine | A former biochemist and pathologist (M) |

| | | |
|---|---|---|
| (aka Dominic) | | |
| SUJE05 (aka Ed) | The Church | A former minister (vicar) (M) |
| SUVH06 (aka Fiona) | Law | A former lawyer (F) |
| SUEB07 (aka Gill) | Sport (UK) | A former British Athlete (F) |

### 2.2.2 Design:

Due to the research involved aspects of potential and actual psychological trauma, safeguarding and the well-being of participants was duly considered from conception and the subsequent interviews were held in accordance with Staffordshire University Ethics Committee guidelines (Appendix 1.1).

The study used a qualitative (Willig, 2013) and exploratory approach in interviewing eight participants identified through purposive sampling (Arber, 2001; Bryman, 2016). As one participant withdrew from the study, following the interview and subsequent transcription, for personal reasons, leaving seven interviews available for analysis. Each interview was audio recorded and later transcribed verbatim. The interviews lasted on average 42 minutes. Inductive Thematic Analysis (ITA) was then completed using Braun and Clarke's (2006) six step methodology.

In preparation for commencing the planned interviews, two pilot interviews were conducted. These developmental pilot interviews were important for understanding how to structure the interviews in line with the chosen thematic analysis methodology, allowing the participants freedom to express their thoughts and feelings while allowing the researcher to gain understanding / data in key areas associated with the participants' actual potentially

traumatic experiences including factors relevant to general human resiliency. The need for a degree of interview organisation and structure led to the formulation of an interview document (Appendix 1.2) including a rough interview guideline for questions (Appendix 1.3) to be considered within the interviews. It was also felt, by the researcher, that a flexible, working definition of trauma, drawn from the work of trauma expert Levine (1997), would prove useful for the participants both in raising awareness and bringing focus to the interview.

As an inductive form of Thematic Analysis was selected as the chosen contextual methodology (Braun & Clarke, 2013), it was important to conduct all interviews with an open mind in order to actively identify key / new themes of interest across all interviews.

### 2.2.3 Data collection

Five of the seven interviews were conducted face to face (Simmons, 2001) at a time and place of the participant's choosing and two were conducted via skype (audio, no visual). The open-ended questions used (Appendix 1.3) during the interviews were derived, following the pilot interviews, from a review of trauma literature (including but not exclusively TRiM and Post Traumatic Growth / Adversarial Growth) and designed to be flexible and adaptive in order to gain the best understanding of the experiences from the participant's point of view, but without causing unnecessary distress. It should be noted that although the TRiM model is of ongoing interest, it was kept very much in the background of Study 1. In line with ITA methodology, care was taken not to ask leading questions. The questions were open and not prescriptive and were used in a manner that best suited the moment, allowing the interviews to flow and the interviewees to feel safe with the opportunity to talk openly and in a direction and manner they chose (see Appendix 1.3).

The seven interviews took nearly 12 months to complete. Each interview took on average 42 minutes with the shortest being 35 minutes and the longest 47 minutes. Each was digitally audio recorded using a Dictaphone, and iPhone app, to allow transcription at a later

date by the researcher. Each interview took the researcher on average 6 hours to transcribe verbatim, but this proved invaluable with familiarisation and gained understanding of the data from the outset (Reissman, 1993).

### 2.3 Data analysis

In order to ensure the production of high-quality qualitative research, rigor was considered throughout the process in line with Smith and McGannon (2017). Although *member checking* is recognised by Smith and McGannon as having a limited evidence base to support it as a verification method of, it was conducted in the initial phase of the data collection to confirm trustworthy interpretation (Birt et al., 2016) of the transcribed text. Transcriptions were sent to participants for any correction and / or comment, as stated in the Study 1 Information Sheet. There were no returns, and no other comments were made on the contents of the transcriptions by participants during any subsequent correspondence and so it was deduced by the researcher that the written transcripts were an accurate reflection of what was actually said during the interviews.

Key gauges of quality or *markers* (Smith & McGannon, 2017) included within Universal Criteria were considered throughout the study as a way of ensuring the quality of the qualitative research and require constant evaluation and re-evaluation by the researcher. Ensuring this research is considered worthy and adds significant contribution to the world of applied performance psychology, as well as society as a whole, have been key factors from initial personal inception through to the research proposal and continue to be as the research evolves. Ethical considerations remain paramount and are assessed accordingly (see Ethics Chapter).

ITA was chosen over Deductive Thematic Analysis (DTA) as it aligned with the overarching aim of the study given that the researcher wanted to fully explore the experiences of the participants and wanted to gain personal information that could provide accurate

accounts rather than concentrating solely on already known trauma risk factors. The analytic steps taken during the data analysis were those advocated by Braun and Clarke (2006, 2013) and started with looking for patterns, meanings and themes of interest in the transcription text. Rather than approaching the data with preconceived ideas of how the participants *may* make sense of their experiences, for instance, the researcher was more interested in *how* they *actually* made sense of their experience.

### 2.3.1 Phase 1: Familiarising self with the data

Familiarisation of the data started during the transcription process, where written notes were also considered (Lewins, 2001). Once each interview transcription was complete it was read and re-read multiple times by the researcher in order to gain further familiarity and deep understanding of the transcribed text and to identify and highlight key areas of interest or codes within on which to pay particular attention to. Whilst writing and evidencing results, the transcription was revisited and re-read many times, gaining continued familiarity with contextual data.

### 2.3.2 Phase 2: Generating initial codes

During analysis, each fragment of interesting text was highlighted, designated with a numbered code and recorded on the transcribed text which was electronically highlighted. Each of the codes, which averaged around 55 per transcription, were named using a phrase or short sentence to summarise the code for it to make contextual sense. Each of the transcriptions took on average 9 hours to code.

### 2.3.3 Phase 3: Searching for themes

Once coding of the data was completed, codes with apparent similarities were clustered together in to two groups of themes. Firstly, by interpreting the analysis, the researcher developed an initial range of broader themes, known as Lower Order Themes (LOT), which

averaged around 19 per transcription. From a practical perspective, each code was assigned to and denoted within a named theme using their designated code numbers.

Through further analysis, a smaller number and far more focused Higher Order Themes (HOT) were identified and named containing groups of associated LOT. Finally, the Higher Order Themes were then analysed and refined further to create the two overarching and concluding General Dimensions (GD) of all data gleaned from all seven interview transcriptions. An example of this can be seen at Appendix 1.4.

The eventual analytical framework for this study was represented as:

**Table 2.2**

**Ascending [ITA] analysis**

| Ascending analysis → | | | | |
|---|---|---|---|---|
| Step 1 | Step 2 | Step 3 | Step 4 | Step 5 |
| Transcription of interviews including initial analysis and coding | Codes | Lower Order Themes (LOT) | Higher Order Themes (HOT) | General Dimensions (GD) |

It is worth stating that not all initial codes or LOTs found their way into a HOT or GD as they may have been identified initially as an area of interest but were perhaps too diverse or lacked consolidating data to support through further analysis. Some codes also became incorporated within other codes if similarities or commonality was deemed suitable through the theme reviewing process.

### 2.3.4 Phase 4: Reviewing themes

Through continuous and systematic analysis of the data, each of the themes (LOT, HOT, GD), and their relevant sub-themes, were continuously referenced, cross referenced and refined with

the coded transcripts to ensure that the codes and sub themes accurately fitted the chosen higher theme, whether that was a LOT, HOT or GD, and maintained relevance and suitability.

### 2.3.5 Phase 5: Defining and naming themes

Once the themes had been identified and given a general title, the researcher then focused on naming each of the themes through further reading and refinement. In line with Braun and Clarke's model, each of theme was named by a short paragraph that contextually summarised the theme. In terms of this study, each theme was supported by a list of relevant codes and sub themes.

### 2.3.6 Phase 6: Producing the report

Initial coding of the transcribed data took on average 9 hours per transcript, identifying initial Low Order Themes took on average 6-7 hours as did initial High Order Themes. However, as in line with Clarke and Braun's ITA methodology, revisiting and revising of the codes, themes and eventual general dimensions throughout the analysis process took countless hours over numerous months to complete in the researcher's part-time capacity. Re-reading in order to become re-familiarised with the data was challenging for the researcher which led to a longer timeline than the researcher had envisaged but also, and as part of ITA process, ensured inductive thematic saturation (i.e. no additional data / no emergence of new codes or themes) (Saunders et al, 2017). In total, over 200 pages of (1.5 spaced) transcribed data were collected, containing over 75 000 words. Appendix D shows the refinement and confirmatory cross-referencing process involved between the High Order Themes and the final General Dimensions, to ensure validity.

## 2.4 Ethics

Due to the particular nature of the research (i.e., dealing with potential trauma) it was vital that Study 1 required, and was granted, ethical clearance by the Staffordshire University Ethics Committee before commencement. The subsequent Study 1 interviews were held in strict

accordance with Staffordshire University ethical guidelines (Appendix 1.1) and a comprehensive interview pack (Appendix 1.2) was given to each participant prior to the interviews taking place. The pack included amplifying information about the research including the consent form and information relating to the withdrawal procedure (should it be required), an interview guide, and a debrief document for signposting to professional mental health services, should the need arise.

One pre-requisite in the selection of suitable participants to be interviewed in Study 1 was that they had to have previously suffered some form of potentially traumatic experience. An immediate ethical dilemma was that the researcher was proposing to interview individuals on subjects that may have previously led to psychological challenges for the participants. Due to the potentially upsetting nature of the study, the health and well-being of the participants was always considered paramount and as such the interviews were conducted sensitively and with regular breaks in order to mitigate any potential risk to the participants (Keller et al., 2005) with each participant being monitored by the researcher for emotional impact (i.e., behavioural changes such as participants withdrawing, becoming agitated or distracted) (Rothschild, 2010) throughout. Prior to commencing each interview, the participants were briefed that exposure to the questions in the study may cause anxiety, distress and psychological discomfort but reassured that the interviews could be abandoned at any time if participants did not wish to continue. During this phase, it was felt by the researcher that participants would benefit from being provided a flexible, working definition of trauma drawn from the work of trauma expert: "There is trauma – anything that overwhelms our ability to cope" (Haines, 2016, pg. 9). At no stage were any participants asked directly to describe their 'traumatic experience', rather open questions allowed the participants to describe their experiences in their own way and at their own pace. Participants were informed of helpline / support details via the accompanying

Information Sheet, Consent Form and Debrief Document and briefed and de-briefed verbally of steps taken to ensure their psychological safety and well-being.

After each interview a short debrief session was conducted by the lead researcher giving participants the opportunity to discuss any questions, queries or concerns they may have and to ensure, with their health and wellbeing being the priority, that they were content and in a fit state to depart the interview safely. Information on suitable signposting was provided verbally and in writing after the interview as well as being covered in the Debrief Document which all participants received before the interviews. In all cases following all interviews, all participants left in a fit and healthy state, with no concerns being raised at any time.

As mentioned earlier, to ensure confidentiality and anonymity, each of the participants was provided with a Unique Participant Number (UPN) which was used in all subsequent correspondence. Care was also taken in blanking certain text within the transcripts that may risk disclosure of identity or other key personal details concerning participants. For ease, each participant was also issue with a pseudonym as shown in Table 2.1.

## 2.5 Results and Discussion:

Through analysis and refinement of the data provided by the participants from the seven interviews, two final overarching themes were identified as the General Dimensions of the Study 1. The requirement for effective *social support* and 2. The requirement for effective *resilience and trauma focused biopsychosocio education*. In short, these are the principal themes that were identified by the researcher, along with nine sub themes (five sub-themes in General Dimension 1, and four sub-themes in General Dimension 2), from the analysis of the research questions investigating how the participants made sense of and managed their experiences. In line with an ITA approach, the themes and sub themes have been named using a combination of descriptive terminologies and accompanying contextual sentences (See Table 2.3 below). Furthermore, the two General Dimensions and nine sub-themes are shown in the

General Dimension Analysis (Appendix 1.5) and explained below in the discussion, along with accompanying participant quotes to support.

**Table 2.3.**

**Study 1 - General Dimensions:**

| **General Dimension 1** | **Social Support:** *The requirement for / provision of effective social support (ecosystems) to provide suitable key elements of social support for working in challenging environments:* |
|---|---|
| Sub Theme | 1. [Effective] **Individual social support:** *provided by trusted family, friends, colleagues, peers etc. How can an individual best look after themselves as well as provide support to others in terms of social construct and social identity?*<br>2. [Effective] **Organisational social support:** *that is inductive, proactive and longitudinal in nature. How can an organisation best look after its staff, colleagues, employees to ensure general health and wellbeing and maintain levels of operational performance?*<br>3. **Effective leadership:** *how can leadership be used to support those working in challenging environments?*<br>4. **Use of non-clinical interventions:** *such as coaching and mentoring, to support general health and wellbeing and maintain levels of operational performance (to incorporate relevant signposting to professional services).*<br>5. **Use of clinical interventions:** *such as General Practitioners (GPs), psychiatrists, counselling and therapy, to support* |

| | |
|---|---|
| | *general health and wellbeing and maintain levels of operational performance (to incorporate relevant signposting to other suitable professional services).* |
| **General Dimension 2** | **Resilience & trauma focussed biopsychosocio education:** *The requirement for / provision of trauma and resilience informing biopsychosocio education suitable for preparing people to operate in challenging environments:* |
| Sub Theme | 6. **Self-efficacy in terms of social identity:** *learning about the importance of personal and organisational values, beliefs and purpose etc.*<br>7. [Effective] **Resilience education, training and longitudinal support*:*** *to include nutrition, exercise and sleep education, etc.*<br>8. [Effective] **Trauma education, training and longitudinal support:** *to be proactive approach rather than reactive and to incorporate elements such as Post Traumatic / Adversarial Growth and PTSD (including complex.*<br>9. **Enhanced Self-efficacy:** *self-regulation / stress management strategies including the avoidance of psychological overwhelm etc.* |
| | *Note: Brackets [ ] have been used by the researcher in the table above to indicate implied emphasis on what is required rather than an individual or organisation 'going through the motions' or 'ticking boxes'. Making these headline themes and sub-themes work requires diligent integration and urges the question, "how do I / we make this* |

| | |
|---|---|
| | *happen ensuring best effect within my / our environment / organisation?"* |

The overarching aim of this study was to explore the experiences of a number of individuals that worked, or had worked, in psychologically and / or physically challenging environments. As part of that aim, I wanted to gain insight into how they made sense of and managed their experiences. ITA was employed to analyse the data using a contextualist approach (sits between essentialism and constructionism), which acknowledges the ways individuals make sense or meaning of their experience, while maintaining focus on the data and how participants understand 'reality' (Braun & Clark, 2006). The following section takes each of the two General Dimensions in turn, starting with Social Support:

**General Dimension 1: Social support**

The findings of the study suggest that those that faired best were the participants that had suitable resources at hand and as such felt prepared for working in challenging environments and regularly trained using the necessary skills and knowledge associated with operating with related risk of potential physical and / or psychological harm. These individuals had access to sufficient individual social support, such as from trusted family, friends and colleagues,

> *"What it showed me at the time was how loved I am by friends"* and *"I realise that in going forward in life, I will never be able to fully repay many of these people but at the time they provided me with this overwhelming hug … type thing"* (Alice)

Organisationally, through provision of suitable supportive programmes and safe environments, where staff, or team / group members, felt able to be open and honest and seek

suitable support without fear of reprisal. One of the participants, Chris, talked of the way his band members rallied around him even when they were facing the personal struggle of carrying on without a key member of the band:

> *"…I know that at the start they felt like 'shit', we need to keep going with this and how are we going to continue without me. But they realised that they had to keep going. In fairness to them, they always called me to see how I was and to keep me updated on what was happening because I genuinely think that they cared, they really cared"* (Chris).

Effective social support facilitates health, growth and restoration through the creation of psychological safe learning environments (Porges, 2017). These supportive environments have the capability to sustain individuals and groups through natural human phenomenon such as loss and grief, hardships that most people experience through life, which are many of the experiences experienced by the participants (Griffiths, 2017).

However, although positive effects of active social support were evident through all interviews, there was also evidence of the damaging, negative effects of not feeling supported or feeling let down by someone held in a perceived or neuroceived[1] trusted position. Another participant, Ed, talked of feeling extremely let down, and actually hurt, by people that he expected to assist in a time of need. The feeling of betrayal by those who you should feel aligned with can often have profound effects:

[1] Neuroception is a term used by Professor Steven Porges to describe the process through which the nervous system evaluates risk without requiring [conscious] awareness. The automatic process involves brain areas that evaluate cues of safety, danger and life threat (Porges, 2017)

> *"You can't be all things to all people and sometimes it just builds up and it's incredible how in a community that is based on a gospel of love can be, at times, so unchristian and uncaring and just unthinkably cruel".* (Ed)

Gill also talked of the profound effects of not feeling supported by those whose role is solely about supporting individuals in elite sport, especially in formative years:

> *"…I think that had the biggest effect on me during my injury time than anything did because I had so much respect for* [redacted] *as a coach and I worked so hard for him and it kind of broke me I suppose because I couldn't believe that he didn't believe me …" (Gill)*

At a time where there is increasing research in the field of resilience and trauma management, especially in areas such as the UK armed forces or the UK emergency services, identifying two already recognised methods for dealing, or coping, with potentially traumatic experiences through social support (Rees & Freeman, 2009) and self-regulation (Levine, 2010) is not all that surprising. This study has, however, found evidence that individuals, operating in perhaps less physically dangerous environments, can also benefit from gaining resilience and trauma informed awareness and preparedness, especially where individuals voluntarily place themselves in potential harm's way.

Effective social support (Rees & Freeman, 2009) from trusted colleagues, mentors, friends and family can provide a safe environment where an individual can normalise potential reactions to adversity, such as trauma, by talking, listening and sharing experiences whilst being cared for and watched over (Turnbull, 2010). Porges refers to this as a *Biological Imperative,* or in other words, human's need of human connection. In terms of working in

potentially traumatic situations, which are often filled with uncertainty, he goes further by suggesting a person has a buffer from trauma if there is a good, underlying developmental base for attachment (Porges, 2017).

An interesting finding from Study 1 is of the perceived psychological *post traumatic growth* (Tedeschi & Calhoun, 2004) or *adversarial growth* (Joseph & Linley, 2006) experienced by individuals from varied backgrounds following challenging experiences, often when supported by others. It is also particularly noteworthy and backed up in studies by Buchanan and Seligman (1995) that growth most often occurred in those that felt prepared for role and who also maintained an optimistic view of their experience, tough as it may have seemed at the time.

When looking at the General Dimension 1: Social Support, it is clear that people seem to manage challenging situations better when they have effective support networks. These networks may be relatively small, perhaps in the case of Gill, or large in the case of Alice, but they are evidently key in helping people get through tough times. The findings also show that the support can come from multiple sources, whether trusted family and friends as with Chris or from professional counselors and therapists (Sub Theme 5) as with Ed:

> *"I had therapy and that began to give insights into what was going on. It gave* [redacted] *and I, and also my peer group, a chance to talk about what was actually happening and to understand, and when look back, this is all deeply involved in who I am".* (Ed)

An interesting observation of the data is how effective non-clinical interventions, such as through effective leadership and peer support were. Values based or compassionate Leadership is considered by some (Shepherd & Smyth, 2012) as synonymous with team / organisational high performance, especially in challenging environments, where hierarchal

systems require the spread of effective devolved leadership. A number of participants that had worked in these types of settings talked of the importance of often straight forward but effective leadership in dealing with potential trauma whilst maintaining levels of performance.

> *"... having a good relationship with team members ... clear and effective communication between each other is crucial. Being able to talk to people is a key factor in processing and decompressing effectively ... ensuring that you or the team members don't bottle things up inside."* (Ben)

However, as effective leadership is a powerful tool in helping people manage challenging environments, poor, unsupportive leadership or teams can actually exacerbate certain situations, especially when someone is struggling.

> *"I would say there's no teams in law firms, I'd say the opposite to that yeah. I mean, they say there is, and they can come up with some of the right language sometimes but all they really want is everyone to be a clone of the other person or better than the person they are next to or at least the same as. You're doing the same thing. If they changed the way that they measure value then they would get a lot more out of it because they have a good collection of individuals in law firms, but no one displays their true selves because that's not what's measured or valued so you've got lots of people pretending to be somebody else. And then the people who can't do that successfully, struggle even though they don't need to really because sometimes those skills are more important. I mean certainly, I asked for coaching once and their response was 'can't you do your job?'"* (Fiona)

A number of participants talked of the benefits of formal [non-clinical] personal assistance, rather than from friends or family for instance, in the form of coaching and / or mentoring. The general term for coaching has been widely discussed for over three decades but a generic definition offered by Sir John Whitmore, a renowned figure in the world of coaching: *"Coaching is unlocking people's potential to maximise their own performance. It is about helping them to learn rather than teaching them"* (Whitmore, 1992, pg. 10).

Coaching comes in numerous forms such as performance, developmental and transformational coaching, but in terms of coaching having relevance to Study 1 and participants dealing with potential trauma, Cox offers a useful 'workman-like' definition:

> *"Coaching can be seen as a human development process that involves structured, focused interaction and the use of appropriate strategies, tools and techniques to promote desirable and sustained change for the benefit of the coachee and potentially other stakeholder"* (Cox et al., 2010, pg. 487).

Here, the focus is on perhaps normalising effects of potential trauma and allowing individuals to safely explore various options available to them (including choices and consequences) and develop their own ways of recovering from challenging experiences rather than automatically seeking clinical or medical assistance.

As well as coaching, there is another non-clinical intervention that most often occurs naturally within groups of humans as well as many other mammals and which has been around for millennia. A term *we* now describe as Mentoring. Mentoring is sometimes used in conjunction with coaching in terms of helping people move forward but requires a quite different approach that should be clearly articulated to those concerned. Whereas coaching encourages development through personal ownership of a challenge using one's own

knowledge, skillset and personal experiences, mentoring utilises the experience and expertise of others [the mentor] to support individuals. Lillian Eby et al, offer the following definition:

> *"... mentoring involves a relationship between a less experienced individual and (protégé) and a more experienced person (the mentor), where the purpose is the personal and professional growth of the protégé ...".* (Eby et al., 2007, pg. 14).

As described above, mentoring is a very human approach to facing challenges by sharing and discussing problems and assisting those, often when facing extremely tough times or when they are 'stuck', to find a way forward. A powerful example of the perceived benefits of these kinds of non-clinical approaches is offered by one of the research participants:

> *"I think if people can get over that fearfulness by just being authentic and discussing your feelings. The false bravado leads down a dead end that is unpleasant really. I think being authentic and honest with yourself and with the people around you will allow you to achieve far more in life and probably held in higher regard for having that honesty and integrity to say, 'actually fucking hell, I'm dealing with something here and I don't think that I can deal with it myself ... it's very much the values of coaching really and being in the moment and owning the perceived problem. It's powerful stuff."* (Dominic)

Altruism, found through providing support to others, as well as receiving it, is considered important in maintaining resilience (Southwick & Charney, 2018) through strong bonds within groups by some of the participants such as Dominic.

What this study's data highlights, is that with the right provision of effective social support, whether individual, team or organisational, people can not only successfully endure

and recover from potentially traumatic experiences but that they can actually learn and grow as a result. Importantly, developing means and adaptable strategies designed and configured to navigate potentially rough waters ahead. This flexible approach can be vital for maintaining effective performance levels in challenging environments. Without appropriate social support, individuals, as talked about by Ed, will often fair less well during tough times, possibly losing important facets like self-confidence and social identity along the way.

**General Dimension 2: Resilience and trauma focused biopsychosocio education**

When considering General Dimension 2: Resilience and trauma focused biopsychosocio education, it is apparent that along with social support, Study 1 evidence suggests that being prepared is a key factor in operating successfully in challenging environments. Preparation for task, or role, is most often subjective, as with mastery of technical skills, but there is much than can be done in preparing people for facing potentially arduous undertakings. As well as providing suitable education and practice in terms of social support and engagement (socio) there are psychological (psycho) and biological (bio) fundamentals that can prove beneficial in terms of gaining personal / group understanding and awareness as to why, as humans, we think, feel and behave the way we do, and importantly what we can do to potentially manipulate subsequent reactions. Effective biopsychosocio education is crucial for performing effectively in challenging situations (Cotterill, 2018) and the requirement is evidenced throughout Study 1. Recognising and understanding signs and symptoms to potentially traumatic experiences can be turning points in people's recovery, especially when they are able to develop personal strategies to regulate levels of arousal, such as increased stress levels. Self-efficacy and social identity are described by participants such as Ben as key elements in maintaining personal resilience and so having increased awareness of normal reactions to such experiences can allay fears and build individual and collective confidence in being able to operate under pressure in challenging environments.

With practice, having the ability to self-regulate can allow individuals to face current, future or past experiences with a balanced approach, allowing them to process current thoughts, feelings and emotions and adapt behaviours accordingly. Rosenberg, a leading and well-respected trauma therapist, talks of helping people recover from challenging experiences which is substantiated by a number of participants in the study: *"If we have suffered a trauma, we will recover more quickly if we can remember our life dreams, mission, and /or goals, which give meaning to our lives"* (Rosenberg, 2017, pg. 101).

In terms of dealing with potential trauma, social identity provides vital resources for recovery such as sense of belonging, sense of efficacy, personal values, beliefs and trust (Muldoon et al., 2019). Within Study 1, a number of participants highlighted the importance of social identity, in terms of how they managed both their potentially traumatic situations and how they recovered from them. Feelings around having meaningful purpose or personal values and beliefs were raised in particular where they were aligned or misaligned with group values. An example of this provided by Alice who talked of her strong ethical responsibility towards others:

> *"Because the event didn't go ahead, as the director of the company, there are certain undertakings and responsibilities I felt I had to do. At that point I felt I had no option but to dissolve the company to protect our suppliers, our ticketholders money and anybody that had spent money towards this particular event"*. (Alice)

Importantly for this participant, even though they experienced a torrid situation at the time, they were subsequently able to [self-regulate] look back and reassure themselves, as well as receive reassurance from others, that they had done what they felt was the right thing at the

time. In terms of their recovery, remaining true to their own self and their values and beliefs was a key point in processing what had happened, learning from the event, finding a way to accept what had happened and moving forward in life.

When performing as part of a group, such as in sport, the military or a surgical team, knowing who you are and what you stand for within a group setting is vital for self-care, personal confidence and resilience and so finding yourself misaligned with a group can leave people feeling isolated, or let down and can impede recovery from significant setback (Clarke & Nicholson, 2010). Weisinger and Pawliw-Fry (2016) refer to this as social-pain which, according to the findings of Eisenberger and Lieberman (2013), shares the same underlying processing system as physical pain.

> *"I struggled because I dedicated quite a key period of my life, when everyone else was developing other skills like going out and socialising and that sort of stuff ... I found it really difficult because I'd always introduce myself as a 'Uni canoeist' or as a 'kayaker' and I didn't know who I was anymore."* (Gill)

Having a healthy sense of identity and purpose often promotes sustained resilience, even when faced by adversity or potentially traumatic situations. Even in the extreme, the acclaimed neurologist, psychologist and survivor of the notorious WW2 concentration camp Auschwitz, Viktor Frankl (1959 – 2004) noted that those who had a sense of purpose and meaning were far more likely to survive than those without. In terms of other key factors of resilience, Clarke and Nicholson (2010) using the Nicholson McBride Resilience Questionnaire (NMRQ) highlight optimism as the No.1 key element. Linking meaningful purpose and optimism, having hope for the future and finding acceptance of what has

happened, has happened is also really important in recovery. In relation to Study 1, Ed evidences this by taking stock of his situation and choosing to change direction in life:

> *"We're vulnerable human beings and you need to be aware of it, although having said that being aware of it, the last one was my worst, but we crawled through. We just decided that probably, there was never going to be a healthy and comfortable or viable life being put in the firing line of these pressures, so we stopped and started looking and exploring new ways of living our lives and finding new meaning and purpose".* (Ed)

The ability to self-regulate cognitively and emotionally is key to the maintenance of personal resilience and recovering from potential trauma according to Rothschild (2010). Maintaining balance, or homeostasis, can be managed using numerous approaches often involving sleep, nutrition, exercise and breathing techniques. Chris talks of how exercise, and running in particular, helped them regain psychological homeostasis during his recovery from a severe physical injury:

> *"That was the first run I done in over two years and it was the magic moment it was as if I'm back. My heart was pumping, and I felt alive again. It was such an important milestone for me as exercise has always been a cornerstone to everything I've done. It's like my base level. Every day I have to do some form of exercise, which is made the last two years extremely, extremely difficult. I felt like I was eventually centered after two years of extreme struggle".* (Chris)

In *Resilience*, *The Science of Mastering Life's Greatest Challenges*, Southwick and Charney talk of the factors quoted by a number of people who considered them crucial in managing great hardship and stressful events. The list of factors is not fixed but includes realistic optimism, facing fear, moral compass, religion and spirituality, social support, resilient role models, physical fitness, brain fitness, cognitive and emotional flexibility and meaning and purpose (Southwick & Charney, 2018).

During Study 1**,** all participants talked of the effects that their varying degrees of resilience had on them during their experience and during their recovery. Aspects such as maintaining positive outlook on life, the importance of sleep, exercise, having meaningful purpose and supportive social networks as well as having the knowledge and skill to self-regulate cognitively and emotionally were all mentioned as key factors to management of the experiences and effective recovery. In his book 'Developing Resilience', Neenan (2018) points out that people are not born resilient but rather it is developed through the struggle, which is often reluctantly undertaken. This widely held point of view is important when considering Study 1 where all participants have voluntarily placed themselves in potential harm's way by choosing their role or profession. Keenan also suggests that maintaining an adaptable and positive mental attitude sits central to resilience in order to maintain a flexible mindset for overcoming adversity. In Study 1, Chris also talked of the importance of maintaining a positive outlook during recovery:

> *"I've also got a very positive mindset, and nothing really gets me down. I can find myself getting really motivated to say that just because I broke my leg will not stop me running. I remember when I was part of the cadet forces school and although I loved it I never really like being told what to do by instructors, but I did love the physical exercise so even when my leg was totally fucked I could with some help get on the floor*

*to do press ups. It sounds crazy but just being able to do press ups text me sane and text me believing that I would recover. For me it was a huge driver that I must keep moving. I thought that if I didn't keep moving forward with this exercise then I wouldn't recover. It's perhaps something that's been ingrained in me. I find that through life I have to remain positive because for me nothing good comes out of being negative. So really positive mindset from the off I'm with stacks of support from friends and family."* (Chris)

Remaining psychologically flexible and being able to manage the ups and downs of challenging performance was noted by a number of participants as an important facete of their role. Ben reflected on handling challenging experiences over a protracted period:

*"…when I look back on it my career has also had a large degree of mundane periods two extreme peaks of highs and lows so being happy and professional in that middle ground is very important. Having the strength to deal with those highs and lows is often down to resilience and I believe you get stronger the more it happens.* (Ben)

Maintaining a sense of control, which is also a key factor in recovering from potential trauma (Turnbull, 2010) during the dynamic nature of often stimulating experiences and not allowing oneself to become overwhelmed by what was happening was talked about by a number of participants. Fiona talked of the fact that she did not understand what was happening to her at the time and as such did not have the insight or know how to remove herself from the adverse predicament that she found herself in:

*"So, I was functioning, not well but I was functioning right up until quite close until it fell apart … I didn't understand what was happening and I certainly didn't feel like anyone else did. The strange thing I suppose is that I didn't really know it was happening to myself. I knew I wasn't right; you know I knew I wasn't happy, and I knew I wasn't living on cloud 9 but I didn't know that I was that unwell. I didn't know that I wouldn't be able to get myself out of it."* (Fiona)

On the other hand, Ed talked of the benefits he found with taking proactive steps and combining regular personal exercise with others:

*"The other aspect of caring for myself has been, making a connection between physical health and fitness and mental health and fitness, and so a much more focused attention on exercise. I mean I've always been fit from cycling but now I know that there is a connection and actually, being fit helps. But It's really difficult when you're having a real struggle to be with yourself, being on a bicycle on your own is really difficult. The reasons I can't run, or anything is because of my knees but I can still ride a bicycle. That's where being a member of a bike club has been extraordinary and it's amazing how many members have been through mental issues and it's lovely that we can now talk about it. They knew why I was riding on a Sunday; I'm not prepared to hide and pretend because I think it's really important to state how you're feeling. And then you find people with something in common and they probably find it comforting to know that someone else is going through it, just to offer them a bit of TLC."* (Ed)

Study 1 interviews highlighted the perils of becoming overwhelmed whilst working in challenging environments especially when those environments form part of that individual's

*meaningful sense of purpose*. This, as raised by the likes of Levine and Cotterill is the point where people can become psychologically injured or traumatised. Challenging environments, such as experienced in the emergency services, hospitals or the military, may be considered obvious examples of where 'having a keen sense of duty' is fundamental and 'going that extra mile' is perhaps expected. In these environments, being overwhelmed by the situation and environment is perhaps taken for granted in these busy 21st Century times, but performance is often and adversely affected:

> *"… it was a nightmare because I just couldn't deal with things. If I was challenged with anything I would just turn into a blubbing baby and it was only, probably June last year, that I actually recognised I wasn't well."* (Dominic)

But being psychologically overwhelmed by a potentially traumatic experience is something that can occur to anyone, such as experiencing devastating shock and grief after losing a loved one (Regel & Joseph, 2010). Many of the experiences such as anxiety, sleep disturbance, guilt, shame and withdrawal are considered normal reactions that most will move through but for some the effects can become too powerful and create a physical and psychological state that for some means that even basic functioning as a normal human being can be difficult.

Ben, who openly regards himself as being resilient, talked of the point that he became overwhelmed, which really took him by surprise:

> *"Being in charge, being the team leader was quite testing because you have perhaps younger individuals that look up to you so you have to carry on leading as you would expect … Subsequently we found out the day after, after speaking to my wife, that my*

*dog had died back in the UK, which rather bizarrely set me off! I had taken everything up until that point in my stride but our dog of 11 years dying set me off."* (Ben)

In taking this point back to the opening paragraph of this paper, Peter Levine describes trauma as anything that overwhelms our ability to cope, so arguably the nearer a person is to becoming overwhelmed, the less able they are to perform 'in the moment' and the more that person risks in terms of becoming traumatised by the experience.

*"During the lead up I think no food and no sleep either and I think working it out after the event I probably had about 17 hours sleep in 10 days I you really. I was drained. Lots of palpitations and an overwhelming sense of collapse would be a good word and the only thing that kept me going was about me delivering this event. Everything to do with my identity as a person was wrapped up in this. It wasn't just about business. This was me [name] putting my head above the parapet and putting myself in a position I hadn't been before. Afterwards I felt that there was a little part of me that would never recover from it. I think it changed me."* (Alice)

The importance of understanding what is going on in our brains and bodies, and then having the ability to do something about it, cannot be understated. Having the knowledge and skills to develop personal effective coping strategies, rather than maladaptive ones, in order to reduce levels of increased stress and anxiety are key to psychologically safe and effective working practices in challenging environments. It is perhaps worthy of note that of the seven participants in Study 1 most had experienced some form of overwhelm, and two to the extent that they had planned and taken the first active steps to actual suicide both due to feeling unable

to cope with the overwhelming pressure of working in challenging, potentially traumatic environments.

In exploring the experiences of people that have operated in challenging environments, it is apparent that effective social support (individual, group, organisational, environmental) along with suitable *resilience and trauma* focused training and support (often but not always dependent of role) can make a significant improvement on how people understand what is happening or has happened to them during the process of operating. It is hypothesised (suggested) that this training and support should be offered, in some fields (medicine, emergency services, etc.) at grass roots level and as part of their initial formal trauma awareness training. However, raising awareness and understanding of how the human body and brain work, especially when undergoing stress and potential trauma, may equip those who chose to operate in wider challenging environments, not necessarily just emergency services, teaching or sport for example, and enable them avoid potential overwhelm and perform effectively and for longer.

### 2.6 Limitations:

This study had some limitations as it was a relatively ambitious study, and it was dealing with highly sensitive subjects requiring moral and ethical sensitivity whilst delicately ensuring significant academic contribution. Choosing suitable candidates to participate in the study took a great deal of consideration and proved challenging, even once people volunteered. Evidence of this was confirmed with the withdrawal of an initially enthusiastic pilot, after reading the information pack and the withdrawal of an experienced doctor, after the interview had taken place (without any issues) and due to personal reasons. The obvious difficulty in exploring participant's experiences in this context was always the primary concern of re-traumatising individuals when asking them to reflect on past, potentially painful memories. In order to mitigate this, along with the detailed information pack, questions during the interviews were

delivered in a sensitive and personalised manner, judged by the researcher and constantly evaluated throughout the interviews. Individual and situationally suitable, tailored open questions were asked in order to create an environment where the participant felt comfortable and not pressured into talking about something that they felt difficult delivering. The researcher has experience of working in the field of trauma management so the choice of ITA in preference to DTA was made in order to fully explore participants *real* experiences and so not to focus on known areas of traumatic experiences where there was always a risk that sometimes obvious, well known trauma factors, such as associated with the TRiM methodology were, somewhat standardised in amongst other personal information or factors offered by participants and considered by the researcher with equal gravitas. Although the researcher attempted full diligence and impartiality when questioning participants as well when deciphering / analysing data, it is accepted that it is perhaps unfeasible to remain totally unbiased /impartial throughout the process (you cannot remove previous knowledge and experience). In diligently analysing the data, over and over again, it was anticipated that these effects were mitigated sufficiently to maintain credibility of the study.

## 2.8 Conclusion:

The overarching purpose of this PhD thesis is to explore the experiences of people operating in challenging / potentially traumatic environments in order to gain evidence to inform and support the requirement of a model or programme (TRiM) that can proactively and dynamically support and maintain effective performance levels as well as protect overall physical and mental health and wellbeing. This Study (1) aimed to explore the experiences of a number of individuals that worked, or had worked, in a variety psychologically and / or physically challenging environments (Aim 1 of the thesis). Each of the participants had suffered some form of PTE during their role or profession and the interviews provided valuable

anecdotal evidence in relation to how they were able to make sense of and managed their experience.

The findings of this study suggest that people who work in challenging / potentially traumatic environments most often have the ability to operate effectively, even under increased stressors if they have the necessary resources available in terms of general self-awareness, effective social support systems and relevant skills, knowledge and attitude to effectively manage person stress levels up until the point of overwhelm where they may falter. At this point their recovery can depend on many factors available to them including the effectiveness of both non-clinical and / or clinical support.

Study 1 explored the personal experiences of several qualifying individuals and through lengthy analysis it provided valuable evidence of methodologies, strategies and ways in which these individuals not only managed potentially traumatic experiences, but in some cases, provided evidence of how some actually *grew* as a result (Zoellner & Maercker, 2006). Interestingly, most of these strategies did not require clinical support, rather they relied on practical approaches, such as support from trusted others, an understanding of what was happening to them and why, and importantly how they could manage themselves through the experience. What was also interesting was how mindset played its part in managing events (affected performance), not only during the actual experience but in the aftermath or the recovery phase. People cannot always plan for potentially traumatic occurrences, but Study 1 has shown that those that felt prepared, aware and retained a positive, optimistic outlook, even through adversity, appeared to maintain balance in terms of homeostasis as well as confidence levels both in self and in others.

It is therefore believed that the two General Dimensions identified in this study can be added to the growing body of research in this subject and be used to inform future development of a model that can assist individuals and organisations operate effectively in challenging and

potentially traumatic environments. The next chapter, therefore, will seek to explore the effects of TRiM, in its current form, on general health, wellbeing, social support and stress in a UK emergency service population.

# CHAPTER THREE:

# STUDY 2: EXPLORING THE EFFECTS OF TRIM ON GENERAL HEALTH, WELLBEING, SOCIAL SUPPORT AND STRESS IN A UK EMERGENCY SERVICE POPULATION

## 3.1 Introduction:

The results of Study 1 highlighted two General Dimensions, with nine incorporated sub-themes, that were common across research participants and which they felt helped them to not only endure the challenges they faced but, in some cases, actually benefit or grow from the experience. Firstly, there is a requirement for effective social support, both from an individual and organisational perspective. Secondly, the study emphasised the requirement for effective resilience (including trauma) informing, [biopsychosocio] education and support within such disciplines that could be considered challenging and potentially traumatic, of which we have discovered through the COVID 19 pandemic, there are many (Charles & Ewbank, 2021). As a point of interest, The American Psychological Association (2014) defines resilience as "the process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress. Based on key findings of Study 1, the following study will measure the psychological outcomes of general health and wellbeing, resilience, stress management and social support.

The COVID 19 pandemic has further underlined the need for effective potential trauma informed education, especially where people voluntarily put themselves in potential harm's way for the benefits of others in to sharp focus. Working on what has been widely termed the '*Frontline'* is now not only reserved for the military, emergency services or the NHS. Frontline workers, that have most often purposefully put themselves in potential harm's way include care home employees, council workers and supermarket staff (Anderson, et al, 2020). In such environments, where often elevated levels of physical and cognitive performance are required

during challenging times, social support, shown through commitment to one another, is considered vital to high-level functioning as well as personal development and growth (Joseph & Linley, 2006).

Studies by scholars such as Southwick and Charney (2018) suggest that most individuals who are exposed to potentially traumatic situations, such as death of a loved one or someone within their care, possess sufficient personal resolve or resilience to process the associated challenges and move on in life, in some form of meaningful way. Using this example, for instance, actual duration and expression of 'normal' grief or bereavement varies greatly across cultural groups, but encouragingly, Griffiths (2017, pg. 116) states: *"Emotions properly understood can enable people to walk this sometimes-uncomfortable truth about reasoned risk-taking constructively*".

Following significant and potentially traumatic events some may suffer temporary distress, which often settles in the first few weeks or months (Shalev, 2002) but most people do not suffer long term negative psychological effects. However, some people do and may go on to develop some form of psychological health issue (including but not limited to PTSD) that require medical intervention such as CBT (Cognitive Behavioural Therapy) or EMDR (Eye Movement Desensitisation and Reprocessing) for instance (NHS). Research has shown that personal resilience is more common than once thought and is often underestimated following trauma or loss (Bonanno, 2004).

Revisiting current guidelines published by the UK Post Trauma Society (UKPTS, 2014, pgs. 3-9), and which remain extant in 2023, suggest that organisations that routinely place employees or staff in potential harm's way should at least: *"…take reasonable steps to promote psychological resilience and prepare staff for the possible impact of trauma exposure…"*. From a duty of care perspective, UKPTS also: *"… believes that there are ethical, legal,*

*economic and reputational reasons for trauma- exposed organisations to proactively protect the mental health of their staff as far as is reasonably practical".*

One trauma-focused, peer delivered system for supporting individuals following exposure to potentially traumatic events is TRiM, which is supported by UKPTS, and which complies with the UK NICE guidelines. As discussed in Study 1, TRiM's purpose is the early identification of psychological illness (Frappell-Cooke et al., 2010), following potentially traumatic experiences through assessment and monitoring by TRiM practitioners and the subsequent referral or signposting to specialist support, such as General Practitioners or Organisational Occupational Health, where required (Dunn et al., 2015).

As we know, the TRiM model was initially designed to maintain functionality with UK military personnel during war or peacekeeping operations. One of its primary aims was to normalise reactions following potentially traumatic events where risk of being traumatised was significant and likely. Since its introduction in the late 1990s, TRiM has now become culturally imbedded in many military units and, as well as providing duty of care in an organisational sense, is proposed responsible for the low rates of post-traumatic stress (Jones et al., 2017) in the likes of the Royal Marines, who regularly train in and use TRiM.

In essence, TRiM comprises three key parts: biopsychosocio / trauma informing education, peer led assessment and peer / social support, with signposting to clinical services if required, and was chosen for this study as it hypothetically fits the requirements, or general dimensions, highlighted in Study 1. TRiM's purpose is the early identification of symptoms of increased stress through assessment and monitoring and the subsequent referral or signposting to specialist support, such as General Practitioners or Organisational Occupational Health, where required (Dunn et al., 2015).

TRiM's relatively straight forward and structured approach has gained popularity, in recent years, amongst other organisations that routinely place their own people in potential

harm's way and who acknowledge that not all reactions to potentially traumatic events require clinical intervention. Some of these organisations, such as SFRS, have hierarchal management or leadership structures or approaches in place, which suits the TRiM peer support philosophy.

Of note, even though TRiM is not a clinical intervention, it does facilitate / encourage human interaction involving potentially sensitive discussions that require careful consideration, both in terms of supporting those requiring support as well those doing the supporting, namely the TRiM practitioner. Highlighting it's non-clinical approach the principal philosophy behind TRiM is 'to do no-harm', which is referenced in the NICE guidelines. With this in mind, TRiM training should not be taken lightly and has historically been delivered over two days using a blend of facilitated workshops and / or didactic style education, where open, 'face to face' practice, role-play and detailed discussions have played a large part in consolidating the learning process ready for implementation in various organisations. On top of these, regular refresher sessions and opportunities to share lessons and experiences are encouraged by training providers and user organisations alike. Once successfully implemented into an organisation, the provision of effective TRiM support requires significant and considerate management, a flexible and dynamic approach and a framework of trained and dedicated practitioners, managers and coordinators.

Unsurprisingly perhaps, within some military organisations and emergency services there can be attached stigma, often associated with negative feelings and perceived weakness, particularly amongst males, being attached to receiving psychological or trauma support (Sharp et al., 2020). Such stigma can be unhelpful and harmful to the vulnerable, as well as to organisations working with risk, and act as a barrier or hinderance to the uptake of such interventions, which are aimed at maintaining performance in challenging conditions. Anecdotally, critics may also question whether TRiM is truly proactive as it is, most often, employed after the event has happened and that support from peers is often unpopular. TRiM

does seem to offer organisational support for some involving potential trauma (Whybrow et al., 2015) but further investigation on TRiM's actual efficacy outside the military, where most research and trials have been conducted, may prove useful in determining its true potential in wider domains.

The hypothesis, based on previously highlighted findings from military studies by the likes of Greenberg et al., (2010) and a more recent non-military (Police) study by Watson (2013), is that those that receive TRiM training and support would benefit, in terms of general health and well-being, stress management and social support in comparison to those that do not receive TRiM. Clearly as much of the research on the effects of TRiM has largely been conducted within the armed forces (Greenberg et al., 2005, Frappell-Cooke et al., 2010) there is a shortage of credible data regarding the use and effects of TRiM in other groups that operate in challenging environments, including, but not solely, the emergency services (Whybrow et al., 2015, Sharp et al., 2020). Furthermore, there is a dearth of both longitudinal and comparative studies providing data between those that receive TRiM (training and support) v non-TRiM (training and support) within other workforces.

Therefore, the main purpose of this study was to build on the findings of Study 1 and conduct a longitudinal, quantitative study within a division of UK's Fire and Rescue Services ($n$ = 44) with two aims. First, to gauge the efficacy of TRiM to determine if the programme improved psychological variables including resilience, social support, general wellbeing, stress, and presenteeism (these variables were selected based on data gained from Study 1), at four specific time points over a twelve-month period (Aim 2 of the thesis). The rationale for this longitudinal design was to assess any changes in variables as a result of TRiM, over time (12 months) as this has not been done before in previous research (see Figures 3.1 – 3.10 and Table 3.1). Second, the study aimed to provide comparative data between the group that had received TRiM training vs. a control group (Aim 3). It was hypothesized that the TRiM group

would report improvements in the psychological variables from pre- to post-programme, while the control group would remain the same.

### 3.2. Methodology:

#### 3.2.1. Ethics

As with Study 1, due to the particular nature of the research (i.e., dealing with potential trauma) it was understandable that Study 2 required, and was granted, ethical clearance by the Staffordshire University Ethics Committee before commencement. Study 2 was therefore conducted in strict accordance with Staffordshire University ethical guidelines (Appendix 2.1) and a comprehensive information pack (Appendix 2.2) was physically given or sent by email to each participant prior to the questionnaire taking place. The pack included amplifying information about the research, including a participant information sheet, exclusion criteria and a debrief document for signposting to professional mental health services, should the need arise. Inclusion and exclusion criteria for the study, and that was relayed to potential participants in the Participant Information Sheet, can be seen below.

- **Inclusion criteria:**
    - All participants are members of SFRS.
    - Any member of SFRS can be a participant in the study as long as they do not meet the exclusion criteria.
    - Members of SFRS that are 18 years of age, or older.
- **Exclusion criteria:**
    - Members of SFRS that under 18 years of age
    - Members of SFRS that are currently receiving medical treatment for a current mental health-related illness.

SFRS HR Department and Occupational Health Team (including psychological wellbeing) were made aware of the ongoing research, and questionnaire, and offered full support to all participants for the duration of the 12-month study.

### 3.2.2. Participants and context

SFRS was chosen as the participating organisation for Study 2 because they were known, through mutual acquaintances, to be in the planning stages of training a significant number of their personnel in TRiM. The designated TRiM lead at SFRS was keen to support the longitudinal, comparative study as they were interested in gauging how effective the TRiM programme was in addressing key concerns around the psychological and physical challenges staff faced but he was also keen to discover how the implementation of TRiM may vicariously affect others throughout the organisation.

To ensure diversity, equality and inclusivity within the study, as well as attracting a broad cross section of participants within SFRS (i.e., front-line fire and rescue, administrative staff, control room staff, telephone operators, leadership, those newly joined and serving in a probationary position, etc.), the study, and accompanying information pack, was offered to anyone that wished to participate. News of the ongoing research study was promulgated by email and word of mouth throughout the service by the SFRS TRiM lead, all station management, the head of Human Resources and the department of Occupational Health and Wellbeing (hardcopy first round, electronically subsequent rounds).

Once a list of volunteers was obtained, email addresses of interested staff were then sent to the lead researcher either individually or through the SFRS TRiM lead. Anonymity was ensured by the researcher during any subsequent correspondence by issuing each participant with a Unique Participant Number. Initial consent was given by the participant by either completing the paper questionnaire or accessing and completing the online version. Participants were informed of the exclusion criteria, that their participation in the study was

completely voluntary and that they could withdraw at any time without consequence, by simply ceasing to input the data and informing the lead researcher, or SFRS TRiM lead. Initial predictions suggested that up to 80 members of SFRS would participate in Study 2, but the final number of participants was 44. During the study 3 fire officers retired and 4 left the study as 'long term sick', resulting in:

- **Group 1** (Gp1) TRiM trained: 27 Participants (4 females, 23 males). Of the initial 27 participants, 16 completed all four TPs. Of the 16 participants that completed all four timepoints of the study, 2 were female and 14 were male.
- **Group 2** (Gp2) Not TRiM trained: 17 Participants (4 females, 13 males). Of the initial 17 Gp2 participants, 9 completed the first (TP1) and last (TP4) which were used in the limited comparative study with Gp2. Of the 9 participants that completed TP1 and TP4 of the study, 4 were female and 5 were male.

**Participating positions, departments and numbers from SFRS participants that completed the study (*n = 25*):**

- Area Command = 5 (6 started the study)
- Firefighter = 4 (10 started the study)
- Fire Training & Development = 7 (9 started the study)
- Fire & Rescue Ops & Risk = 5 (5 started the study)
- Prevention (HQ) = 0 (1 started the study)
- Operations Control = 4 (11 started the study)
- Crew Manager = 0 (1 started the study)
- Chaplaincy = 0 (1 started the study)

### 3.2.3. Design

This study employed a between (TRiM trained group vs. control group) and within longitudinal design with participants completing measures at four time points across 12 months. To gather

baseline data, the questionnaire was distributed in person at the beginning of each of the three training courses, prior to any TRiM training being undertaken. The three TRiM training courses were delivered to 40 members of the SFRS by an appropriately certified and experienced TRiM provider, which included the lead researcher. It was considered paramount during the planning and design of the training, and the study, that those receiving the training were from a diversified group taking into account gender, ranks / positions, roles, abilities, age and experience.

Due to the nature of the research topic involved, in terms of exploring aspects of potential and actual psychological trauma, safeguarding and the well-being of participants was duly considered from the outset, and the subsequent deployment of questionnaires was held in full accordance with Staffordshire University ethical guidelines (Appendix 2.1).

In order to gain the greatest breadth of biopsychosocio data, a number of measures and scales were employed as part of the longitudinal study. The research questionnaire was designed to encompass a broad range of general health questions, including physical and psychological scales, to explore how people considered their own personal situation, what support they received from or provided to others and how connected they felt towards others, including but not exclusively their organisation.

#### 3.2.3.1 Scales and Measures used in Study 2 questionnaire:

**General Health Questionnaire GHQ12 (Goldberg, 1978)**

*General health* was measured with twelve items. Participants were asked to reflect on the previous few weeks and asked if they had recently: (1) “been able to concentrate on what you’re doing”; (2) “lost much sleep over worry”; (3) “felt you were playing a useful part in things”; (4) ‘felt capable of making decisions about things”; (5) “felt constantly under strain”; (6) “felt you couldn’t overcome your difficulties”; (7) “been able to enjoy your normal day-to-day activities”; (8) “been able to face up to your

problems"; (9) "been feeling unhappy and depressed"; (10) "been losing confidence in yourself"; (11) "been thinking of yourself as a worthless person"; (12) "been feeling reasonably happy, all things considered". This questionnaire is scored from 1 (*better than usual*) to 4 (*much less than usual*) and an overall mean score was used. The questionnaire has been found to be valid and reliable (= .87: Montazeri et al., 2003).

**Warwickshire-Edinburgh Mental Well-being Scale (WEMWBS – University of Warwick & University of Edinburgh, 2006)**

*Mental wellbeing* was measured with fourteen items. Participants were asked whether over the past month: (1) "I've been feeling optimistic about the future"; (2) "I've been feeling useful"; (3) "I've been feeling relaxed"; (4) "I've been feeling interested in other people"; (5) "I've had energy to spare"; (6) "I've been dealing with problems well"; (7) "I've been thinking clearly"; (8) "I've been feeling good about myself"; (9) "I've been feeling close to other people"; (10) "I've been feeling confident"; (11) "I've been able to make up my own mind about things"; (12) "I've been feeling loved/cared for"; (13) "I've been interested in new things"; (14) "I've been feeling cheerful". This questionnaire is scored from 1 (*none of the time*) to 5 (*all of the time*) and an overall mean score was used. The questionnaire has been found to be valid and reliable in previous research (= .83: Tennant et al., 2007).

**Perceived Stress Scale (Cohen, 1994)**

*Perceived stress* was measured with ten items. Participants were asked, in the last month: (1) "How often have you been upset because of something that happened unexpectedly"; (2) "How often have you felt that you were unable to control the important things in your life?"; (3) "How often have you felt nervous and stressed?" (4) "How often have you felt confident about your ability to handle your personal problems?"; (5) "How often have you felt that things were going your way?"; (6) "How

often have you found that you could not cope with all things that you had to do?"; (7) "How often have you been able to control irritations in your life?"; (8) "How often have you felt that you were on top of things?"; (9) "How often have you been angered because of things that happened that were outside of your control?"; (10) "How often have you felt difficulties were piling up so high that you could not overcome them?". This questionnaire is scored from 0 (*never*) to 4 (*very often*) and an overall mean score was used. The questionnaire has been found to be valid and reliable (= .78: Baik et al., 2019).

**Resilience Scale R14 (Gail et al., 1993)**

*Resilience Scale R14 (RS5 & RS12)* is an established, consistent and validated version of the RS-25 questionnaire and was measured with fourteen items. Participants were asked how they would answer about the following endorsements: (1) "I usually manage one way or the other"; (2) "I feel proud that I have accomplished things in life"; (3) "I usually take things in my stride"; (4) "I am friends with myself"; (5) "I feel that I can handle many things at a time"; (6) "I am determined"; (7) "I can get through difficult times because I've experienced difficulty before"; (8) "I have self-discipline"; (9) "I keep / remain interested in things"; (10) "I can usually find something to laugh about"; (11) "my belief in myself gets me through hard times"; (12) "in an emergency, I'm someone people can rely on"; (13) "My life has meaning"; (14) "when I'm in a difficult situation, I can usually find my way out of it". This questionnaire is scored from 1 (*strongly disagree*) to 7 (*strongly agree*) and an overall mean score was used. The questionnaire has been found to be valid and reliable (= .88: Surzykiewicz et al., 2019).

**Berlin Social Support Scale (BSSS – Schwarzer & Schulz, 2013)**

As part of the BSSS six separate measures were used for perceived emotional support, actually received support and actually provided support. This questionnaire is scored

from 1 (*strongly disagree*) to 4 (*strongly agree*) and an overall mean score was used. The questionnaire has been found to be valid and reliable (received support = .93, perceived support = .90, Roomaney et al., 2019).

***Perceived emotional support*** was measured with four items. Participants were asked for the following endorsements: (1) "there are some people who truly like me"; (2) "whenever I'm not feeling well, other people show me that they are fond of me"; (3) "whenever I am sad, there are people that cheer me up"; (4) "there is always someone there for me when I need comforting".

***Perceived instrumental support*** was measured with four items. Participants were asked for the following endorsements: (1) "I know some people upon whom I can always rely"; (2) "when I am worried, there is someone who helps / supports me"; (3) "there are people who offer me help / support when I need it"; (4) "when everything becomes too much for me to handle, others are there to help / support me

***Need for support*** was measured with four items. Participants were asked for the following endorsements: (1) "when I am down, I need someone who boosts my spirits"; (2) "it is important for me always to have someone who listens to me"; (3) "before making any important decisions, I absolutely need a second opinion"; (4) "I get along best without any outside help".

**S*upport seeking*** was measured with five items. Participants were asked for the following endorsements: (1) "in critical situations, I prefer to ask others for their advice"; (2) "whenever I am down, I look for someone to talk to"; (3) "when I am worried, I reach out to someone to talk to"; (4) "If I do not know how to handle a situation, I ask others what they would do"; (5) "whenever I need help / support I ask for it".

***Actually received support*** was measured with fourteen items. Participants were asked how the person closest to them reacts to them in the past week: (1) "the person showed me that he / she loves and accepts me"; (2) "the person comforted me when I was feeling bad"; (3) "the person left me alone"; (4) "the person did not show much empathy for my situation"; (5) "the person criticised me"; (6) "the person made me feel valued and important"; (7) "the person expressed concern about my condition"; (8) "this person assured me that I can rely completely on them"; (9) "this person encouraged me not to give up"; (10) "this person was there when I needed them"; (11) "this person took care of many things for me"; (12) "this person took care of things that I couldn't manage on my own"; (13) "this person helped me find something positive in my situation"; (14) "this person suggested activities that might distract me".

***Actually provided*** *support* was measured with fourteen items. Participants were asked how they interacted with the same closest person to them in the past week: (1) "I showed them how much I cherish / care about and accept them"; (2) "I comforted them when they were feeling bad"; (3) "I left them alone"; (4) "I did not have much empathy for them"; (5) "I criticised them"; (6) "I made them feel valued and important"; (7) "I expressed my concern about their condition"; (8) "I reassured them that he / they can rely completely on me"; (9) "I encouraged them not to give up"; (10) " I was there when they needed me"; (11) "I did a lot for them"; (12) "I took care of daily duties that they could not fulfil on their own"; (13) "I helped them find something positive in their situation"; (14) "I suggested an activity that might distract them".

**Group Identification Scale (Slater et al., 2017)**

*Group identification* was measured with three-items (cf., Haslam, 2004). Participants were asked the extent to which: (1) "you feel a strong connection with the group"; (2) "you identify strongly with the group"; and (3) "you feel no connection with the group" (reverse scored). The Cronbach alpha for this scale was .81. This questionnaire is scored from 1 (*strongly*

*disagree*) to 7 (*strongly agree*) and an overall mean score was used. The questionnaire has been found to be valid and reliable (= .86: Miller et al., 2020)

**Relational Identification (Slater et al., 2017)**

*Relational identification* was measured with three items. Participants were asked the extent to which: (1) "you identify strongly with the group"; (2) "you feel a strong connection with your colleagues in the group"; (3) "you feel no connection with the group" (reverse scored). This questionnaire is scored from 1 (*strongly disagree*) to 7 (*strongly agree*) and an overall mean score was used. The questionnaire has been found to be valid and reliable (= .89: Miller et al., 2020)

**Presenteeism Scale SPS6 (Stanford University School of Medicine and Merck & Co.)** *Presenteeism and absenteeism* were measured with six items. Participants were asked, in the past month: (1) "because of health problem, the stresses of my job were much harder to handle"; (2) "despite health problems, I was able to finish hard tasks in my work"; (3) "my health problem distracted me from taking pleasure in my work"; (4) "I felt hopeless about finishing certain work tasks, due to my health problem"; (5) "at work, I was able to focus on achieving my goals despite my health problem"; (6) "despite my health problem, I felt energetic enough to complete all my work". This questionnaire is scored from 1 (*I strongly disagree with the statement*) to 5 (*I strongly agree with the statement*) and an overall mean score was used. The questionnaire has been found to be valid and reliable (= .82: Bezzina et al., 2023)

During the design phase the number of scales encompassed within the questionnaire was duly considered, as a balanced approach was preferred by the researcher; it was felt that if the questionnaire was too extensive and potentially time consuming that SFRS participants may be discouraged from fully engaging, but after consultation with university supervisors and

importantly speaking with the SFRS TRiM lead, it was decided that a comprehensive approach was preferred.

Once finalised, the first questionnaire was distributed amongst Gp1 participants as a paper copy which was completed prior to the training starting and collected by hand. This happened after each of the three training courses and provided a baseline to the study. Once collated, all data was manually uploaded onto Qualtrics by the lead researcher as Time Point 1 (TP1).

Those within GP2 were sent the questionnaire for TP1 via email. All subsequent questionnaires were sent to both groups electronically via email link to Qualtrics at TP2, TP3 and TP4.

#### 3.2.3.2 Timelines

- TP1: Questionnaire was distributed and completed before the start of each respective TRiM training session by Group 1 (Gp1) in order to get a baseline. Participants that had not completed TRiM training (Group 2 (Gp2)) completed the first questionnaire between the dates of the first and last TRiM course (August).
- TP2: Questionnaire completed by the same participants (both Gp1 and Gp2) roughly four months after TP1 (December / January).
- TP3: Questionnaire completed by the same participants (both Gp1 and Gp2) roughly four months after TP2 (April / May).
- TP4: Questionnaire completed by the same participants (both Gp1 and Gp2) roughly four months after TP3 (August).

### 3.2.4. Data collection

The intention was to collect data from as many completed questionnaires from both groups as possible at each of the four timepoints. Of the 44 participants in the study, 16 of the 27 in Gp1 completed all four TPs.

In Gp2, only 2 participants fully completed questionnaires at all four TPs but as 9 had completed TP1 and TP4 it was decided, by the lead researcher, to run the analysis accepting that the data was incomplete but attempting to use data rather than disregard potentially useful information. Explanations for the low numbers of questionnaire completions include high workloads, a number taking sick leave and early retirements but there is also the factor that members of Group 1 had already volunteered to engage in the TRiM programme and so already had bought in to the whole experience. The study was perceived by some, especially in Group 1, as just part of the ongoing programme whereas for those in Group 2 it may not have been appreciated in the same way. During the collection of data using the Qualtrics survey tool there were a number of uncompleted questionnaires submitted that were registered as returns but were unusable as they did not provide sufficient data (i.e., less than half complete).

### 3.3 Data analysis

The first step of analysis involved transferring data captured on Qualtrics across to IBM SPSS Statistics Data Editor. Data were screened for outliers and normal distribution, and this indicated the presence of eight outliers. In accordance with Chadha et al. (2019) these data points were windsorised, and retained, and shown in Appendix 2.4.

To examine the hypothesis, that those that receive TRiM training and support would benefit, in terms of general health and well-being, stress management and social support in comparison to those that do not receive TRiM, three one-way MANOVAs and a single one-way ANOVA were conducted on Gp1 data to examine changes in variables over time (TP1 vs. 2 vs. 3 vs. 4). This allowed for comparison from before, during, and after TRiM to see if there were any significant increases or decreases, and to address the hypothesis. The same approach was used on Gp2 data but via paired-samples *t*-tests to examine changes in variables from TP1 to TP4, given that there were two timepoints. Descriptive statistics were calculated for all variables, and figures created to show changes from pre- to post-programme.

## 3.4 Results

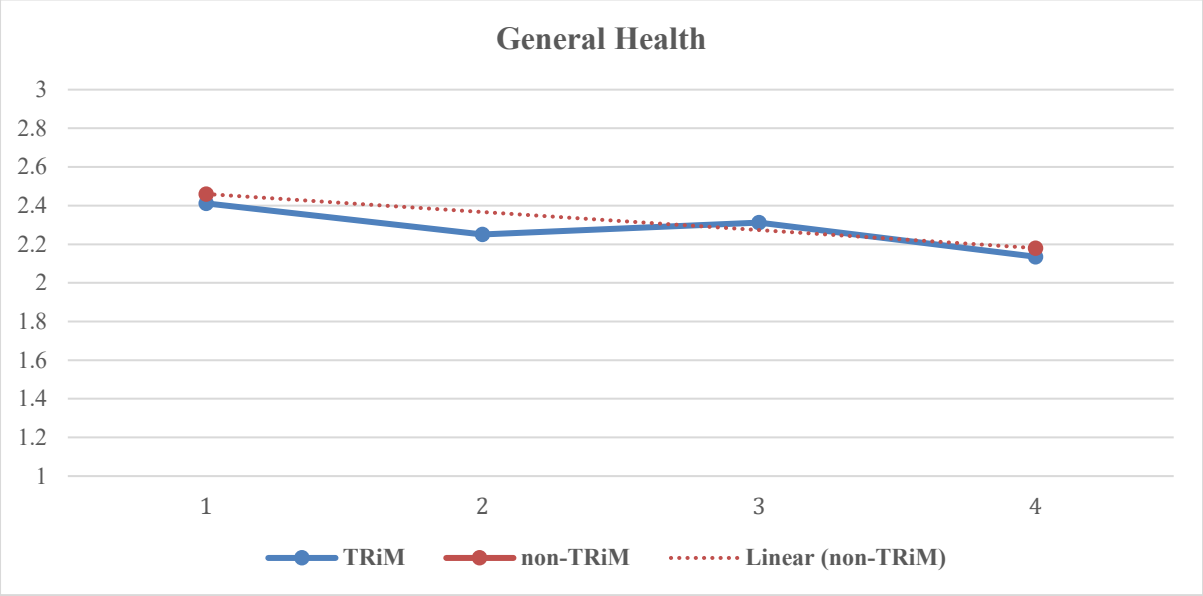
As previously stated, the hypothesis to be tested is that those that receive TRiM training and support would benefit substantially, in terms of general health and well-being, stress management and social support in comparison to those that do not receive TRiM. To test this hypothesis, we used statistical tests across both groups: (1) General Health, Wellbeing, Stress and Resilience, (2) Social Support, (3) Group and Relational Identification and (4) Presenteeism. The headline summary of the study is that overall findings suggest *no significant change*, in terms of the perceived / actual benefits after receiving TRiM training, by Gp1. This could also, however, suggest that TRiM training contributes to the maintenance of required levels of wellbeing during challenging periods or roles. There was also a non-significant increase in individual absenteeism and presenteeism recorded.

In sum, the statistical analyses indicated that there were no significant changes across all variables in both Gp1 and Gp2. In order to provide a visual analysis of the comparison between groups, the recorded data are presented in a graph format using MS XL Spreadsheet. Below, the descriptive data and visual analysis on plotted graphs are presented first, before the statistical tests.

### 3.4.1 General health

With a slight downward variance, the data shows that General Health within the SFRS declined marginally between TP1 and TP4 for both Gp1 and Gp2.

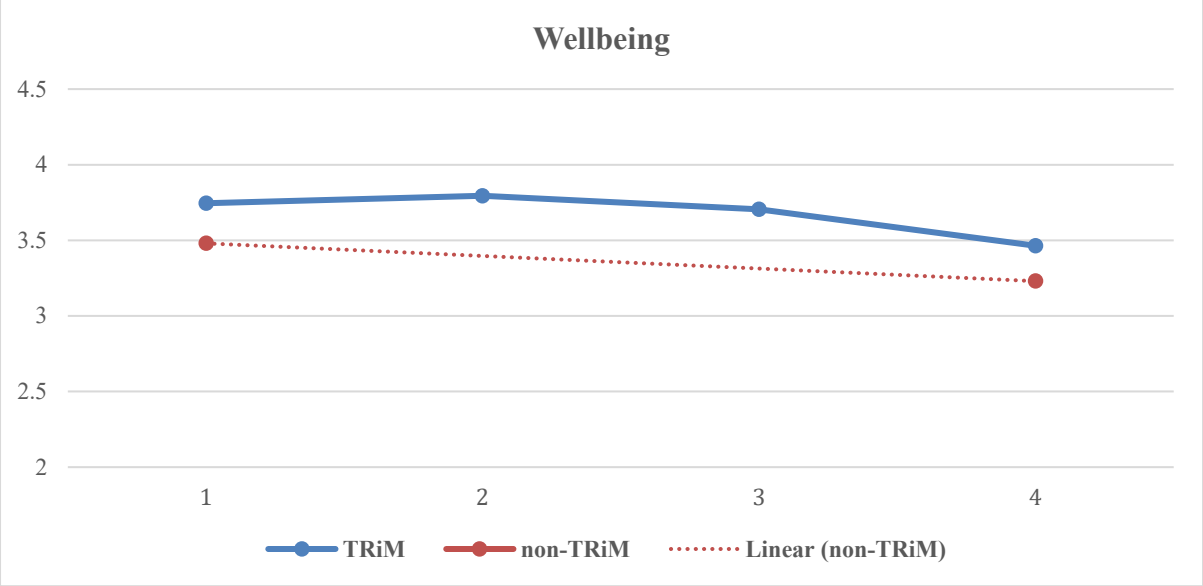
**Figure 3.1: General health:** Questionnaire scored from 1 to 4




### 3.4.2 Wellbeing

In terms of overall wellbeing of SFRS, the data shows a marginal decline in both Gps between TP1 and TP4.

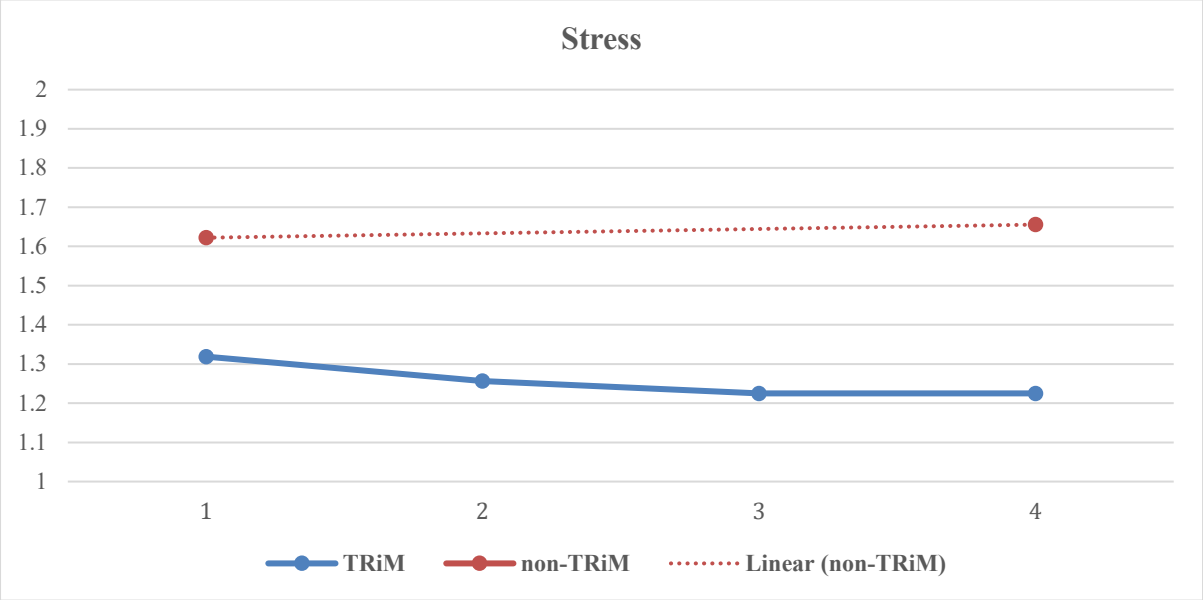
**Figure 3.2: Wellbeing:** Questionnaire scored from 1 to 5



### 3.4.3 Stress

There were minimal differences in levels of stress recorded by both Gps but the stress levels increased minimally in Gp2 and dropped to a small degree over the twelve months in Gp1.

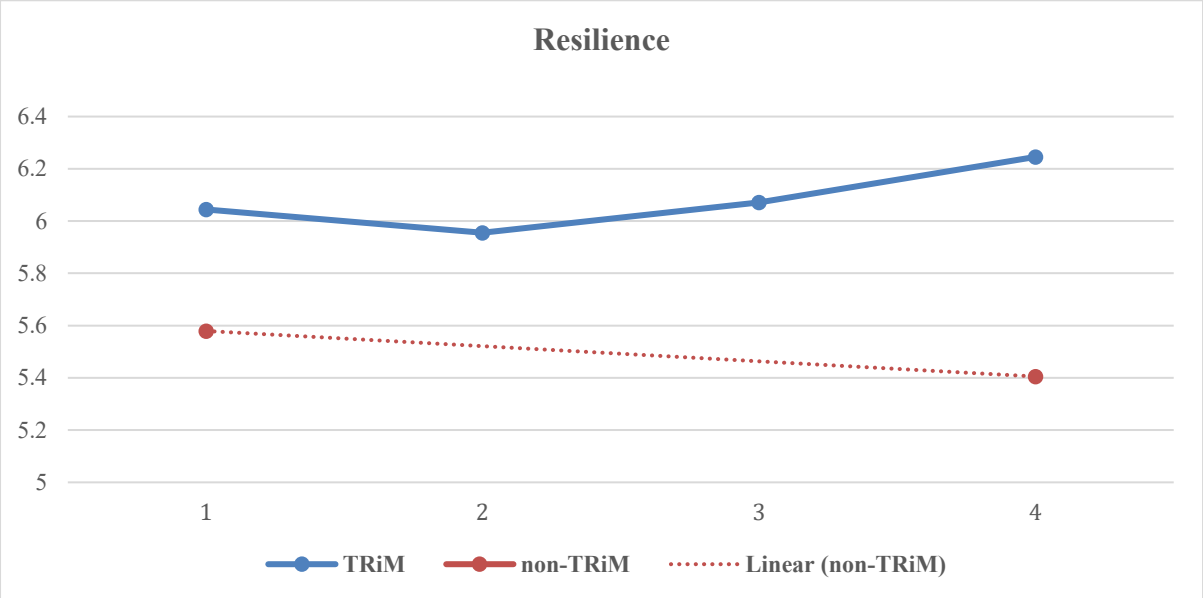
**Figure 3.3: Stress:** Questionnaire scored from 0 to 4




### 3.4.4 Resilience

Comparison between Gp1 and Gp2 shows Gp1's resilience increasing in value and Gp2's resilience decreasing between TP1 and TP4.

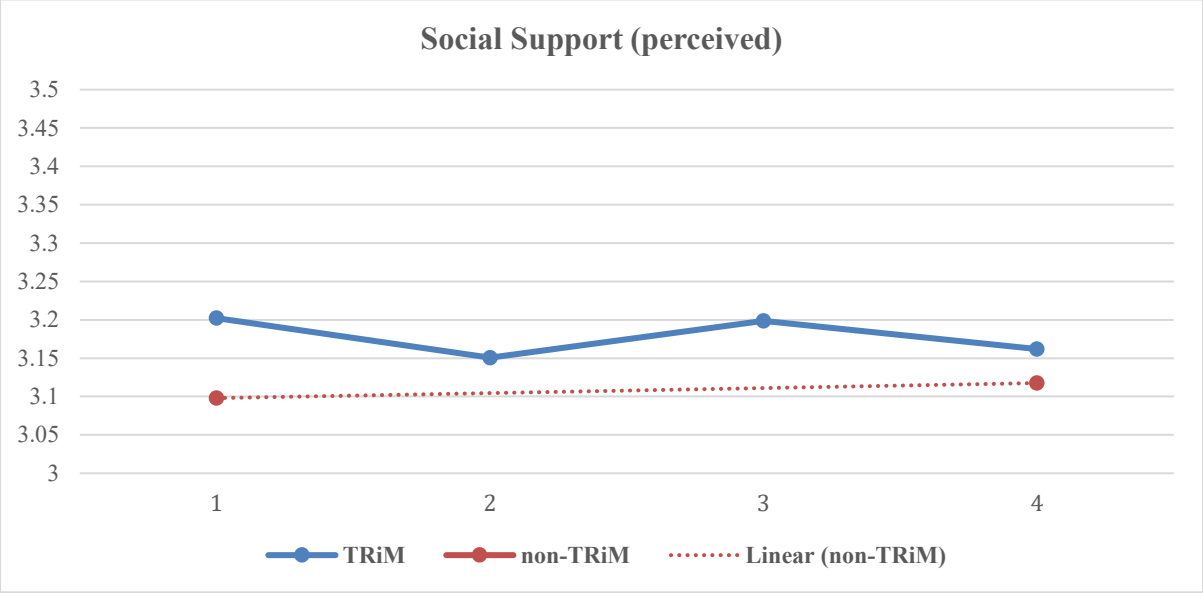
**Figure 3.4: Resilience:** Questionnaire scored 1 to 7



### 3.4.5 Social support

In terms of perceived social support, data recorded shows a minimal decrease for Gp1 and a minimal increase for Gp2 between TP's 1 and 4.

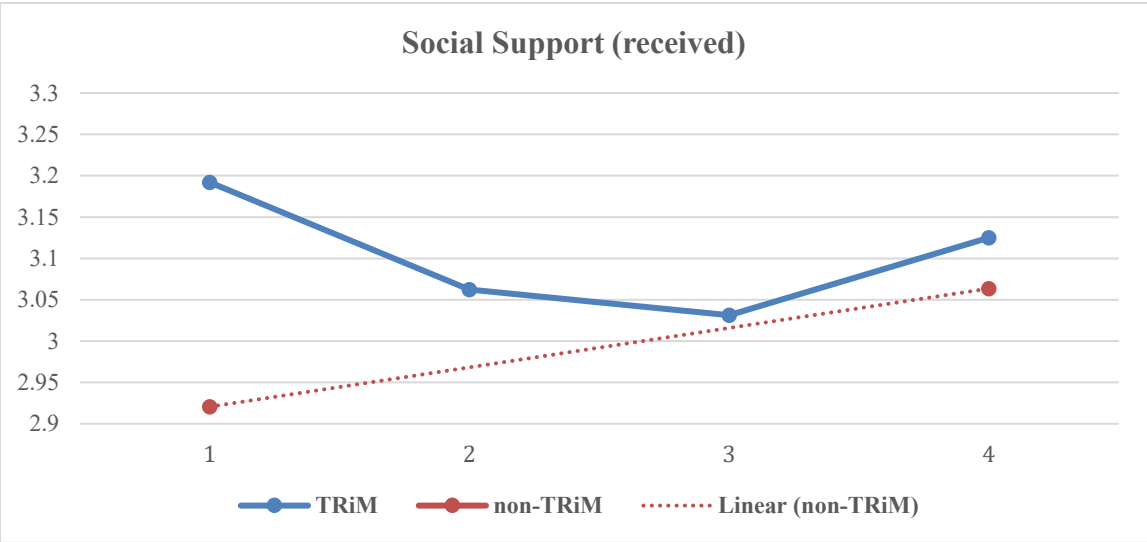
**Figure 3.5: Social support (perceived):** Questionnaire scored 1 to 4




### 3.4.6 Social support (received)

Data recorded for received social support shows an overall, if small, increase for Gp2 between TP1 and TP4. Gp1 show a drop in received social support between TP1, through TP2 and onto TP3. Gp1 data does indicate a rise in received social support between TP3 and TP4 for Gp1.

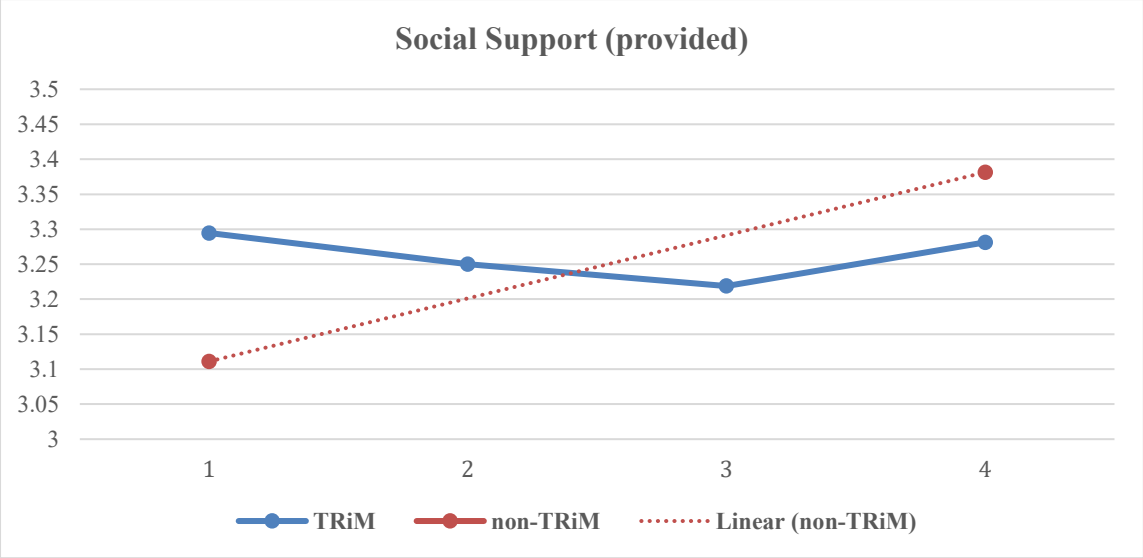
**Figure 3.6: Social support (received):** Questionnaire scored 1 to 4



### 3.4.7 Social support (provided)

Gp1 data shows and consecutive drop between TP1, TP2 and TP3, however there is a rise to TP4. The comparison between Gp1 and Gp2 shows an overall increase for Gp2 and negligible change for Gp1.

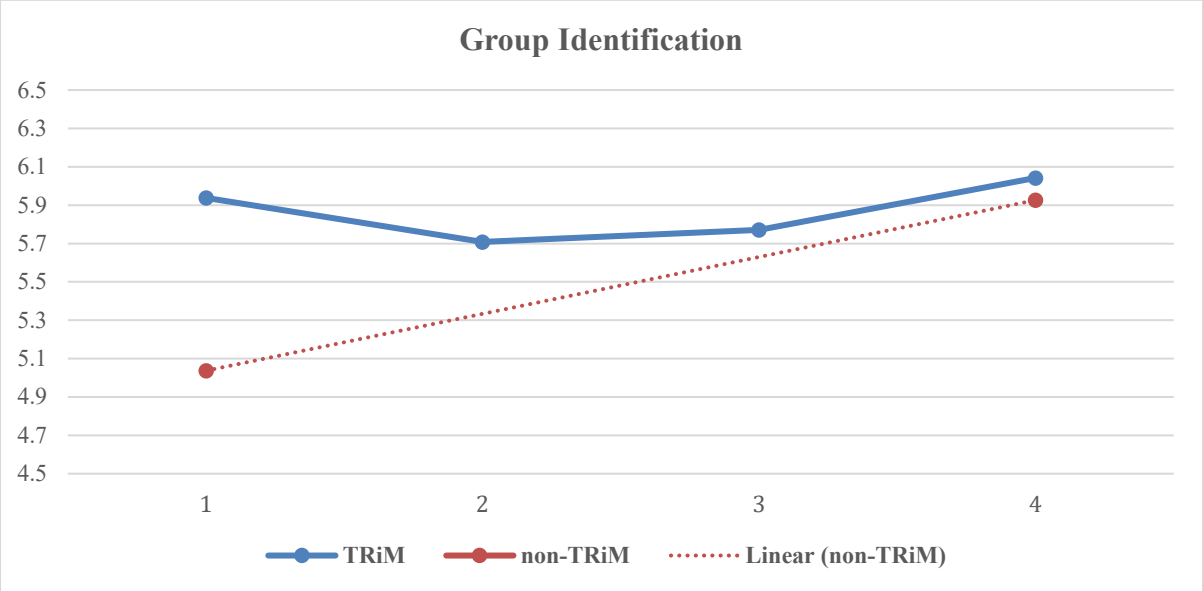
**Figure 3.7: Social support (provided):** Questionnaire scored 1 to 4




### 3.4.8 Group identification

Data shows no overall change in value in terms of Group Identification for Gp1 but Gp2 data indicates a small rise between TP1 and TP2.

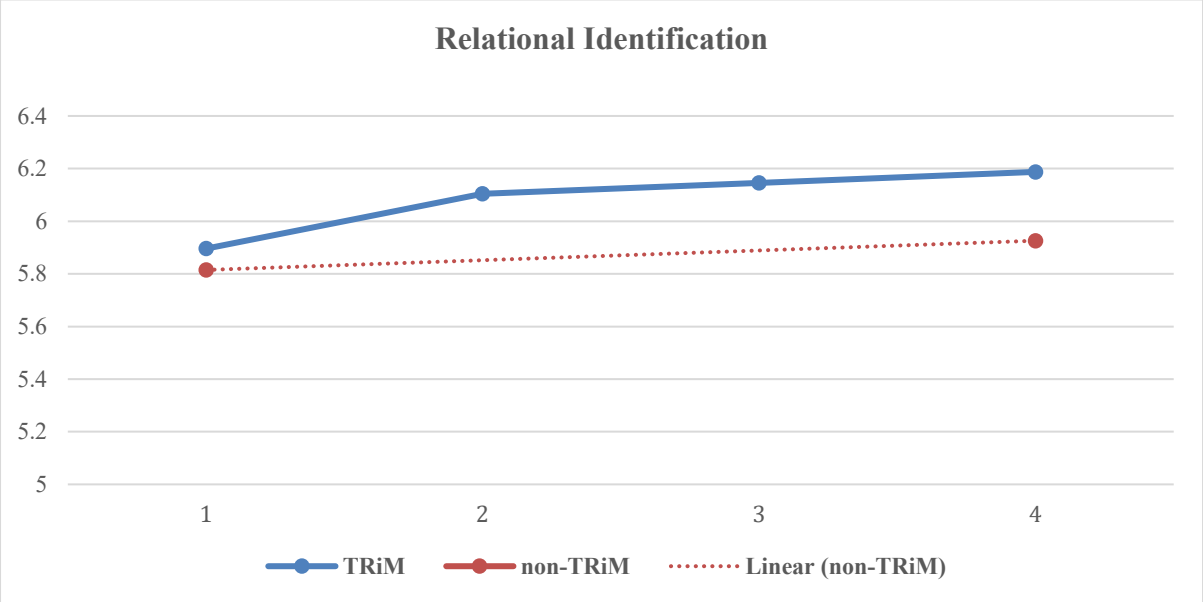
**Figure 3.8: Group identification:** Questionnaire scored 1 to 7



### 3.4.9 Relational identification

Gp1 data shows a slight increase between TP1 and TP2 but levels off through TP3 and TP4. Gp2 data indicates a negligible rise between TP1 and TP4.

**Figure 3.9: Relational identification:** Questionnaire scored 1 to 7




### 3.4.10 Presenteeism

Data recorded shows a contrast between Gp1, whose values raise slightly overall between TP1 and TP4, to that of Gp2 whose data indicates a drop in presenteeism between TP1 and TP4.

**Figure 3.10: Presenteeism:** Questionnaire scored 1 to 5

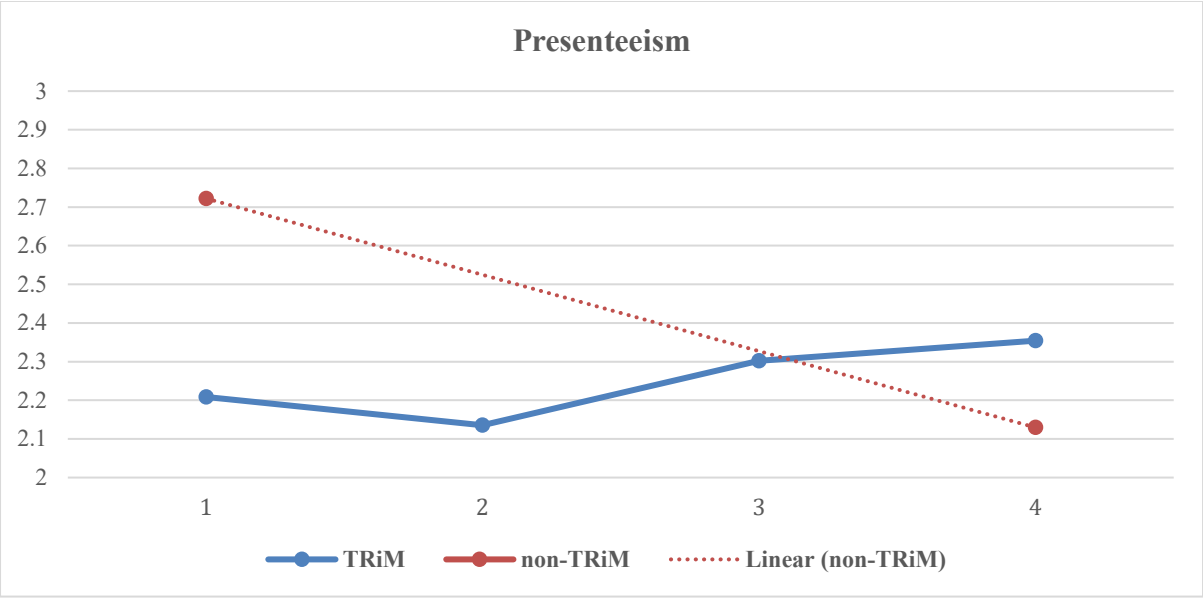


**TABLE 3.1**

**Descriptive statistics (Group 1 TRiM received & Group 2 non-TRiM)**

| Variable | Timepoint | TRiM Mean | TRiM SD | Non-TRiM Mean | Non-TRiM SD |
|---|---|---|---|---|---|
| General Health | 1 | 2.41 | .22 | 2.41 | .22 |
| General Health | 2 | 2.25 | .28 | - | - |
| General Health | 3 | 2.31 | .22 | - | - |
| General Health | 4 | 2.14 | .44 | 2.18 | .46 |
| Wellbeing | 1 | 3.75 | .53 | 3.48 | .56 |
| Wellbeing | 2 | 3.79 | .47 | - | - |
| Wellbeing | 3 | 3.71 | .57 | - | - |
| Wellbeing | 4 | 3.46 | .94 | 3.23 | .91 |
| Stress | 1 | 1.32 | .39 | 1.62 | .65 |
| Stress | 2 | 1.26 | .36 | - | - |
| Stress | 3 | 1.22 | .57 | - | - |
| Stress | 4 | 1.22 | .61 | 1.65 | .59 |
| Resilience | 1 | 6.04 | .54 | 5.58 | .61 |
| Resilience | 2 | 5.95 | .32 | - | - |
| Resilience | 3 | 6.07 | .70 | - | - |
| Resilience | 4 | 6.24 | .53 | 5.40 | 1.04 |
| Perceived Social Support (SS) | 1 | 3.20 | .31 | 3.10 | .36 |
| Perceived SS | 2 | 3.15 | .30 | - | - |
| Perceived SS | 3 | 3.20 | .30 | - | - |

| | | | | | | |
|---|---|---|---|---|---|---|
| Perceived SS | 4 | 3.16 | .29 | 3.12 | .46 | |
| Received SS | 1 | 3.19 | .37 | 2.9 | .46 | |
| Received SS | 2 | 3.06 | .20 | - | - | |
| Received SS | 3 | 3.03 | .41 | - | - | |
| Received SS | 4 | 3.12 | .33 | 3.06 | .66 | |
| Provided SS | 1 | 3.29 | .25 | 3.11 | .37 | |
| Provided SS | 2 | 3.25 | .21 | - | - | |
| Provided SS | 3 | 3.22 | .29 | - | - | |
| Provided SS | 4 | 3.28 | .27 | 3.38 | .42 | |
| Group Identification (GI) | 1 | 5.94 | .85 | 5.04 | 1.29 | |
| GI | 2 | 5.71 | .62 | - | - | |
| GI | 3 | 5.77 | .80 | - | - | |
| GI | 4 | 6.04 | .68 | 5.92 | .64 | |
| Relational Identification (RI) | 1 | 5.89 | .60 | 5.81 | .87 | |
| RI | 2 | 6.10 | .58 | - | - | |
| RI | 3 | 6.14 | .61 | - | - | |
| RI | 4 | 6.19 | .59 | 5.92 | .81 | |
| Presenteeism | 1 | 2.21 | .59 | 2.72 | .56 | |
| Presenteeism | 2 | 2.13 | .64 | - | - | |
| Presenteeism | 3 | 2.30 | .64 | - | - | |

| | | | | | |
|---|---|---|---|---|---|
| Presenteeism | 4 | 2.35 | .84 | 2.13 | .89 |

**Gp1. TRiM trained:**

**General Health, Wellbeing, Stress, and Resilience.**

A one way (TP1 vs. TP2 vs. TP3 vs. TP4) repeated measures multivariate analysis (MANOVA) indicated a non-significant change in general health, wellbeing, stress, and resilience, Wilks' Lambda = .18, $F$ (4, 12) = 1.48, $p$ = .378. Please see Table 2 for all descriptive statistics.

**Social Support.**

A one way (TP1 vs. TP2 vs. TP3 vs. TP4) repeated measures MANOVA indicated a non-significant change in perceived, received, and provided social support, Wilks' Lambda = .61, $F$ (9, 7) = .49, $p$ = .840.

**Group and Relational Identification.**

A one way (TP1 vs. TP2 vs. TP3 vs. TP4) repeated measures MANOVA indicated a non-significant change in group or relational identification, Wilks' Lambda = .54, $F$ (6, 10) = 1.42, $p$ = .296.

**Absenteeism and Presenteeism.**

A one way (TP1 vs. TP2 vs. TP3 vs. TP4) repeated measures analysis of variance (ANOVA) indicated a non-significant change in presenteeism, $F$ (3, 45) = .45, $p$ = .720.

**Gp2. Not TRiM trained:**

**General Health, Wellbeing, Stress, and Resilience.**

A one way (TP1 vs. TP4) repeated measures MANOVA indicated a non-significant change in general health, wellbeing, stress, and resilience, Wilks' Lambda = .22, $F$ (4, 5) = 4.45, $p$ = .066. Please see Table 3 for all descriptive statistics.

**Social Support.**

A one way (TP1 vs. TP4) repeated measures MANOVA indicated a non-significant change in perceived, received, and provided social support, Wilks' Lambda = .46, $F$ (3, 6) = 2.38, $p$ = .168.

**Group and Relational Identification.**

A one way (TP1 vs. TP4) repeated measures MANOVA indicated a non-significant change in group or relational identification, Wilks' Lambda = .51, $F$ (2, 7) = 3.34, $p$ = .096.

**Presenteeism.**

A repeated measure (TP1 vs. TP4) $t$-test indicated a non-significant change in presenteeism, $t$ (8) = 1.62, $p$ = .144.

### 3.5. Discussion

The main purpose of Study 2 was to build on the findings of Study 1 and conduct exploratory longitudinal analysis of a workforce, Shropshire Fire and Rescue Service (SFRS), over a 12-month period to determine if TRiM was not only suitable to provide effective structured support following potentially traumatic events but also to address the General Dimensions identified in Study 1 and be used for supporting in more general terms other professions and organisations that routinely operate in challenging environments.

The research question therefore asked:

*'Does TRiM training and support improve general health and wellbeing, resilience, stress management and social support in UK emergency service personnel compared to those that do not receive TRiM training and support?'*

The assumption, based on the findings of Study 1, as well as previous findings from military studies (Greenberg et al., 2005), was that those that receive TRiM training and support would benefit substantially, in terms of general health and well-being, stress management and social support in comparison to those that do not receive TRiM. The results from study 2 however did not support the hypotheses as the individuals who received TRiM did not report

significant improvements in any variable assessed, including general wellbeing, resilience, stress, social support, and presenteeism.

Study 2, therefore, set out to test this assumption / hypothesis by conducting a longitudinal quantitative analysis, to explore the bio-psycho-social benefits and overall wellbeing of a division of UK's emergency services, namely Shropshire Fire and Rescue Service (SFRS), following the implementation of TRiM. Interestingly, even though the quantitative data gathered during Study 2 suggested insignificant changes in all variables, subsequent anecdotal evidence did suggest a reduction in attached stigma and that it is often the older, more experienced officers that started to actively encourage the use of TRiM.

Like all UK fire and Rescue Services, SFRS aspires to ensure a positive and diverse working culture and follows advice provided by the National Operational Guidance Programme. In these services, training and development are considered top priorities, encouraging an environment of openness, learning and trust. TRiM now sits within this framework in terms of provision of required skills and methodologies within SFRS with the aim of maintaining high levels of performance whilst providing suitable support for the general health and wellbeing of all staff, which is also in line with both NICE and UKPTS guidelines.

Absenteeism was not necessarily seen as an acute problem within SFRS but managing levels of stress and resilience were viewed by the SFRS TRiM lead as key factors in terms of reducing, or at least keeping a mindful eye on, organisational presenteeism.

It could, of course, be suggested that the implementation of TRiM within SFRS did lead to the maintenance of expected performance levels during an extremely busy 12-month period. At worse the introduction of TRiM did not appear to do any harm which supports Watson's (2018) much larger study ($n$ = 859) that found no detrimental effects of using TRiM. Watson's questionnaire included measures of PTSD symptomatology, depression, attitudes to stress and PTSD, barriers to help-seeking, self-stigma and public-stigma, and post-traumatic

psychological change. The results from his study showed that those that had received TRiM training, like Gp1 in study 2, reported lower levels of psychological distress than the non-TRiM group (like Gp2). Furthermore, the TRiM trained group demonstrated less stigmatised views towards experiencing mental health difficulties, perceived fewer barriers to help-seeking, and reported greater positive psychological change following adversity, than the non-TRiM trained group.

Study 2 concluded that TRiM provided negligible benefit to improving the overall general health and wellbeing and reducing stress within both Focus Groups of the SFRS, certainly within the first 12 months of implementation. Interestingly, in Watson's study, there were no significant differences between the two groups' attitudes towards PTSD and stress.

All TRiM trained practitioners, contained within Gp1, previously volunteered for the role and saw it as a previously proven approach to supporting colleagues following challenging, potentially traumatic, incidents or following the accumulation of such factors over time. Through discussion, during the TRiM training programme, they also saw TRiM as an effective way of raising their own awareness and having the ability to recognise the signs and symptoms in themselves as well as others.

The 'can do attitude' of staff, on a general basis, may also be a significant contributing factor when considering a slight rise acknowledged presenteeism during the study as these individuals may feel more obligated to turn up on their shift to support colleagues and provide the service. Participants of Study 2 were all members of SFRS and either employed in a full time or part time capacity. The study ensured diversity, equality and inclusivity and attracted a broad cross section of participants within SFRS (i.e., front-line fire & rescue, administrative staff, control room staff, telephonists, leadership, those newly joined and serving in a probationary position, etc.). Throughout the 12-month period of the study these participants maintained active roles and responsibilities involving many operations, which challenged all

at some stage either physically, emotionally and / or mentally. During the study a number of officers either retired or left the study, which in some ways demonstrates the relentless pressures faced by members of the emergency services but interestingly this occurrence was not considered unusual by other staff at the time.

In terms of the practicalities of facilitating the study at SFRS, management of Study 2 was directed by the lead researcher who liaised directly and regularly with the SFRS TRiM lead. This relationship was essential in ensuring participants were able to find / use on duty time to complete questionnaires at the designated TPs. The designated TRiM lead at SFRS was keen to support the longitudinal, comparative study as he was interested in gauging how effective the TRiM programme was in addressing key concerns around the psychological and physical challenges staff faced. Along with the wider SFRS organisational leadership, he was also keen to discover how the implementation of TRiM may vicariously affect others throughout the organisation. It was hoped it would.

From the outset, Study 2 was considered an ambitious study by the lead researcher as it involved participants, who were all volunteers, from a fully operational fire and rescue service, with participants expected to complete the questionnaire at four specific timelines, even during busy or heavy workloads.

After initial discussions help with key figures within SFRS the lead researcher optimistically hoped that up to 80 members of SFRS would participate in Study 2. The final number of 44 participants completing the study, however, was viewed as creditable by the wider research team, considering pace of work / life of those involved. It should be noted that although the overarching aim of Study 2 was to highlight ways to improve the wellbeing of emergency personnel, the last thing the researcher wanted was to be a hinderance or unnecessarily distraction, potentially upsetting the current effectiveness of an extremely professional organisation doing its best in a dynamically demanding role. To that end, no

unwarranted pressure was added through the pestering of participants by the SFRS TRiM lead although an email was sent to all participants as a reminder of the questionnaire prior to each TP. On reflection, although this 'light touch' approach was considered suitable at the time, it may well have led to those in Gp2, and who arguably had less actual 'buy in' or commitment to the study as they hadn't received the TRiM training, obliging less frequently than perhaps those of Gp1. Here, only 9 of the initial 17 Gp2 participants completed TPs 1 and 4, affording only a limited comparison with Gp1. This may suggest that those Gp1, who received TRiM training, felt more invested in by the organisation that those in Gp2 and that the vicarious bio-psycho-socio benefits of TRiM may not have been as initially effective as hoped for by the SFRS TRiM lead and wider SFRS management / leadership.

### 3.6 Limitations

The study had numerous limitations in aiming to gain data from a busy operational fire and rescue service unit over a prolonged period. This was substantiated with the leaving of seven participants, 3 due to early retirement and 4 who were placed on long term sick largely due to the effects of stress, fatigue and burnout often associated with the nature of the work and lifestyle of emergency services (Duran, *et al*, 2018)

As highlighted, 16 participants from Gp1 completed all four TP's but only 2 from Gp2 completed all 4 TP's. These figures meant that detailed comparative analysis was not possible, but as 9 from Gp2 had completed the first TP (1) and the last TP (4) it was decided to run the analysis on the premise that all data has some use. In this case, the fact that 9 Gp2 participants had completed the first TP it allowed us to see recorded data at the beginning of the study and as the same 9 had completed the final TP, it meant that we could see the data recorded 12 months later, or simply view a start and finish point and note the variance. It is, however, noted that the analysis between the two groups cannot be considered detailed analysis but it does provide some indication.

Although organisationally SFRS were wholly supportive of the study, they were rightly not at liberty to intervene or influence participants completion of each questionnaire as it was entirely voluntary, unless it was negatively affecting their work routines. This approach was encouraged by the researcher as the full list of participants [names] taking part in the study remained anonymous to everyone outside the immediate research group, namely lead researcher and supervisor, including the SFRS TRiM lead. Reminders of deadlines were issued to participants by the lead researcher at key times, but these were more of prompts rather than instructions.

The length and content of the questionnaire was comprehensively thought through at length by the research group and the SFRS TRiM lead, who in turn sought feedback from a number of senior TRiM practitioners, to test suitability of questions and scales, before commencing the study. That said, in hindsight the questionnaire may have been shorter, but it is understood that does not necessary guarantee that participant completion numbers would have been higher.

For the duration of the study, all correspondence between SFRS and the researcher was done via phone or email as there was significant distance between the two participating parties. It is believed that this had little, if no, effect on the collection of data as it was all completed online.

### 3.6.1 Future research ideas

Results from Study 2 suggest that there was no significant change for Gp1 (those that had received TRiM training) in terms of any discernible / noticeable related benefits to receiving TRiM training, although, it arguably contributed to maintaining levels of performance during a busy 12 months.

That said, anecdotal evidence from participants of the study, following a 6-month period of ‘bedding in’, suggests that the implementation of TRiM has subsequently led to a

positive cultural change within the service, with the way that challenging incidents are managed in order to cater for the overall physical and psychological wellbeing of staff as well as maintain levels of performance as two examples.

An idea for Study 3 would be to conduct a study of organisations that have used TRiM over a protracted period, or a number of years, to determine how TRiM has fared. It would also be useful to gain data on certain timescales, such as how long does it take before the benefits of TRiM are seen or what parts of TRiM (education or assessment for example) are perceived as most useful.

### 3.6.2 Applied implications

As mentioned previously, the study suggests that the vicarious benefits of TRiM were not initially evident, demonstrated perhaps by lack of contribution by Gp2 participants. Six months on, however, the cited cultural change may suggest that the benefits of TRiM followed its operationalisation or activation, where elements of it were intertwined into current practice such as adding TRiM's normalisation brief into post operational de-briefings. Another example is where TRiM has been made obligatory to all junior firefighters during their probationary period following fatalities, which again spreads knowledge and awareness, not only to those directly involved but to colleagues and wider members of the organisation. Time pressures are also often cited as being one of the main factors when establishing TRiM programmes and infrastructures within demanding organisations.

TRiM training is routinely run over two days but there is suggested merit in running half or one day TRiM awareness programmes which can be delivered to more people / staff as there is less practical assessment involved.

## 3.7 Conclusion

The overarching aims of this quantitative study, and to address the wider purpose of the thesis was to build on the General Dimensions identified in Study 1 by firstly conducting further

exploratory longitudinal analysis of a unit of SFRS to determine if TRiM provided overall biopsychosocial benefits and wellbeing (Aim 2 of the thesis), and secondly conducting an integrated comparative study between those that received TRiM training and a control group (Aim 3). The research question therefore asked: *'Does TRiM training and support improve general health and wellbeing, resilience, stress management and social support in UK emergency service personnel compared to those that do not receive TRiM training and support?'*

Although it was anticipated that there would be significant benefits associated with employing TRiM at SFRS, Study 2 concludes that TRiM, in its present format, currently provides negligible benefit to improving the overall general health and wellbeing and reducing stress within a member of the UK's Emergency Services, namely SFRS, certainly within the first 12 months of implementation. The study, however, does not suggest that TRiM is not an effective tool or methodology for supporting those following a PTE. If the limited comparison with Gp2 is made then there appears to be slight overall benefit to receiving TRiM training between Gp1, who received TRiM training, over Gp2, who did not. This, however, is only a limited comparison and so it should be deducted that there was actually 'no change' between the two groups. It could be suggested that the implementation of TRiM within SFRS did lead to the maintenance of expected performance levels during an extremely busy 12-month period. At worse the introduction of TRiM did not appear to do any harm.

Furthermore, anecdotal evidence gleaned from SFRS six months after the completion of the study, and eighteen months after initial TRiM training and implementation, suggests that TRiM is starting to have a positive impact on the health and wellbeing of its force as well as reported general reduction of absenteeism and presenteeism. This could suggest that it can take time for the full benefits of TRiM to be recognised and felt across busy organisations. The study may indicate that TRiM does not typically cater for everyone, especially in terms of

helping them manage their challenging, potentially traumatic, experiences, at that time. It may also suggest that it takes time for TRiM practitioners and TRiM managers to operate effectively in such challenging settings and perhaps overcome the 'unspoken about' stigma attached with receiving psychological support. Perhaps that belief in one's abilities to overcome adversity is required.

The delayed cultural change may be somewhat expected in the dynamic environment of the fire and rescue services, but it may suggest further research / studies into how TRiM affects other organisations over time that operate in other challenging environments, where staff are routinely placed in potential harm's way, would be useful. Therefore, in the next chapter, the study will explore the perceived effectiveness of TRiM across multiple organisations that operate in challenging, potentially traumatic, environment.

# CHAPTER FOUR:

# STUDY 3: A QUALITATIVE STUDY EXPLORING THE PERCEIVED EFFECTIVENESS OF THE TRAUMA MANAGEMENT PROGRAMME 'TRIM' ACROSS MULTIPLE ORGANISATIONS THAT OPERATE IN CHALLENGING, POTENTIALLY TRAUMATIC, ENVIRONMENTS.

## 4. 1 Introduction

In line with guidance offered by UK Psychological Trauma Society (UKPTS) outlined in Chapter one, it seems sensible that formulation of an effective resilience and potential trauma management plan is required by organisations that operate in challenging, potentially traumatic,environments, both from a legal and moral point of view as well as for maintaining levels of performance. Excessive stress and poor psychological health, often associated with working in such challenging environments, are also recognised in UK as two of the most recurrent causes of sickness absence (Office of National Statistics (ONS), 2017).

The TRiM model, supported by UKPTS, and which complies with the National Institute for Health and Care Excellence (NICE) guidelines (2018) and that offers a pragmatic and structured approach to operating in such environments has gained popularity amongst other organisations who acknowledge that not all reactions to potentially traumatic events require clinical intervention. Some of these organisations, many of them with hierarchal management or leadership approaches, typically include the police, fire and rescue service, the ambulance service (including air ambulance) and increasingly the NHS, which has seen increased interest in TRiM since the outbreak of the COVID 19 pandemic. With unprecedented increases in global mental health conditions (Xiong et al, 2020), other, less-typical, organisations, such as teaching and education, law, social care and veterinary services are now starting to see benefits of implementing peer supporting approaches, such

as TRiM, in boosting organisational resilience.

However, social distancing restrictions associated with the COVID-19 pandemic has demonstrated that flexibility in the approach to delivery of current medical or psychological interventions may require further deliberation in going forward. Even though TRiM is not a clinical intervention, it does encompass potentially sensitive discussions that require careful consideration not only in terms of supporting those requiring assistance but also to the TRiM practitioner. It should also be reaffirmed that TRiM is typically run or facilitated on top of an organisation's normal routine with the majority of TRiM practitioners, managers or leaders holding the position in a voluntary role, not as mental health professionals but part of a TRiM trained team that provide peer-based support as part of the wider TRiM programme.

The results from study 1 highlighted, firstly, in order to mitigate risk factors associated with working in challenging, potentially traumatic environments there are a number of perceived requirements such as effective social support, both from an individual and organisational perspective (social ecosystems), all highlighted within Study 1 General Dimensions (GD). In such circumstances, people need to feel cared for, knowing that if something unfavourable was to happen to them in their line of work, that the relevant people and organisations would support them. Porges (2017) suggests that people need to at least feel a degree of safety, if not physically then psychologically, in order to operate and function effectively in such environments, which is a view reinforced in Study 1:

> *"Regarding mental health or mental wellness, I will always choose to speak to my friends first. For me, and I appreciate that everybody is different, speaking to my friends or team members is my decompression it's the way that I release stress and tension in life and on operations. That's how it works for me"* (Ben, Study 1)

Secondly, the study emphasised the requirement for some form of effective resilience (including trauma) informing, [biopsychosocio] education and support within such potentially testing disciplines that could be considered challenging and potentially traumatic, of which we have discovered through the COVID 19 pandemic, there are many. This, if nothing else, allows a degree of normalisation in terms of understanding of the natural effects on the human body during challenging times.

The COVID 19 pandemic has further underlined the need for wider effective potential trauma informing education, especially where people voluntarily put themselves in potential harm's way for the benefits of others. Working on what is now commonly termed the '*Frontline'* is now not only reserved for the military, emergency services or the NHS. Frontline workers, that have most often purposefully put themselvesin potential harm's way include care home employees, council workers and supermarket staff. In such communal environments, where (wide ranging) indistinct levels of physical and cognitive performance are often required during challenging periods, social support, shown through understanding and commitment to one another, is considered vital to high-level functionality as well as personal development and growth (Joseph & Linley, 2006).

The most recent studies by the likes of Bonanno (2022) provide evidence that most individuals who are exposed to challenging situations, even to the extent of being in one of the New York Trade Centre towers during the 2001 attacks, possess sufficient personal resolve or resilience to process the associated challenges and move on in life, in some form of meaningful way. It is widely known that following significant and potentially traumatic events some may suffer temporary distress, which often settles in the first few weeks or months (Shalev, 2002) but most people do not suffer long term negative psychological effects. However, some people do, and may go on to, develop some form of mental or psychological health issue (including but not limited to PTSD) that require medical intervention such as

TFCBT or EMDR for instance. Research, however, has shown that personal resilience is more common than once thought and is often underestimated following trauma or loss (Bonanno, 2004).

Although compliant with the NICE guidelines and supported by UKPTS, research on the actual effectiveness of TRiM is limited, having predominantly been conducted within the UK armed forces (Greenberg, *et al*, 2005, Frappell-Cooke, *et al*, 2010). There is, however, less credible data regarding the use and effectiveness of TRiM in other areas such as the emergency services (Whybrow et al., 2015) or Healthcare. For example, TRiM is employed across numerous NHS Trusts, and although anecdotal evidence is available referring to its effectiveness, there is currently limited empirical data to show its efficacy and value in a wider setting. This is particularly pertinent especially when considering the psychological needs of healthcare staff during the coronavirus pandemic (Highfield et al., 2020).

The purpose of Study 2 was to build on the findings of Study 1 and explore if TRiM was not only suitable to provide effective structured support following potentially traumatic events but also to address the General Dimensions identified in Study 1 and proactively influence performance resilience on a more universalscale ranging from individual general health and wellbeing to organisational presenteeism.

Given the very nature of the emergency services unpredictable day to day activities, the study aimed to provide an exploratory longitudinal analysis of a unit of Shropshire Fire and Rescue Service (SFRS). The quantitative study was conducted over a 12-month period using an anonymous online questionnaire utilising the Qualtrics Survey Tool. To ensure diversity and inclusivity, the questionnaire was offered to all SFRS officers and staff who fell into either one of two distinct groups; those that had conducted a TRiM practitioner training course and those that had not.

Subsequent analysis of the 12-month longitudinal study concluded that TRiM

provided negligible, immediate benefit to improving the overall general health and wellbeing and reducing stress within SFRS. What is worthy of noting however, in the period since the questionnaire was completed, and after a period of embedding, anecdotal evidence suggests that the implementation of TRiM has led to significant cultural change at SFRS including raised awareness, improved functionality and proceduralism and the unit has also seen a drop in presenteeism.

Therefore, it was proposed that creating an opportunity for those that routinely use TRiM from other organisations to offer amplifying feedback, information, opinions and views from a wide rangeof experiences would be extremely useful in improving the implementation and overall effectiveness of TRiM across organisations that may require or provide regular, non-clinical support for its workforce in helping it function proficiently whilst ensuring a charter for health and well-being.

Study 3, consequently aimed to build on Studies 1 and 2 by creating an opportunity for those that are / were routinely involved in the use TRiM (TRiM practitioners, managers / coordinators, Leaders) to offer feedback and amplifying information, opinions and views from a wide range of sectors and experiences (Aim 4 of the thesis). A series of Focus Group discussions were conducted to explore further the actual effectiveness of TRiM and, if / where suitable, suggest updates and enhancements to be made to its implementation aiding its long-term utility.

The individuals who took part in the research were recruited due to their profession, working or operating in challenging, potentially traumatic, environments, which were diverse and perhaps unorthodox in terms of people's perceptions of what a challenging environment may be, (i.e., they were not necessarily members of the armed forces or emergency services).

Given the lack of qualitative research on TRiM, it was proposed that Study 3 would

focus on qualitative experiences and would prove useful in appraising an inconclusively proven and credible model in similar sectors and organisations that also require regular, non-clinical support in helping it function proficiently. Study 3 therefore set out to answer the question: *In exploring TRiM's efficacy in organisations that operate in challenging, potentially traumatic environments, what are the perceived benefits, drawbacks and recommendations to be considered for its wider use in more general settings?*

## 4.2 Methodology

### 4.2.1 Participants

Due to the ongoing unpredictable nature of the restrictions and limitations caused by COVID 19, and in particular the effect that this was having on the target group of participants (i.e., dealing with organisational / individual resilience and potential overwhelm and trauma) it was decided by the researcher that the approach to this study would be pragmatic and manageable, rather than unwieldy and potentially unachievable.

The participants (see Table 4.1), of which 4 were female and 7 were male, and whose ages ranged from 40 – 60, offered a wealth of experience. Some had experience and expertise in one of the principal categories, while the majority had experience in all; 11 being TRiM trained Practitioners or former Practitioners, 10 being TRiM trained Managers or former Managers and 7 holding the position of TRiM trained Coordinator or former Coordinator / Lead. Representative organisations amongst participants included: private healthcare providers, UK emergency services (police, fire and rescue services, private / charity led paramedics / air-ambulance teams), the law society, government services, and international disaster relief and recovery. Nine of the participants (TRiM Practitioners, 8 Managers and 5 Coordinators) involved in this study fulfilled their TRiM roles in a voluntary capacity in addition to their regular paid role. A number of the participants ($n$ = 2) were however solely fulfilling a paid TRiM role, which were both in a TRiM Manager or Coordinator role.

**Table 4.1**

**Participants, organisations and TRiM experience**

| Pseudonym | Organisation | Role |
|---|---|---|
| Amanda | Former Police (UK) | Former TRiM Practitioner and Manager, Coordinator (Female) |
| Andrew | Cross-sector | Current TRiM Practitioner, Manager, Coordinator, instructor (Male) |
| Daniel | International Disaster Search & Rescue | Former TRiM Practitioner and Manager (M) |
| Alan | UK Paramedicine / air-ambulance (private / charity) | Current TRiM Practitioner and former TRiM Manager (M) |
| Stephen | Fire & Rescue Service (UK) | Current TRiM Practitioner, Manager and Coordinator (M) |
| Nick | UK Government Service | Current TRiM Practitioner, Manager, Coordinator and Instructor (M) |
| Sara | UK Private health sector support | Current TRiM Practitioner and Manager (F) |
| Clive | UK Mental Health Charity | Current TRiM Practitioner, Manager and Coordinator (M) |
| Rebecca | UK Law (Barrister) | Current TRiM Practitioner, Manager and Coordinator (F) |
| Karen | Former NHS Nurse | Current TRiM Practitioner, Manager and Coordinator (F) |

| | | |
|---|---|---|
| Pamela | UK Military Charity | Former TRiM Practitioner and Instructor (F) |

### 4.2.2 Design

The concept of the study was to explore the wider efficacy of TRiM by bringing a wide-ranging variety of individuals together with extensive experience of using TRiM. Due to the COVID 19 restrictions in place at the time, it was felt by the researcher that an online, synchronous FG approach was preferable to individual interviews, as it was bringing TRiM professionals together who had been on similar, or the same, journey and that could converse and facilitate rich conversations (Kitzinger, 1994).

A series of FGs were designed to facilitate constructive discussions surrounding the merits, shortfalls and difficulties faced with the employment of TRiM in order to provide informed empirical data. A qualitative (Willig, 2013) and exploratory approach was used in running four Focus Group discussions that were audio (not visually) recorded and later transcribed verbatim by the researcher. The transcriptions were in turn analysed, using Inductive Thematic Analysis (ITA) and Braun and Clarke's (2006) six step methodology to identify significant themes associated with using TRiM, which would be presented as key General Dimensions.

### 4.2.3. Procedure

All participants for Study 3 were identified through purposive and criterion sampling (Palys, 2008) and as such were considered eligible for achieving the aim of the research study by the researcher. All participants were considered TRiM professionals as each had been formerly trained in TRiM (Practitioner, Manager or Coordinator / Lead) and each used TRiM as part of their role within their profession. Participants were chosen from a wide range of organisations in order to gain data from a broad cross section of individuals and organisations (Bryman, 2016) that operate in challenging, potentially traumatic, environments and who use

/ used TRiM on a regular basis. Although some of the participants recollections of TRiM were based on former roles or experiences, which happened to be no longer than 12 months before participation in the study, the majority were still regularly engaged in the wider use of TRiM. As hoped, the study attracted diverse and inclusive participation from a number of suitable organisations that routinely employ(ed) TRiM with a spread of experiences, roles and professions. In line with the aim of the study, however, the roles of participants fell into three principal categories: current or former TRiM practitioner, TRiM Manager or TRiM Coordinator / Lead.

The participants' professional role within their own organisation differed significantly but importantly, in terms of suitability, individuals were not known until the prospective participant contacted the Research Lead and filled out their consent form. As hoped, each FG comprised a variety of ages, gender, roles, responsibilities and seniority which provided a basis for the collection of rich and detailed data from an eclectic and valuable source from real-life experience of TRiM's use and perceived, or actual, effectiveness. As such the study intended to explore the participant's personal experiences of TRiM to discover what they genuinely thought of TRiM as a programme and as a methodology for effectively supporting staff and colleagues that operate in challenging, potentially traumatic, environments. As set out in the initial information document sent to each potential participant, comprehensive working knowledge and understanding of TRiM were considered vitally important for participation in the study.

Again, in line with SU guidelines, all willing participants were first sent a detailed information pack / document detailing key features of the study. On agreement, each prospective participant was required to sign a Consent Form as part of the FG Information Document and return it electronically to the lead researcher. Once consent was received and approved, each participant was sent an email containing a number of short questions about

basic demographics (Appendix 3.2) and a further email inviting them to attend one of the online FGs via an MS Teams link.

At the beginning of each FG, the lead researcher explained how the session would run before facilitating the discussion. As members of the group discussions, participants were encouraged to share their experiences and ideas of TRiM, from both an individual and organisational perspective, via a number of general, open and probing questions offered to the group. Each of the four FGs lasted between 77 minutes and 96 minutes.

Anonymity through the study was offered to all participants with the use of an alias name (chosen by the participant) and personal deactivation of their own camera during the online sessions. Two participants requested anonymity. All subsequent data collected through the study was also coded and any personal details removed or redacted to protect the identity of those participating. However, it was also anticipated that some of the participants may have seen the FGs as an opportunity to make contacts or connections and use their real names, titles and organisations to expediate future dialogue outside the study.

The well-being of all participants was always considered paramount by the researcher and as an initial duty of care, all participants were briefed electronically and verbally that they could leave the FG Discussions at any time if they no longer wished to continue. Furthermore, participants were reminded of their option to withdraw from the study altogether and ask for all pertaining personal information either withdrawn or redacted from subsequent transcriptions by emailing the lead researcher or research supervisor asking to be withdrawn from the study. Participants were, however, informed early on in the process that as it was difficult to withdraw individual data, given the nature of the FG discussions, and therefore to take it into consideration before providing initial consent to participate in the research. Of note, no participant exercised their right to leave the study once FGs had taken place.

Although there was no intention to discuss any trauma related subjects in detail during the FG Discussions, it was stated, again both electronically and verbally, that participation in the study may cause anxiety, distress and psychological discomfort. For those that suffer with Post Traumatic Stress Disorder (PTSD) there was a potential risk to their mental health and the possibility of a recurrence of previous symptoms as a result of participation. Participation in the study may have also revealed facts about psychological status in relation to showing signs of PTSD, again which may have caused distress and discomfort in some participants.

Finally, it was suggested to the participants that by taking part in the study, they had an opportunity to contribute to scientific understanding of the use and effectiveness of TRiM and assist with the wider ongoing provision of effective support for staff, colleagues and organisations that routinely operate in challenging environments.

As anticipated, during the planning of this study, the fluid and unpredictable nature of the COVID 19 pandemic did affect the availability of a number of participants. The original plan was to hold 3 FG discussions, each with 6 – 10 participants, being mindful not to make the online FG too large (Mann & Stewart (2000). However, due to external, largely COVID related factors, numbers of volunteers were lower, and numbers of last-minute dropouts were higher than anticipated. In order to mitigate the deficiency of potential participants it was decided to run a fourth FG to increase opportunity and the overall number participating. The study finally comprised 4 FG Discussions involving 11 participants in total. Although this number was below the desired target number, over 6 hours of rich and detailed data were gathered through the study. As with Study 1, ethnicity, social history and nationality were initially considered by the researcher, but it was felt that these issues had limited relevance in this particular study, as potentially traumatic events can happen to anyone, from all backgrounds. As such, an inductive approach was chosen because of its inclusivity and 'open-mindedness' to all incoming data from all manner of people. As the study sought a varied cross

section of participants, detailed stratification was felt unnecessary during the allocation of FG members.

In line with qualitative research, the lead researcher's aim was to glean the participants perspectives of TRiM and as such acted as moderator for all four FGs. This not only provided continuity throughout the sessions, ensuring conversations were relevant, but it ensured mitigation any form of potential 'power dynamics' within the groups and, as such, a degree of *control* (Krueger, 1988). During the discussions, the lead researcher, who is an experienced facilitator, took time to enable rapport between participants (Curasi, 2001), encouraged group interaction (Kitzinger, 1995) and reminded all participants of the limited time frame available and the wish to allow each participant ample opportunity to share their experiences and views fully. To keep the discussions relevant to the subject matter, a series of semi-structured questions were used by the moderator as a guide (see Appendix 3), interspersed by more generally open and probing questions to encourage further engagement where necessary. From a practical perspective, the researcher acting as moderator, was also able to, if required, and prevent participants talking over each other which may have impeded the recording of the FGs. The participants were informed that at the end of each FG there was an opportunity to offer any other comments or observations that may not have already been covered. In order to reiterate this point, prior to the FGs commencing there was a process of verbal contracting to remind participants of etiquette and confidentiality whilst encouraging participants to speak openly and honestly.

Having first-hand experience and integration with all groups also aided the researcher with increased familiarity and subsequent analysis in line with ITA. From preparation through to the analysis of the FG discussions the lead researcher was also mindful of Hurd and McIntyre's (1996) opinion that there is 'seduction in sameness' between researcher and researched, which can hinder critical reflexive research (Smithson, 2000).

### 4.2.4. Ethics

As with Studies 1 and 2, it was acknowledged that due to the nature of this particular research (i.e., dealing with potential trauma), the study required, and was granted, ethical clearance by the Staffordshire University Ethics Committee before commencement. FGs were accordingly held in strict accordance with SU Ethical Guidelines (Appendix 3.1) and a comprehensive FG Supporting Information Document (SID) (Appendix 3.2) was sent electronically to each participant prior to the FGs taking place. The document included amplifying information about the research including the consent form and information relating to the withdrawal procedure (should it be required), an FG guide, and a debrief document for signposting to professional mental health services if required.

The intention of the study was to explore the real time efficacy of TRiM with, in particular, an aim to highlight areas where the TRiM model works well and where it works less well. As a prerequisite of the study, participants required significant experience in the delivery of TRiM and as such it was expected that members of the FGs had at the very least, encountered some form of potentially traumatic experiences as part of their role as TRiM practitioner, coordinator or leader either personally or vicariously. To that end, individuals involved in the FGs were reminded of the potential risks involved in taking part in the study, both verbally and via the SID.

Included within the SID was a participant de-brief document, providing a helpline and support details, should participants need it. These details were also reiterated verbally prior to each FG commencing. The Participant Consent Form was also included and required signing to participate in the study. These signed copies can be found with each of the participants transcriptions.

Time was taken to ensure that each FG was conducted diligently and considerately by the moderator to mitigate any potential risk to the participants (Keller et al., 2005) with each participant being monitored on screen and audibly for emotional impact throughout.

To ensure further protection and confidentiality, each participant was, as previously mentioned, offered anonymity in the study with an opportunity to use a pseudonym and have their camera switched off during the online FG discussions. Following transcription, content concerning key personal details was either coded, redacted or blanked out. As further reassurance, all participants had the opportunity to view their personal transcripts in order to check the written text for themselves. Following guidance on the ITA employed (Smith and McGannon, 2017), 'member reflections' were encouraged but vigilance was employed by the lead researcher when sharing such written information which could possibly provoke such feelings of unease, disappointment or discomfort when re-reading (Sparkes and Smith, 2014).

In line with SU guidelines, following each FG all data obtained from the study, including the consent form, FG recorded files, transcriptions and any written notes were uploaded and separately, securely stored electronically on a password protected device. Following the full transcription of all FG discussions, uploaded files were deleted from MS Teams and the iPhone Dictaphone App used for recording.

### 4.2.5. Data Collection

In total, four FG discussions were held over a three-month period, from December 2021 to February 2022, using MS Teams and involving 11 people. Initial design and scoping of the study did envisage more participants attending each FG but due to the ongoing COVID 19 pandemic, combined with the nature of the roles of those potentially interested in the study, numbers remained lower than anticipated. During the study a number of FGs were re-scheduled, for the same or similar reasons, meaning, disappointingly, a number of potential

participants became entirely unavailable.

All four FGs were moderated by the lead researcher who used a blend of ten semi structured questions and further open /probing ones (see Appendix 3) to facilitate focussed discussion between participants. Limited direction to who should answer first within the discussions was given by the moderator and conversations were allowed to flow naturally, unless major focus was lost on the subject matter requiring subtle intervention by the moderator to get back on track.

Each FG was recorded online using MS Teams and a digital iPhone Dictaphone App was usedfor backup, to enable subsequent, and accurate, transcription by the lead researcher. Following transcription, each participant had the opportunity to request a copy of the transcript to ensure information recorded was accurately represented and for those that requested anonymity check for unsolicited identifying personal information that they deemed unsuitable which was consequently redacted (blanked out).

Of potential interest, two participants opted for anonymity and no participants requested a copy of any transcription.

### 4.2.6. Data analysis

Inductive Thematic Analysis (ITA) was chosen as the method of qualitative analysis for this study as it facilitated the systematic formation of key themes associated with the research aims (Braun & Clarke, 2013). Following transcriptions of each FG discussion, each participant was offered the opportunity to read through their personal transcript in order to firstly, check the accuracy of text and secondly, and arguably more importantly in terms of ‘member reflections’ (Braun & Clarke, 2013) over ‘member checking’ (Morse, 2015), was to re-engage with participants to find out if text / data had been misconstrued or important points missed by the transcribing lead researcher (Schinke et al., 2013). In reply there were no comments requiring any changing of or adding to any transcribed text therefore it was deduced by the lead

researcher that the written transcripts were an accurate reflection of what was actually said during the interviews.

Tracy's (2010) eight *hallmarks* included within Universal Criteria namely: 1) Worthy topic, 2) Rich topic, 3) Sincerity, 4) Credibility, 5) Resonance, 6) Significant contribution, 7) Ethics, and 8) Meaningful coherence were again routinely deliberated throughout Study 1 as a way of ensuring the quality of the qualitative research and required constant evaluation and re-evaluation by the researcher. Ensuring this research is considered worthy and adds significant contribution to the world of applied performance psychology, as well as society as a whole, have been key factors from initial personal inception through to the research proposal and continue to be as the research evolves. Ethical considerations remain paramount throughout this entire study and are assessed accordingly (see Ethics section).

ITA was chosen over Deductive Thematic Analysis (DTA) as the researcher's aims were to generate themes determined by the data provided by the participants in the FG discussions rather than presenting preconceived themes or ideas to test. The steps taken during the data analysis were those advocated by Braun and Clarke (2006, 2013) and involved the following:

**Phase 1: Familiarising self with the data**

Initial familiarisation of the data essentially began during the FG discussions, where questions were asked, dialogue flowed and written notes were taken (Lewins, 2001). Deeper familiarisation was gained during the subsequent transcription of each FG discussion, which were read and re-read multiple times by the researcher to gain increased knowledge and a deeper understanding of the data with particular attention given to identifying and highlighting key areas of interest or codes. Whilst writing and evidencing results, the transcription was scrutinised many times, gaining continuous familiarity with contextual data.

**Phase 2: Generating initial codes**

During analysis of transcriptions, each fragment of interesting text was highlighted, designated with a numbered code, highlighted and recorded on the transcribed text. Each of the codes, which averaged 99 across all 11 transcriptions, were named using a phrase or short sentence to summarise the code for it to make contextual sense. Each of the transcriptions took on average 11 hours to code.

**Phase 3: Searching for themes**

Once initial coding of the data was complete, codes with apparent similarities were clustered together into groups or themes. Firstly, by interpreting the analysis, the researcher developed an initial range of broader themes, known as Lower Order Themes (LOT), which numbered 73 across the four FG transcriptions. From a practical perspective, each code was assigned to and denoted within a named theme using their designated code numbers.

Through further analysis, a smaller number and far more focused Higher Order Themes (HOT) were identified and named containing groups of associated LOT. Finally, the HOTs were then re-analysed and refined further to create the three General Dimensions (GD) of all data gleaned from the four FG discussions. An example of this can be seen at Appendix 3.4. The analytical framework for this study was represented as:

**Table 4.2**

**ITA Ascending Analysis**

| Ascending analysis | | | | | |
|---|---|---|---|---|---|
| Step 1 | Step 2 | Step 3 | Step 4 | Step 5 | Step 6 |
| Familiarisation of initial data during FG discussions | Transcription of FG discussions including initial analysis and coding | Identification of Codes | Identification of Lower Order Themes (LOT) | Identification of Higher Order Themes (HOT) | Identification of General Dimensions (GD) |

It is worth stating that not all initial codes or LOTs found their way into a HOT or GD as they may have been identified initially as an area of interest but were perhaps too diverse or lacked consolidating data to support through further analysis. Some codes also became incorporated within other codes if similarities or commonality was deemed suitable through the theme reviewing process.

**Phase 4: Reviewing themes**

Through continuous and systematic analysis of the data, each of the themes (LOT, HOT, GD), and their relevant sub-themes, were continuously referenced, cross referenced and refined with the coded transcripts to ensure that the codes and sub themes accurately fitted the chosen higher theme, whether that was a LOT, HOT or GD, and maintained relevance and suitability.

**Phase 5: Defining and naming themes**

Once the themes had been identified and given a general title, the researcher then focused on naming each of the themes through further reading and refinement. In terms of this study, each theme was supported by a list of relevant codes and sub themes.

**Phase 6: Producing the report**

Initial coding of the transcribed data took on average 11 hours per transcript, identifying initial LOT took on average 9 hours and 8 hours for initial HOTs. However, as in line with Clarke and Brawn's ITA methodology, revisiting and revising of the codes, themes and eventual general dimensions throughout the analysis process took countless hours over 6 months to complete in the lead researcher's part-time capacity. Re-reading and re-reading, in order to become re-familiarised with the data, took time but ultimately ensured inductive thematic saturation (i.e. no additional data / no emergence of new codes or themes) (Saunders et al, 2017) or as Aiken et al (2015, pg. 154) refer being "confident of having achieved, or at least closely approached thematic saturation". In total, 99 pages of transcribed data were collected and analysed, containing over 40 000 words.

Appendix 3.4 shows the refinement and confirmatory cross-referencing process involved between the High Order Themes and the final three General Dimensions.

## 4.3 Results and discussion

It should be noted that this discussion henceforth sets out to consider TRiM in relation to people's experiences of its use, rather than in comparison to other post-incident psychosocial interventions such as Critical Incident Stress Debriefing (CISD) (Mitchell, 1974), Mental Health First Aid (MHFA) (Department of Health: National Institute of Mental Health in England (NIMHE), Eye Movement Desensitisation (&) Reprocessing (EMDR) (Shapiro, F., 1980) or Trauma Focused Cognitive Behavioural Therapy (CBT) for example.

The analysis of the data collected from the four FGs generated three General Dimensions:

1. Perceived benefits associated with TRiM
2. Perceived drawbacks associated with TRiM
3. Potential recommendations for implementing TRiM effectively

As called for by Braun and Clarke's ITA approach, each General Dimension is accompanied by accompanying contextual and explanatory text, firstly in the form of sub-themes, shown in the table (4.3) below, and secondly described and evidenced subsequently in amplifying text.

**Table 4.3**

**Study 3 - General Dimensions**

| **General Dimension 1** | **Perceived <u>benefits</u> associated with TRiM:** |
|---|---|
| Sub Theme | - *Staff feel supported* |

| | |
|---|---|
| | - *Provides suitable psychological resilience / trauma informing education*<br>- *Provides both a proactive and reactive structured peer / clinical support programme that can be adapted to organisational / individual needs*<br>- *Has proven efficacy*<br>- *Can lead to a positive cultural change through raising inclusive (all staff structures, leadership etc) organisational awareness and provision of necessary skills / training*<br>- *Can be provided through blended delivery methods (face to face, online etc)*<br>- *Can be used to support staff, staff families and the wider community*<br>- *TRiM can reduce stigma attached to mental / emotional health issues and promote 'normalisation' of responses associated with increased / overwhelming stress* |
| **General Dimension 2** | **Perceived <u>drawbacks</u> associated with TRiM:** |
| Sub Theme | - *Time: takes organisational time to initially set up, takes time to bed-in, takes time to run effectively and takes individuals time to support colleagues appropriately*<br>- *Requires organisational 'buy-in' and the initial / ongoing support of leadership, management and staff to succeed*<br>- *TRiM can be perceived negatively by organisations where it has not succeeded* |

| General Dimension 3 | Potential recommendations for implementing TRiM effectively: |
|---|---|
| | - *Careful consideration should be given to selecting those responsible for delivering TRiM (Leads, Managers, practitioners), i.e.. 'the right people'*<br>- *Organisational TRiM programmes need to encompass the wellbeing of those being supported as well as those providing support*<br>- *The TRiM programme should aim to proactively raise general resilience / trauma awareness / normalisation as well as providing peer assessments and ongoing psychosocial support*<br>- *TRiM needs to be inclusive to be successful, involving all departments, staff, leadership and management, regardless of whether individuals require support or not*<br>- *TRiM effectiveness can be increased through regular and timely integration i.e. during training or through CPD*<br>- *TRiM can be delivered flexibly and in a way that suits organisation requirements / needs*<br>- *TRiM assessments are best delivered face to face, but other elements of TRiM can be delivered effectively using IT (blended approach)*<br>- *TRiM can encourage / enhance organisational communication / co-cooperation with other TRiM users*<br>- *TRiM may be useful in serving a wider audience (the public, families etc)*<br>- *TRiM on it's own may not be able to answer all organisational questions or concerns but when used proactively, it's composite* |

*sections can be used as part of a wider approach to providing education and support for those that operate in challenging, potentially traumatic environments.*

With limited documented empirical data regarding the use of TRIM, including benefits and shortfalls in the wider community, the principal aim of this study was to gather meaningful information from experienced TRiM professionals to further investigate the perceived efficacy of the trauma management model [TRiM] across a varied range of organisations that routinely operate in challenging, and potentially traumatic, environments. As highlighted earlier in the paper, most of the participants are not mental health professionals, but rather they are TRiM trained individuals that provide peer-based support as part of the wider TRiM programme. In terms of this discussion, it is worth pointing out that the participants of the study that are, or were, mental health professionals (n=3) delivered, or have previously delivered, TRiM in a peer support manner, rather than that in a mental health profession capacity.

**General Dimension 1: Perceived benefits associated with TRiM:**

The shared opinion amongst all participants during the four FG discussions was that TRiM programmes, when run well, do offer beneficial support to those that operate in challenging environments, often leaving staff feeling cared for and invested in: *"... it made our officers and staff feel valued ... and that the organisation actually cared about them"* (Amanda, FG1).

Although there are firm guidelines regarding how TRiM is delivered, it was raised that there is scope for support to be delivered creatively, bearing in mind all organisations are configured and operate differently. An example of this discussed was when a TRiM methodology has been employed in a proactive manner it can reassure and educate an 'at potential risk' workforce encouraging them to seek assistance, if required rather than worry and avoid. For those that operate in such challenging, potentially traumatic environments,

provision of knowledge and understanding in basic Psychotraumatology, goes some way to explaining and normalising signs and symptoms of elevated stress reactions associated with emotional responses to demanding experiences. This in turn can raise collective trauma and resilience awareness and 'gets the conversation going', encouraging inclusive support and assistance at all levels from and to peers, colleagues, managers and Leaders. Normalisation and confidence, rather than perceived shame or guilt, heartens people into discussing noticeable changes in self and /or others and by doing so helps reduce the stigma, sometimes associated with issues surrounding mental and emotional (psychological) health, and thus encourages people to learn, use resilience guidance and techniques in order to manage themselves and support each other more effectively.

> *"... it broke down so many barriers. The conception around mental health in public services and all that sort of stuff was always like Stephen just said that, you know, it was a poster on the wall. If you're feeling a bit, you know, blue or low or whatever, it was 'call this number' and you speak to a faceless person on the end of the phone ... there was this kind of misconception that you're supposed to be in a frontline service, and you should be robust enough to be able to take whatever comes at you. ... all of a sudden changed people's mindset. And the fact that it was a visible presence, there was a practitioner or, a team of practitioners spread out amongst a bigger, wider team, just made it far more personal and broke down a lot of those barriers very, very quickly".*
> (Alan, FG2)

Providing some form of support, following challenging and potential traumatic experiences, is considered vital for many organisations that routinely place their staff in potential harm's way, often because they want to do what they consider the right thing. It is

not necessarily just because the likes of UKPTS or Health and Safety Executive (HSE) deem it a requirement, it is simply a human requirement (Porges, 2017). Interestingly, where TRiM is viewed merely as an organisational 'box-ticking' exercise, it is widely considered less favourably or is less accepted by a workforce*, "… this* [TRiM] *for me isn't a tick box exercise".* (Karen, FG4)

Where TRiM does work well, is where organisations have adopted a holistic and proactive approach to its use and where staff feel invested in: *"… they've been having some amazing feedback from their staff saying, 'this is brilliant, this is such an investment in us".* (Clive, FG3). TRiM also enables a considered and informed approach to being both supported as well as supporting others safely, rather than relying on or being directed to clinical intervention / care / support, which is often what some people simply do not want, or necessarily need.

Another key strength of TRiM, raised during the FGs, was that the TRiM model can provide a welcomed structure (approach) for handling theoretically problematic and sensitive subjects that may encompass potentially traumatic experiences or events. If people need further assistance in dealing with distressing events, for instance, a proactive TRiM approach encourages an organisation to already have set in place a manner in which to refer individuals to professional services.

There is a common belief amongst the participants that TRiM has evidence based, well researched, efficacy, which was highlighted as a key reason in choosing TRiM in the first place. This belief, however, seems largely based on the experiences of other organisations that employ TRiM, including TRiM providers, but is also reinforced by their own experiences of when it goes well and becomes an accepted methodology. Others talked of the benefits of the TRiM programmes to not only increase general resilience awareness within organisations but also to encourage and reaffirm good practice with families and related wider communities.

Once again, insistence of the necessity for engaged and compassionate leadership / organisational buy-in (including HR, Occupational Health etc.) in order to create psychologically safe environments and / or facilitate organisational change, where required, was reiterated across all four FGs.

**General Dimension 2: Perceived drawbacks associated with TRiM:**

One of the biggest criticisms of TRiM is that it clearly requires significant investment in terms of time, effort and manpower, as well as funding, to implement and employ successfully. Initial organisational 'buy-in' at all levels, as raised in GD1, was seen as vital from the point of a successful launch of TRiM but is also required in the provision of ongoing support of TRiM staff, nearly all of whom are volunteers and who conduct their TRiM on top of their regular job / role, taking the necessary time they need to conduct assessments, for instance.

> *"I think it's time. Certainly, that's what we found when we've been dealing with the NHS, you know, with our place, it's quite bad. But certainly, with the NHS, it's been even worse because they are so strapped for time ... I think part of that is a misunderstanding or a lack of understanding of what is actually happening. Because literally giving somebody that hour, has kept so many of our guys at work and has stopped them going off for six months. It's when you can get the hierarchy to see it, and they buy into it, that it doesn't become a problem."* (Stephen, FG2)

FG participants suggested that timely and detailed organisational planning and preparation is essential. Clear and positive communication between leaders, managers, TRiM team and staff on why and how TRiM is being implemented is also seen as imperative in ensuring inclusivity as well as a joint approach in taking the model into effective organisational

actualisation: *"So, I think the weakness from our system is the communication, the line of communication about who to point people to, has broken down …* (Alan, FG2)

It was raised by participants that by negating these significant factors, which can often be underestimated, can lead to, at best, the TRiM approach losing credibility and effectiveness, and at worst leading to the possibility of doing harm. Also, the time required by individuals or groups requiring assessment or those involved in the running or management of TRiM programmes, such as TRiM Leads or practitioners can be significant and needed to be factored into its use.

In organisations where TRiM struggles to get traction or acceptance, it is often dismissed as a poor programme rather than it being poorly implemented. A previous study by Professor Greenberg *et al* (2011) with the Royal Navy adds to this, citing confidentiality issues, as an example, and a lack of support from leaders by 19% of those interviewed as reasons for lack of acceptance of TRiM.

What is clear though, TRiM does not work well, if at all, in organisations where it's staff, leadership and / or management doubt it's worth or effectiveness.

**General Dimension 3: Potential considerations for implementing TRiM effectively:**

It is clear throughout the FG discussions that the employment of TRiM needs careful consideration and management for it to work optimally. When asked 'what advice would you give to other organisations that were thinking of implementing a TRiM programme', the general consensus suggested the focus being on the initial implementation and management of the programme. Having a plan in place before you start the process was highlighted by a number of participants as being crucial as well as ensuring organisational buy-in from key influencers such as leadership, management and HR departments. Requiring particular attention, and highlighted by numerous participants, was the selection of those responsible for the provision of the TRiM team, from coordinators / leaders through to practitioners. This

selection should be based on suitability, not just in terms of personal skills but also of an individual's time available to fulfil their TRiM roles. Interestingly, in Greenberg's study quoted above in GD 2, the other key factor he highlighted for non-acceptance of the TRiM programme was the negative effects of inexperienced practitioners. Picking the right people to be TRiM practitioners, managers, leads or coordinators, and training the right numbers of those people, to manage and run the programme was again raised. In particular, a number talked of the importance of picking a TRiM lead, for example, who is passionate about what they do and who has time to build an effective team around them as well as showcase, advertise and influence others. It was raised that many other organisations run TRiM programmes effectively and so linking in or collaborating with them could be considered really useful for all parties involved.

As well as time and funding, consideration also needs to be given to how an organisation can best support it's TRiM Team, in terms of general health and wellbeing after shouldering the burden of other's psychological challenges.

Of note, the small number of participants that no-longer use TRiM, still see significant benefits to using the model but are cognisant that it also needs to fit an organisational needs / philosophy in order to work effectively.

> *"... in my other world, it's not accepted methodology. It's accepted that it works. It's not formally part of our process, it's available, however, I would caveat that which might come in later on with our culture and behaviour that contains virtually all the components of it. It just doesn't have a name as such. And we're small and what have you. So, it'll probably come in in a little while, but not in our bit".* (Daniel, FG2).

The majority of participants stated that a proactive approach to employing TRiM was needed for it to be successful within an organisation. Integrating general resilience and potential trauma management in normalising human responses to operating in challenging environments was viewed as being extremely useful, especially when incorporating it into daily practice, and was seen by a number as the only way to ensure necessary cultural change. The view that TRiM is a purely a reactive methodology was not held by anyone within the study, but there was an acknowledgement by most participants that TRiM was suited to a reactive response, especially following significant, potentially traumatic incidents. In order for it to be successful as a reactive tool, however, TRiM did require credibility amongst a work force, which was largely down to it being a widely understood, accepted and practiced tool. Examples of where TRiM worked less well was when it was used purely reactively i.e., when things went wrong.

> *"My philosophy of TRiM being employed as its best, is it's very much a proactive tool. Yes, an element of the management is reacting to people's potentially traumatic experiences but the whole management approach itself is very proactive in helping people identify and label experiences that are potentially traumatic. Otherwise, that was just 'that is the nature of what we get exposed to in this nature of this job', so absolutely proactive.*

> *Initiating a point of contact after experiences had been identified is proactive. Following up after an initial assessment is proactive. Giving people some time … is proactive. So yes, I think it's initiated in reaction to something generally, but it can still be proactive when it's initiated because it seems to have been an accumulation of lower-level challenges that staff in an organisation may have faced. So, whichever way*

*we spin it, my perspective is very much about it being proactive methodology".* (Amanda, FG1)

In order to maintain the effectiveness of the TRiM programme through a proactive approach to management and delivery, regular TRiM awareness sessions were raised as good practice by many of the participants throughout the discussions. This was seen as an important part of the TRiM programme in maintaining a watchful eye on general health and wellbeing in challenging environments. It was also suggested that this could / should be offered to families and dependents in order to strengthen social support available, both at home and work. A number of participants did, however, raise the importance of nomenclature, in particular the overuse of the term 'trauma', and management of regular trauma awareness sessions, suggesting a change in phrasing to an approach more akin to 'resilience' and the importance of ensuring such sessions or approach did not become themselves overwhelming.

It was suggested that one way of delivering and maintaining both TRiM training and facilitated regular awareness education could be through a combination of using face to face and online interactions. With increased access to IT and ever improving quality of online training aides available to both training provider and recipients, a blended approach was deemed a pragmatic solution to delivering TRiM efficiently. In establishments, such as the emergency services, where time is considered such a precious commodity this approach would provide organisations greater flexibility in rolling TRiM out effectively, allowing staff to conduct training, whether it's initial TRiM practitioner training, refresher training or maintaining general trauma and resilience awareness at a time that is convenient for them. A number of participants did, however, raise some trepidation around the approach stating that it needed to be carefully considered and managed, in particular when conducting TRiM assessments. In times of need, humans prefer actual human contact, to feel safe. The well-

known psychologist Stephen Porges (2017) would describe this as 'the biological imperative. So, in terms of TRiM risk assessments, it was felt strongly by some that these should always be conducted in a face-to-face manner rather than virtually.

It was acknowledged by some that TRiM was not necessarily the answer to everything concerning the management of potential traumatic experiences and it does not necessarily suit every organisation, but there was the feeling that doing something was better than simply doing nothing.

> *"In implementing TRiM in our organisation and I always said it's like trying to fit a square peg into a round hole. We're having to shave the edges off really. And so, I think with the TRiM model was clearly set up in the military and it's been adapted for other areas. So that's one of the biggest challenges we have had with TRiM … We really do try and do the best we can with a model that wasn't really geared up for our kind of type of organisation".* (Karen, FG4)

Also, taking that every organisation operates differently, even NHS Trusts operate independently for instance, it was mentioned by a number of participants that it was often easier, even in the initial stages, to adapt TRiM around the organisational needs rather than try to bend the organisation around TRiM. Once a degree of acceptance was formulated then the changes were more likely to encourage behavioural changes or activities related to good practices, such as seeking help when needed or concerning health and wellbeing in general. On this subject, however, a number of concerns were raised during discussion, ensuring that any deviance from original TRiM protocols should be discussed with the TRiM training provider prior to implementation.

On this theme, a number of participants did suggest that TRiM could offer support in a broader context regarding wider use in communities to educate and upskill in a general sense but also for use following significant incidents such as the Grenfell Towers Fire.

One final point raised by participants was that even though TRiM may not be the answer to every scenario, it does offer structured, often effective support through arduous times. With one of TRiM's founding principles being 'to do no harm', it is arguably better than providing nothing in terms of support, both for individuals and organisations that want to maximise operation performance whilst actively supporting its most precious commodity, staff that work in environments that are both challenging and potentially traumatic.

### 4.4 Summary of results

The results showed that all eleven participants across the four focus groups saw some benefit in employing a TRiM methodology within 'risk facing' organisations that place their staff in challenging and potentially traumatic environments. There were, however, numerous examples and anecdotes of where TRiM has worked less well, such as where organisational buy-in has not been achieved or when credibility of the methodology has been lost.

There is no question that TRiM takes time to plan, implement, embed and run effectively, and for some organisations this can prove too much and the TRiM programme ultimately becomes diminished or fails. However, for those that integrate the TRiM methodology into their daily routine, as regular trauma and resilience awareness sessions or part of operational debriefs (as suggested in the anecdotal evidence raised in Study 2), rather than 'pulling the TRiM manual off the shelf' when something goes wrong, data from Study 3 strongly suggests that TRiM can provide a welcomed source of education, structure, guidance and support.

## 4.5 Limitations

This study encountered a number of limitations along the way, largely but not solely attributable to the ongoing COVID19 pandemic, which, in terms of this study, were mostly expected and ultimately managed effectively. As well as taking a considerable toll on general populations globally, the scope of this study, involving people that worked in challenging environments, meant that many of the potential participants were caught up in front line positions and sometimes found great difficulty in justifying time to attend the focus groups. To this end, a number of planned FGs had to be rescheduled to allow subsequent participation. That said, a number of participants were in great demand and eventually, and understandably from a lead researcher perspective, found it impossible to dedicate themselves to the study.

Another limitation was highlighted during the ethics application process when it was determined that serving NHS staff were unable to participate without obtaining NHS ethical approval. The NHS ethics coordinator also felt that this project did not fall within their service evaluation. Although NHS staff inclusion would have added much credibility to the study, as well as providing invaluable data regarding the use of TRiM in an NHS setting, and especially in the midst of a global pandemic, the decision was made by the lead researcher not to involve any serving NHS staff in the study. This disappointment was, however, offset by the fact that a number of the participants had previous experience with using TRiM in an NHS setting.

Ultimately, this meant that fewer numbers of participants than hoped for attended the four FGs and less data collected. The eventual participants were, however, considered a high-quality field of experts on the subject of using and managing TRiM and provided extremely valuable data for analysis.

## 4.6 Conclusion

The primary aim of Study 3 (Aim 4 of the thesis), and as part of the overall purpose of thesis, was to gather meaningful data from experienced TRiM practitioners to further investigate the

perceived efficacy of the trauma management model ‘TRiM’ across a wide range of organisations that routinely operate in challenging, and potentially traumatic, environments. In summary, the [FG] study revealed that the TRiM model was largely considered by participants as an effective tool, or programme, for supporting individuals that are expected to perform effectively in often arduous settings, helping them feel valued and cared for by their respective organisations.

Participants from all four focus groups did, however, acknowledge that there were a number of significant challenges faced by organisations wishing to implement TRiM effectively. Through this study, involving thorough analysis of rich data, a number of criteria, or measures, have been identified as General Dimensions and that collectively the participants felt were vital for ensuring the future successful employment and enduring management of a TRiM programme such as organisational ‘buy-in’, effective preparation and planning and considered ongoing control and administration.

# CHAPTER FIVE:

# GENERAL DISCUSSION

## 5.1 Summary of findings

This thesis firstly set out to explore the experiences of people that operate in challenging, potentially traumatic (CPT), environments and secondly to offer an informed opinion on whether the trauma management model known as TRiM (Jones et al., 2003) could offer an effective approach to support a wider community of risk facing professions and roles than it currently serves. Three specific studies were designed, conducted and analysed in order to provide empirical evidence to shape an informed opinion as to whether TRiM could be deemed suitable for wider employment in settings potentially outside those that the model was originally designed for, namely the UK armed forces / emergency services.

Therefore, Study 1, which was a qualitative study, aimed to investigate the experiences of a number of individuals that worked, or had worked, in psychologically and / or physically challenging environments (Aim 1 of the thesis). The participants were purposively recruited from a wide-ranging group of civilian organisations, with only one currently serving in the military, but with a commonality that each of them had suffered some form of *potentially* traumatic experience (PTE) during their role or profession. In order to collect as much useful data as possible, semi-structured interviews were conducted to primarily explore how they made sense of and managed their experiences.

The results of Study 1 indicated that that those that faired best following their PTE were the participants that had suitable resources at hand and as such felt prepared for working in challenging environments and regularly trained using the necessary skills and knowledge associated with operating with related risk of potential physical and / or psychological harm. Broadly, these individuals had access to sufficient individual social support, such as from trusted family, friends and colleagues, and through provision of suitable supportive

programmes and safe environments, where staff, peers or team / group members, felt able to be open and honest and seek suitable support without fear of reprisal. The two General Dimensions identified from the study were firstly, the requirement for effective *social support* and secondly, the requirement for effective *resilience and trauma focused biopsychosocio education*.

Study 2, as a longitudinal, quantitative study, had two key aims. The first was to gauge the overall biopsychosocial benefits and wellbeing of a division of UK's emergency services following the implementation of a TRiM programme, which also included individual and organisational presenteeism associated with operating in CPT environments (Aim 2). Secondly, the study aimed to provide comparative data between two groups, namely Group 1 that had received TRiM training and a control group (Aim 3). The study, involving Shropshire Fire and Rescue Service (SFRS) employed a series of on-line questionnaires at four specific time points over a twelve-month period.

In summary, and even though it was hypothesised that there would be significant benefits associated with employing TRiM at SFRS, the results of the statistical analysis carried out in Study 2 suggested *no significant change*, across all variables in both Gp1 and Gp2, in terms of the perceived / actual benefits after receiving TRiM training. The study, however, does not suggest that TRiM is not an effective tool or methodology for supporting those following a PTE as it could be suggested that the implementation of TRiM within SFRS did lead to the maintenance of expected performance levels during an extremely busy 12-month period. Crucially, at worse the introduction of TRiM did not appear to do any harm.

The primary aim of Study 3 was to build on Studies 1 and 2 and gather further independent and informed data from individuals who serve(d) across a wide range of organisations that use TRiM. Vitally, these individuals, from all levels of leadership and / or management are well practiced in using TRiM whilst routinely operating in, or supporting

others, within CPT environments and who offered informed knowledge and experience to help further deliberate the perceived efficacy of TRiM across 'real-world' settings (Aim 4). The participants involved in the qualitative study were knowledgeable TRiM experts, trained and experienced TRiM Practitioners, Managers and Coordinators / Leads, who offered a plethora of vital information to inform perceived efficacy of TRiM in a real-time setting. The results of Study 3, which involved four Focus Group Discussions, provided three General Dimensions highlighting firstly, *the perceived benefits associated with TRiM*, secondly, *the perceived drawbacks with TRiM* and thirdly, *potential recommendations for implementing TRiM effectively*.

In summary, by using a mixed-methodology approach (Bryman, 2016), this body of research firstly provides original and meaningful data on what individuals and organisations may require in order to effectively support themselves / their staff whilst performing or working in CPT environments. Secondly, the body of research offers an informed view as to whether TRiM can be considered as a suitable methodology for providing support to such CPT groupings, regardless of whether they are part of the armed forces community or not. Most of these 'requirements', such as maintaining a sense of purpose and feeling supported, are written about in numerous, credible resilience literature (e.g., Bonanno, 2021), affirming that stress (per se) is a normal reaction to feeling challenged or threatened by a particular stressor(s) (Porges, 2010) and have all been importantly reaffirmed across the three studies contained within this thesis. The studies, in supporting wider literature, show that all humans experience stress to varying degrees when faced with life / occupational stressors, but each person's response, can be quite different (Van de Kolk, 2014). When levels of stress, in CPT environments for instance, reach a point where individuals, lacking suitable resources (such as perceived lack of social support or lack of emotional regulation strategies), can no longer cope,

or function efficiently, they can become overwhelmed often leading to potential burnout or potential traumatisation (Haines, 2016).

The data gained from this research further provides a greater understanding of the nuances of what resources are required by those that operate in CPT environments in order to mitigate potential overwhelm, what benefits these resources provide and how to make them readily available to both the individual and organisation. The firsthand input from participants in all three studies throughout this research, have been key to determining whether TRiM provides these particular resources.

The evidence gathered from the three studies and covered in this thesis suggests that TRiM (Model and / or Programme) contains valuable biopsychosocial education, pragmatic assessment and support practices that could be considered beneficial for individuals that operate in CPT environments. Importantly, this includes both individuals and organisations that sit outside the typically associated realms of who TRiM was designed for (UK armed forces and emergency services). Amplifying information gathered from all three studies does, however, suggest that TRiM biopsychosocio education could be improved by containing more proactive and practical resilience-based education and self-help / support strategies.

Crucially however, and highlighted in Study 3 particularly, considered preparation and planning, as well as a diligent attitude and proactive approach to the employment of TRiM, by the individual or organisation, is required in order to ensure best chance of acceptance and effectiveness. These key points are offered summarily in Table 5.1 below.

## 5.2 Theory and research contributions / implications

Although TRiM is considered a predominantly trauma focused intervention (Hunt et al., 2013), in the current thesis it was theorised that TRiM could also be suitable for providing a wider valuable psychological support function in terms of facilitating individual resilience, as well as general health and well-being in wider populations of risk facing groups that routinely operate

in CPT environments. TRiM is currently used effectively within the UK armed forces, as well as across many emergency services in UK and internationally. TRiM, as with a number of other early post-trauma / psychosocial interventions, does receive a degree of skepticism in regard to associated benefits (Maglione et al., 2021) and concerns around TRiM in terms of confidentiality and lack of leadership support (Greenberg, 2011) for instance. Others rightly question the efficacy of TRiM (Billings et al., 2022), suggesting its limited evidence base may be insufficient to make it truly credible in the eyes of those aiming to provide the required support for organisations or individuals that work in CPT environments. Therefore, and in line with some of the latest findings by Paton (2022), this thesis aimed to investigate whether TRiM offers some form of effective support to a risk-facing populace, by conducting a series of focused and combined qualitative and quantitative studies (the mixed-methodology approach; Bryman, 2016).

Previously, it is understood that TRiM is effective in many military settings (Jones et al., 2017) but also that TRiM had not been widely explored in other populations. This thesis addresses that, providing evidence from interviews, questionnaires and Focus Group Discussions, throughout the three studies, suggesting that TRiM, in the worst-case scenario provides negligible benefit (as shown in Study 2) but in the majority of cases (Study 3) TRiM is presented in an extremely positive way, especially by those experienced in its wider use. Even those that participated in Study 1, the majority of which had no knowledge of TRiM, presented themes consistent with the benefits of early psychosocial interventions (Firing et al., 2015) as well as much of the contents of the TRiM Model (namely, requirement for biopsychosocio education and effective social support). Accordingly, in this thesis, the qualitative studies demonstrate how people deal with Potentially Traumatic Experiences (Study 1), see no statistical quantitative changes as a result of TRiM (Study 2), and that TRiM is seen as largely as a positive intervention (Study 3). Furthermore, the only time during the

research that data suggests that there is any potentially elevated risk with using TRiM is where individuals or organisations deviate from the tried and tested TRiM methodology taught by credible TRiM training providers (Study 3).

In discussing this research, three principal original contributions have been highlighted as further increasing knowledge of TRiM and being key to determining TRiM's potential wider efficacy namely: 1) Understanding what is needed to operate effectively in CPT environments; 2) Defining TRiM - The importance of understanding TRiM, it's nomenclature and what it offers; and 3) Recommendations - The practicalities of implementing an effective TRiM programme. Furthermore, the findings of this thesis provide new data that should be considered both useful for non-military and military organisations alike, and it is hoped that Table 5.1 is considered useful to all organisations contemplating the implementation of a non-clinical, biopsychosocial intervention such as a TRiM initiative.

**Table 5.1**

**Recommendations for the implementation of a TRiM Programme**

| Recommendations | Evidenced |
|---|---|
| - The implementation of a TRiM Programme requires careful deliberation by all [potentially] involved if TRiM is to be seriously considered as an option to support a workforce that works within CPT environments, involving honest cultural, financial and manpower discussions / requirements | Studies 1, 2 & 3 |
| - TRiM should be considered as both a proactive and reactive tool / programme | Studies 1, 2 & 3 |
| - It may take time for the full benefits of TRiM (Model and / or Programme) to be realised and felt accepted across busy organisations | Studies 2 & 3 |

| | |
|---|---|
| - Careful consideration should be given to selecting those responsible for delivering TRiM (Leads, Managers, practitioners), i.e.. 'the right people' | Studies 2 & 3 |
| - Organisational TRiM programmes need to encompass the wellbeing of those being supported as well as those providing support | Studies 2 & 3 |
| - The TRiM programme should aim to proactively raise general resilience / trauma awareness / normalisation as well as providing peer assessments and ongoing psychosocial support | Studies 1,2 & 3 |
| - TRiM can be used to provide a framework where other non-clinical interventions such as coaching and mentoring can be used to good effect | Studies 1 & 3 |
| - TRiM needs organisational endorsement or 'buy-in' and to be inclusive to be successful, involving all departments (HR, OH etc), staff, leadership and management, regardless of whether individuals require support or not | Studies 2 & 3 |
| - TRiM effectiveness can be increased through regular and timely integration i.e. during 'TRiM awareness' sessions, training or through CPD | Studies 2 & 3 |
| - TRiM can / should be delivered flexibly and in a way that suits organisation requirements / needs | Studies 2 & 3 |
| - TRiM assessments are best delivered face to face, but other elements of TRiM (education etc) can be delivered effectively using IT (blended approach) | Study 3 |
| - TRiM can encourage / enhance organisational communication / co-cooperation with other TRiM users / organisations | Studies 2 & 3 |
| - TRiM may be useful in serving a wider audience (the general public, families, clients etc) | Studies 1, 2 & 3 |

| | |
|---|---|
| - In some cases, TRiM support may not be enough and clinical support may be required. All organisations that employ TRiM initiatives should have in place a robust plan for taking that step | Studies 2 & 3 |
| - TRiM on it's own may not be able to answer all organisational questions or concerns but when used proactively, it's composite sections can be used as part of a wider approach to providing essential education and support for those that operate in challenging, potentially traumatic environments | Studies 1, 2 & 3 |

### 5.2.1 Contribution 1: Understanding what is needed to operate effectively in CPT environments.

Study 1 documented and analysed the experiences of a number of individuals that worked, or had worked, in a variety of psychologically and / or physically challenging environments. Each of the participants had suffered some form of potentially traumatic experience (PTE) during their role or profession. The interviews provided valuable evidence in relation to how they were able to make sense of their experience, and importantly perceptions on how they successfully managed their resilience and performance at the time and in their subsequent recovery.

The findings of Study 1 suggest that people who choose to work in CPT environments most often have the ability to operate effectively, even under increased stressors, if they have the necessary resources available to help them to manage whatever challenge they are facing. These resources, suggested by participants, comprise general self-awareness, effective social support networks or trusted social ecosystems as well as the relevant strategies skills, knowledge and attitude to effectively manage or navigate personal stress levels, up until the point of overwhelm where they may falter (Van der Kolk, 2014). At this point their recovery can depend on many factors available to them including the effectiveness of both non-clinical and / or clinical support available (Bryant & Nicholson, 2014). In short, this thesis found that

if participants feel supported and capable of dealing with a stressor then they are likely to maintain levels of performance or recover. If they have limited or no support and lack the necessary skills to cope, then they may struggle maintain performance or recover in the same way (Yates & Masten, 2004).

Non-clinical support identified by participants in Study 1 included close support from family, friends and colleagues but also included specialised support from the likes of coaches and mentors, even following PTEs. Clinical support, on the other hand, provides professional support from highly skilled individuals that have undergone specific training related to their particular interventions. Such support may include psychotherapists, counsellors, General Practitioners, psychologists and psychiatrists.

Following analysis, study 1 provided valuable evidence of methodologies, strategies and ways in which these individuals not only managed PTEs, but in some cases, provided evidence of how some actually *grew* as a result. These unique findings align with the phenomenon is known as Post Traumatic Growth (PTG; Zoellner & Maercker, 2006) or Adversarial Growth (Tedeschi & Calhoun, 2004). Interestingly, most of the strategies highlighted by participants relied on practical approaches, such as taking exercise, support from trusted others, having an understanding of what was happening to them and why, and importantly how they could manage themselves through the experience (taking good quality sleep, using breathing strategies, and taking exercise). What was also interesting was how mindset, or attitude, played its part in managing events (inciting positive or negative performance), not only during the actual experience but in the aftermath or the recovery phase. People cannot always plan for PTEs, but Study 1 has shown that those that felt prepared, aware and retained a positive, optimistic outlook, even through adversity, appeared to achieve self-efficacy by maintaining balance in terms of managing homeostasis and confidence levels both in self and in others. These findings are in line with Van de Kolk (2014), who suggests that

having the ability to effectively regulate elevated levels of arousal, such as stress, is vital when working in CPT environments, both for maintaining 'in the moment' performance as well as maintaining medium to long term health and happiness. Porges (2017, pgs 23-24) goes further, suggesting that even when enduring PTEs: "*it's all about finding a path back to psychological safety"*.

In terms of where study 1 fits in with the TRiM model, the findings suggest TRiM could be of potential benefit to participants as a number of the themes identified, and contained within Study 1 General Dimensions, are enclosed within the TRiM model and programmes such as gaining a deeper understanding of associated potential human reactions when working in CPT environments.

### 5.2.2 Contribution 2: Defining TRiM - The importance of understanding TRiM, it's nomenclature and what it offers

Throughout this research, various terms have been used interchangeably to describe TRiM, such as the TRiM Model, TRiM Methodology, TRiM Process and TRiM Programme. However, in terms of addressing the final chapter of this research, and to avoid confusion, two terminologies will be used in discussing TRiM: The TRiM Model and the TRiM Programme. This may seem a small point in terms of theoretical implications but is one the thesis consistently suggests plays a large part in how TRiM, per say, is generally perceived and how well it is accepted. Where it works, organisations *love* TRiM. Where it does not, or has not worked, it is often seen as a *waste of time*, which in some cases has proved detrimental to an organisation's overall credibility in safeguarding its workforce, which was raised in Study 3.

In simple terms the TRiM Model includes the fundamental TRiM construct which comprises three main parts; firstly, the Biopsychosocio education section, secondly the TRiM assessment process, which includes numerous sub-models, such as the TRiM planning timeline (Fig. 1.1), the 72+hrs initial TRiM assessment (including the one month and three month (if

required) follow up) and the TRiM risk factors (Tables 1.1 and 1.2) and the BDA questioning structure (Fig 1.2). Thirdly, the support phase, which may include ongoing peer support and / or signposting an individual for suitable professional and /or clinical assistance.

The TRiM Programme, on the other hand, describes the methodology of how TRiM Is employed within an organisation, one which may differ significantly depending on organisational culture, preferred approach and budget for example. As such, the TRiM Model can be seen as a standard fixed, tool whose composite parts (Jones et al., 2003) should be used as they were designed. The TRiM Model, therefore, is used as a structured resource within a TRiM Programme that is adapted to suit organisational needs. These needs, requirements or indeed limitations may in turn direct, for instance, the size, capability and reach of the TRiM Team, including numbers of TRiM Practitioners versus scale of workforce, time / money available to imbed the programme before expectations, whatever they are, are realised. All of these facets make impacts on time, which is raised in this research as a critical factor; time for training practitioners, time for delivering assessments (both for the practitioner delivering the session and for the person requiring support) and time for planning of ongoing support for example.

#### 5.2.2.1 The TRiM Model

During this thesis the use of the TRiM Model was raised numerous times, in terms of its use and suitability. This section highlights some of the main issues raised within the current research that highlight potential implications with the TRiM Model and the part it plays within a TRiM Programme.

The TRiM Model comprises three main parts. Firstly, the Biopsychosocio education phase aims to inform and educate with the experience of Psychotraumatology. It does this by introducing several sub-models that help with understanding the nature of the individual reactions to traumatic stress, such as explaining the characteristics of a PTE. As an example,

threat, horror and loss are well known characteristics of a traumatic event but TRiM may go on to explain further:

- **Threat**: Where the traumatic event is perceived as threatening to the integrity or the life of an individual.
- **Reaction**: Individuals may experience a range of predominately arousal responses, such as anxiousness or apprehension.

In this phase, TRiM also covers how people respond after a PTE using the Three System Model where physical, psychological and behavioural responses are explained, as well as some of the associated possible emotional responses such as guilt, anger and depression. Even though this phase clearly explains numerous human responses to PTEs, it rarely goes into explaining how humans can increase resilience and potentially offset the effects of [potentially] overwhelming situations. During the research, a number of participants from Study 1 (e.g., SUZW03) and Study 3 stated how understanding basic factors surrounding resilience, such as the benefits of sleep, movement / exercise, using breathing techniques and a healthy diet have helped them through challenging times employing what could be described as a proactive approach. In its typical format, for instance when employed within the UK police, the TRiM Model could be considered as a reactionary model, such as 'responding to a major event' (Hunt et al., 2013), rather than a proactive one as asserted by Greenberg et al., (2005). Interestingly, all participants of the focus groups in study 3 that considered TRiM favourably, saw TRiM best employed as either a proactive tool or as both a reactive and proactive tool. None of the participants, with positive experiences, saw TRiM as purely a reactionary model.

Both studies 1 and 3 suggest that a proactive approach to supporting individuals operating in CPT environments is beneficial. This includes the inclusion of resilience-based education and support. The TRiM Model is based on provision of effective peer support, rather than seeking immediate clinical intervention at every PTE, which is clearly valuable in a CPT

organisational setting which may experience many. This research, however, leads to the proposition that the TRiM Model could also go further in explaining the benefits of wider social support, from family and / or friends for example, and not just 'work colleagues' such as suggested by Robinson and Mitchell (1993). In this scenario, lone workers or individuals that operate in CPT environments could find benefits in identifying social support within their own particular ecosystem. Social support, that provides a form psychological safety is seen by experts in the field such as Porges (2010), as the number one factor in maintaining resilience.

In summary, based on the findings of this research the biopsychosocio phase of the TRiM Model would benefit from inclusion of enhancing resilience information, education and training. With these enhancements, it is suggested that TRiM could provide a more proactive approach to maintaining levels of performance in CPT environments as well as enhancing the provision of both psychological and social support in the aftermath of a PTE.

In terms of the TRiM assessment, which forms the second part of the TRiM Model, this research suggests it is most often delivered in one of two ways. Either as an informal approach used, for instance, in general conversation, or in a formal manner where TRiM protocol is activated within an organisation and structured assessments are conducted using the TRiM Risk Factors checklist and scoring system.

In the first informal option, the TRiM risk factors and acute stress reactions can be used as background trauma informing knowledge to gauge how someone if faring following a PTE, perhaps over a coffee or whilst out walking with someone. As evidenced within the research (Studies 1 and 3), participants believe this human and compassionate approach lends itself to enhancing and affirming available support from colleagues, friends and trusted others as well as practicing 'good' management or leadership skills in CPT facing organisations.

In the second, formal option, the TRiM Team sets in motion a series of events that involves documented planning, choosing a TRiM Practitioner, timings and location, for

instance, to ‘officially’ support someone following a PTE. This formal approach is most often instigated by either an individual asking for TRiM support or colleagues raising concerns for another colleague’s wellbeing following a PTE. At this juncture it should be reaffirmed that TRiM is normally received in a voluntary manner, as no-one is obliged to undertake a TRiM process. Although not part of the 12-month longitudinal study in Chapter 3, the researcher maintained a relationship with the organisation. In conversations with SFRS following Study 2, and having seen such an increased level of positive engagement with the TRiM programme, SFRS have incorporated a mandatory TRiM assessment policy for all new firefighters following significant PTEs during their probationary period. This is both interesting given the fact that the statistics showed no significant change in Study 2, but it also shows the value of a balanced and objective position and approach by SFRS.

In terms of verifying the TRiM assessment’s criteria and credibility as a key part of the TRiM Model, both the list of TRiM risk factors and the list of acute stress reactions are well researched (e.g., Greenberg, 2011). Like all models and tools, it is down to the responsibility of the user to ensure they are used safely and most effectively, which is why it is advised that those individuals or organisations providing support using the TRiM Model should be suitably trained by an established and accredited TRiM trainer. In terms of the ten risk factors listed in the TRiM assessment, the research in this thesis furthers our understanding in that other risk factors associated with PTEs such as pre-trauma, home life / experiences, depressive symptoms and dissociative symptoms (Boyer et al., 2022) have been highlighted as specific organisational pertinent risk factors by psychological wellbeing teams and/or Occupational Health, for instance. Inclusion of alternative or ‘extra’ risk factors that an organisation may feel relate more closely with organisational requirements are sometimes added as part of a bespoke TRiM Programme, highlighted by one of a participant of Study 3, to good effect but are done so at

risk and should involve detailed consideration by qualified personnel. An example of this may be the inclusion of 'dissociation' within some UK police TRiM assessments.

One interesting finding of the research is one that has seemed to have occurred as a result of the COVID 19 pandemic and that is the popularity of a blended learning approach. Prior to the pandemic, TRiM training was conducted in a 'face-to-face' manner, but through necessity those undergoing subsequent TRiM training (during and post pandemic) had an option to receive their TRiM education via an online portal / platform and consolidation of the learning either conducted online, using virtual facilitated workshops or face to face workshops (where practical and permitted). The research does, however, highlight concerns expressed by participants in using the online methodology to hold TRiM assessments (Study 3).

Social support is seen as the third stage of the TRiM Model but, in terms of the delivery of TRiM, is often viewed as the provision of support following a PTE. Participants in Studies 1 and 3, however, highlighted the benefits of social support which is ongoing on a daily basis, due to the perceived nature of working in CPT environments, and which is supported by significant evidence on the importance of social support (e.g., Rees & Freeman, 2009). Frisch's (et al., 2014) findings from their study into *Making support work* and the interplay between social support and social identity, back these findings, pointing out, that effective social support, that is routinely available during stressful times, can actually mitigate physiological stress reactions and temper cortisol secretion (Heinrichs et al., 2003). They go on to suggest that such social support can take various forms such as emotional support, with the provision of empathy and concern, instrumental / tangible support, with the provision of material aid / resources or appraisal support, providing amplifying information and awareness to understand what is happening and what can be done. Study 2 goes further in highlighting the perceived importance of social support actually 'provided' to and from members of SFRS. In appraising the social support aspect of the TRiM Model, we should remember that TRiM is based on the

provision of structured and considered peer support and that the perceived efficacy of this approach is key to the success of the TRiM programme. The idea and benefits of a peer support approach, provided through the TRiM process in this case, are also supported by Haslam's social identity approach (2004), which reinforces related positive health and wellbeing as well as lower levels of stress recorded whilst operating in challenging environments (Hausser, et al., 2012). As an example of this, Haslam (et al., 2011) goes to the extent of suggesting that effective social identification / support is a significant moderator of the relationship between life / job satisfaction, even in the likes of bomb disposal experts. Therefore, this research, demonstrated during Studies 1 and 3, has shown, supported by wider literature, that the ongoing provision of social support is vital in maintaining the overall wellbeing and functionality of individuals and organisations that operate in CPT environments (Turnbull, 2011), and that participants in all studies have evidenced its importance as part of the TRiM Model within a wider TRiM programme.

One final key point has been raised both in Study 1 and 3 as having crucial importance within TRiM, and that is if non-clinical, peer support is not adequate for an individual and they require further professional assistance, then an organisation must have in place a tried and tested plan to execute this assurance. This may involve routine involvement from the likes of Occupational Health or Human Resources departments to clinical support from internal psychological wellbeing teams to external GPs, for instance.

#### 5.2.2.2 The TRiM Programme

The TRiM Programme differs from the TRiM Model in that there is more scope to deviate from the TRiM regular structure, in order to mold the TRiM Model around organisational needs and requirements which, although allows a useful bespoke approach to implementing a TRiM process brings potential benefits as well as potential drawbacks, depending on how, an organisation for instance, instigates TRiM.

As highlighted by TRiM experts in study 3 and demonstrated in study 2, the implementation of TRiM should be given serious consideration before starting. The findings from study 2 suggested a number of considerations that should be taken into account to safeguard TRiM realisation. One of the perceived drawbacks, highlighted was the time it can take to set up and embed TRiM within an organisation. Although it was anticipated that there would be benefits associated with employing TRiM at SFRS, the results from the subsequent analysis in study 2 show negligible advantages between the group that received TRiM training and the group that did not. In other words, there were no significant changes in wellbeing, general health, stress, and social support in the TRiM or non-TRiM groups and no significant reduction in perceived or actual absenteeism and presenteeism. It could, of course, be suggested that the implementation of TRiM within SFRS did lead to the maintenance of expected performance levels during an extremely busy 12-month period. At worse the introduction of TRiM did not appear to do any harm which supports Watson's (2018) much larger study ($n$ = 859) that found no detrimental effects of using TRiM. Watson's questionnaire included measures of PTSD symptomatology, depression, attitudes to stress and PTSD, barriers to help-seeking, self-stigma and public-stigma, and post-traumatic psychological change. The results from his study showed that those that had received TRiM training, like Gp1 in Study 2, reported lower levels of psychological distress than the non-TRiM group (like Gp2). Furthermore, the TRiM trained group demonstrated less stigmatised views towards experiencing mental health difficulties, perceived fewer barriers to help-seeking, and reported greater positive psychological change following adversity, than the non-TRiM trained group.

Study 2 concluded that TRiM provided negligible benefit to improving the overall general health and wellbeing and reducing stress within both Focus Groups of the SFRS, certainly within the first 12 months of implementation. Interestingly, in Watson's study, there were no significant differences between the two groups' attitudes towards PTSD and stress.

Encouragingly though, the anecdotal evidence gleaned from SFRS via an ongoing relationship six months after the completion of Study 2 (eighteen months after initial TRiM training and implementation), although not part of Study 2's data, suggested that the TRiM programme has had potential a somewhat *delayed* positive impact on the general health and wellbeing of the SFRS force as well as a reported general reduction of absenteeism and presenteeism. Findings from Study 3 also suggested a delayed positive impact of TRiM training, and this provides further understanding of the nuances of TRiM in suggesting it may take time for the full benefits of TRiM (Model and / or Programme) to be realised and felt across busy organisations. Furthermore, this finding may also suggest that it perhaps takes a longer time for TRiM Teams (Practitioners, Managers and Leaders) to operate effectively in such challenging settings, during a period of cultural change in overcoming the stigma sometimes associated with receiving psychological support (Watson, 2018).

In line with the findings from Study 2 that TRiM had no statistically significant benefit, participants from all four focus groups of study 3 highlighted a number of significant challenges faced by organisations wishing to implement TRiM effectively. Through this study, involving thorough analysis of qualitative data, a number of criteria, or measures, that collectively the participants felt were vital for ensuring the future successful employment and enduring management of a TRiM Programme were identified and incorporated within the three General Dimensions. These included organisational 'buy-in', effective preparation and planning, and considered ongoing control and administration. Subsequent analysis of the data gathered with cross-disciplinary participants (TRiM Practitioners, Managers / Leads and Coordinators) indicated that TRiM, *per se*, was widely considered by participants as an effective tool / model and programme, for supporting individuals that are expected to perform effectively in often arduous settings, helping them feel valued and cared for by their respective organisations.

### 5.2.3 Contribution 3: Recommendations - The practicalities of implementing an effective TRiM Programme (see Table 5.1)

Study 3 offers a unique insight into TRiM from experts who, having years of experience in running TRiM programmes, are able to provide inimitable data whilst providing salient advice and guidance on how best to employ TRiM. Interestingly, although the TRiM Model was considered as a useful tool by all involved in the study, there were examples of where TRiM Programmes were run well and other examples of where they were run less well, highlighting the negative impact this had on perceptions of 'TRiM' experiences. Seemingly, where TRiM Programmes worked well, the TRiM Model held credibility, whereas in examples where TRiM Programmes worked less well, the TRiM Model lost credibility, often amongst both frontline services and leadership / management structures. Other examples of this occurrence, found outside this thesis, can be found within a recent pilot study by the Royal National Lifeboat Institution (Lakey et al., 2018), suggesting that both survey respondents and case study participants felt that support services were more likely to be available since TRiM's introduction.

The data gathered and analysed during Study 3 offers new and valuable information for those seriously considering the use of TRiM either for personal or organisational use. Both the TRiM Model and the TRiM Programme require careful deliberation by all [potentially] involved if TRiM is to be seriously considered as an option to support such a valuable commodity as a workforce that works within CPT environments.

Two main factors to consider when implementing an effective TRiM Programme are the requirement for cross-organisational endorsement, or buy-in, and associated time constraints. Participants in both Studies 1 and 3 highlighted initiatives that could play a part in encouraging further organisational endorsement of TRiM, which may already be implemented as part of an organisational development structure such as coaching and mentoring in the

workplace. Such practices encourage rapport building, listening skills and caring for others (Hall et al., 1999) as well as highlighting the benefits of raising self-awareness and supporting self and others (Passmore, 2007).

For TRiM to work effectively, according to the findings of this research, it needs to be an accepted methodology and / or philosophy throughout an organisation. From senior leadership, through management, to the frontline and junior operators, TRiM needs to be seen as a useful and credible investment for supporting those that operate in CPT environments, maintaining levels of performance and the overall health and wellbeing of a workforce. If it is not seen in this way, then the evidence suggests that a TRiM initiative will struggle to work (Billings et al., 2022), losing integrity with staff and leading ultimately to failure, especially in times of fiscal scrutiny. Where this happens, TRiM is often anecdotally blamed as a model that does not work, rather than an organisation that failed to implement effectively enough to keep the initiative progressing. If a TRiM Programme is to be implemented successfully then comprehensive, focused, and informed communication needs to be conducted from the beginning, during implementation, and maintained through employment, thus gaining cultural acknowledgement. The evidence, provided by the studies and covered in this thesis, suggests TRiM most often takes a lot longer to implement effectively than at first envisaged. Planning takes time and should include representatives from all levels of an organisation. The implementation of a TRiM initiative also takes time, often from those selected to be the TRiM Team and who often fill the role on top of their normal daily business. TRiM also requires time to conduct assessments (informal and / or informal) and potential follow-ups. If TRiM is, however, seen as an asset and, as such, a worthy use of time, then time becomes less of an issue. When TRiM is embedded effectively within an organisation, levels of performance are most often maintained as well as the general health of staff who may otherwise go off sick, as demonstrated at SFRS during the period of Study 2.

## 5.3 Applied implications

Collectively, the data included in this research can be used to improve the support available for those that operate in CPT environments, and also provide an informed opinion on the applied recommendations for implementing a successful TRiM initiative. These implications are outlined further in the following section.

TRiM offers a functional, structured peer support methodology that can be adapted to suit organisational needs, that can be used reactively following PTEs but also when used proactively, enables individual and organisational resilience and a flexible mindset (Bonanno, 2021). TRiM is not the 'silver bullet' in terms of being able to provide effective support for all of those that operate in CPT environments and without the correct allocation of time and resources will struggle to be implemented in most organisations successfully. Importantly, in terms of this research, TRiM does offer many of the factors highlighted in study 1 as certain resources required for working in CPT environments, such as providing suitable trauma and resilience informing education, perceived / actual immediate and enduring support from others (individuals and organisations) and a pragmatic (non-clinical) intervention. As evidenced by SFRS following Study 2, successful integration of TRiM sometimes requires a cognitive or cultural shift by the whole organisation in terms of attitude and practices to be most accepted and effective, which may take more than 12 months. Although Study 3 highlighted that staff felt supported as part of a TRiM initiative, Study 2 suggested that the vicarious benefits of TRiM were not always initially evident, although this occurrence could be explained by the lack of contribution by Gp2 participants (those that did not receive TRiM training). Six months on, however, following the study members of SFRS cited a cultural shift that may suggest that the benefits of TRiM followed its actualisation or activation. In particular, elements of TRiM were intertwined into current practice such as adding TRiM's normalisation brief into post operational de-briefings. Another example of cultural change is where TRiM has been made

obligatory to all junior firefighters during their probationary period following fatalities, which spreads knowledge and awareness, not only to those directly involved but to colleagues and wider members of the organisation. These examples provide subjective evidence of where both an adapted reactive to proactive structured peer support (no clinical support required) programme has been potentially effective within a real-time CPT environment, increasing a sense of acceptance of normal human responses in CPT environments (Regel & Joseph, 2010) and reducing associated stigma.

All three studies integrated into this research have raised a series of themes that collectively provide meaningful information that can inform and guide best practice for working in CPT environments. The list is not exhaustive, as the points have been raised by only a number of participants in relation to working in CPT settings. Regardless of the participants personal / organisational experiences of using TRiM, each organisation is different and will, in turn, have differing ideas or points of view. What this research does offer is a sound body of information that will help any organisation in initiating a TRiM Programme with the best chance of effective actualisation. Furthermore, TRiM has been presented within this research as being effective, and having a real use within these settings, if employed conscientiously with the following applied implications ratified and employed.

From the outset of any TRiM initiative, it should be explained that TRiM, on its own, may not address all organisational concerns, but when used proactively, it's composite sections can be used as part of a wider, effective, approach to providing ongoing education and support for those that operate in CPT environments. Prior to this thesis, less was known about the importance of requirements for TRiM to be effective (cross-organisational structure, culture and personnel characteristics). What has been identified during this research and highlighted in Study 3 is that serious planning, preparation and consideration need to go into who is chosen to lead the TRiM initiative in the immediate and long term, and they need to be afforded all

necessary resources such as cross-leadership support and adequate time and funding. Analysis from Study 3 suggest this does not necessarily mean it is automatically handed to HR or OH simply because they seem the most obvious or easiest option to use. The composition of the TRiM Team (Leaders/ Coordinators, Managers and Practitioners) is also vitally important as these individuals must have the necessary personal qualities and skills, as well as being able forge a motivated and effective team. An example of this could be using identity leadership [theory] (Haslam et al., 2011) to identify and select suitable people who are not only interested in the subject of potential trauma management / resilience, but also perceived as a role models and *influencers* within an organisation. Another crucial consideration when choosing TRiM team members, and highlighted in Study 3, is that they need to have sufficient allocated time to train, coordinate and run TRiM based activities.

As part of the wider, ongoing education, this research suggests that the TRiM initiative needs to be inclusive to be successful. TRiM must involve all staff, leadership and management, regardless of whether individuals require 'actual' support, which can encourage, even enhance, internal organisational communication and externally with other TRiM users. One way of ensuring this cultural enhancement, raised in Study 3, is to hold regular and timely TRiM training sessions as part of leadership courses or CPD sessions for instance. As an example, SFRS demonstrated this after a sixth month period following this study in incorporating the "Possible reactions and symptoms to expect following a PTE" in particular debriefs where it was felt useful or needed by experienced staff. In many ways, as increased stress levels can affect all human beings, TRiM Biopsychosocio education needs to incorporate and encourage proactive resilience practices (sleep; Beattie et al., 2015), movement / exercise (Williams, 2021), breathing practices (Nestor, 2020), healthy eating habits (Spector, 2020), and social interaction (Porges, 2017) by all staff, from those in leadership or managerial positions to those operating on the front line to encourage self-efficacy and the ability to support others.

In pushing inclusivity, this research also suggests (Studies 1, 2 and 3) that TRiM can potentially serve a wider audience in terms of incorporating and encouraging good practices by the families and friends of staff of particular CPT facing organisations who may inadvertently support the general health and wellbeing of those concerned. Study 3 also demonstrated how TRiM has the ability to cut across and influence culture, leadership and workforces, connecting at a human, peer level within CPT environments encouraging equality, diversity and inclusion.

From an organisational perspective, TRiM Programmes should be delivered in a way that suits the needs of the organisation as well as the individuals that work within it. With advances in technology, those responsible for delivery of the TRiM Programmes have greater flexibility and should consider blended learning approaches which may incorporate TRiM awareness sessions, face to face discussions, online self-directed learning and regular workshops, for example, in order to support a wider audience. On this note, a number of experienced participants in Study 3 did raise a degree of caution as they felt TRiM assessments should, wherever possible, be conducted face to face and not virtually as not to miss nuances associated with human connection at stressful times.

With TRiM Programmes aiming to proactively raise general resilience and trauma awareness and to normalise natural human reactions associated with operating in CPT settings (Southwick & Charney, 2018), the ongoing provision of support should be seen by any participating organisation as fundamental. This research has highlighted, in all three studies, that people want to be part of an organisation where they feel supported. In organisations whose workforce routinely place themselves in potential harm's way (physical and/or psychological) provision of non-clinical or clinical psychosocial support should be available should it be needed, not just following a PTE. This provision of support, it is suggested, should be for those that feel they need it, it's what TRiM is for, but it is also important to recognise that the support

should also be for those supplying the support, such as members of the TRiM Team, who as human beings, are also vulnerable (Brooks et al., 2018).

Finally, TRiM is a non-clinical psychosocial intervention, based on pragmatic and structured support from colleagues to colleagues and as such will not always be enough to support those that sustain psychological injury. In some cases, clinical support may be required and all organisations that employ TRiM initiatives should have in place a plan for taking that step. Whether that is through HR, OH or through the local health service, the option should be a viable alternative, that has been thought through, planned and tested in order to ensure the individual(s) receives the timely support they require.

### 5.4 Strengths and limitations of the research

As is the nature with mixed methodology approach (Creswell, 1999), numerous strengths and limitations are often identified as part of the research process. First, the ambitious approach has led to the production of a robust piece of work that, is felt, can genuinely contribute to the general health and wellbeing of those that operate in the most challenging (CPT) environments.

Researching psychological trauma related topics is often fraught with difficulties because of the sensitive nature of the subject, and as a non-clinician, there is a strong desire to do no harm during the process. TRiM uses a combination of clinical diagnostic criteria found in the DSM ($5^{th}$ edition), involving physical threat (including threat to life or serious / sexual injury) and well-founded studies that suggest psychological trauma related symptoms are part the normal human survival instinct (Turnbull, 1998). More broadly speaking trauma may not need to involve any physical harm (Horowitz, 1989). Therefore, a mixed method approach was felt appropriate as it provided an opportunity to create and conduct a number of empirical studies that were both safe and thorough (i.e., they collected rich qualitative and quantitative data from individuals from CPT environments), while ensuring rigor in all subsequent analysis.

Study 1 faced limitations as it was a relatively ambitious study, and it was dealing with, at times, highly sensitive subjects requiring moral and ethical objectivity whilst delicately ensuring significant academic contribution. Choosing suitable candidates to participate in the study took a great deal of consideration and proved challenging, even once people volunteered. Evidence of this was confirmed with the withdrawal of an initially enthusiastic female pilot, and experienced female doctor due to personal reasons. The obvious difficulty in exploring participant's experiences in this context was always a limiting factor with the primary concern of not wanting to re-traumatising individuals while asking them to reflect on past, potentially painful memories (Warren, 2006). In order to mitigate this, along with the detailed information pack, questions during the interviews were delivered in a sensitive and personalised manner, judged by the researcher and constantly evaluated throughout the interviews. Individual and situationally suitable, tailored open questions were asked in order to create an environment where the participant felt comfortable and not pressured into talking about something that they felt difficult delivering. Interestingly, confidence was raised in the process with each of the interviews, as they provided an opportunity for participants to talk of their experiences, which as well as confirming their desire to help others in sharing their precious information, each interview helped each participant through talking and sharing those experiences.

Throughout Study 1 the researcher attempted full diligence and impartiality when questioning participants, as well as when deciphering and analysing data, but it is accepted that it is perhaps unfeasible to remain totally unbiased or impartial throughout any process when you cannot remove previous knowledge and experience in that particular subject. In diligently analysing the data, over and over again in line with Smith and McGannon's (2017) methodology, it was anticipated that these identified limitations were mitigated sufficiently to maintain rigor and thus credibility of the study.

Study 2 also faced a number of limitations in gaining data from a busy operational fire and rescue service unit over a prolonged period of time. This perceived constraint was substantiated with the leaving of seven participants during the 12-month study due to early retirement and being placed on long term sick, largely due to the effects of stress, fatigue and burnout often associated with the nature of the work and lifestyle of emergency services, which is highlighted in a number of empirical studies (Miller, 2021). In summary, sixteen participants from Group1 completed all four time points (TP) but only two from Gp2 completed all four TP's. These figures meant that detailed comparative statistical analysis was not possible, but as nine from Gp2 had completed the first TP (1) and the last TP (4) it was decided to run the limited and cautionary analysis on the premise that all data has some use. It is, however, noted that the analysis between the two groups cannot be considered detailed analysis but it does provide a limited indication. Interestingly, however, two similar but larger comparative studies of TRiM, carried out within UK policing (Hunt et al., 2013; Watson, 2017), using much larger sample sizes ($n$ = 640 and $n$ = 859 respectively), resulted in similar findings of limited significant change across populations regarding sickness absence and associated stigma. So, although small in sample size, the 12-month findings align with previous larger-scale studies on the effectiveness of TRiM. The length and content of the questionnaire was comprehensively thought through at length and the SFRS TRiM lead, who in turn sought feedback from a number of senior TRiM Practitioners, to test suitability of questions and scales, before commencing the study. That said, in hindsight the questionnaire could have been shorter, but it is understood that does not necessary guarantee that participant completion numbers would have been higher.

Finally, one strength of Study 2 within the overall research is a contribution to furthering knowledge in that there is now a longitudinal, empirical, quantitative study of the impact TRiM has on general health and wellbeing within a real-time, busy UK Fire and Rescue

Service. What this study has highlighted, in terms of the importance of follow up conversations, is that although TRiM may not appear to have immediate impact within all workforces, which is not uncommon in other comparative studies on TRiM (Greenberg et al., 2010; Watson, 2018), but with a considered approach over time (6 months following the study completion in this case) the subsequent anecdotal evidence shows significant cultural improvements in how a UK emergency service can effectively support it's risk facing workforce as a result of implementing a TRiM initiative.

Limitations associated with Study 3 were largely, but not solely, attributable to the ongoing COVID19 pandemic, which, in terms of this study, were mostly expected and ultimately managed effectively. As well as taking a considerable toll on general populations globally, the scope of this study, involving people that typically worked in CPT environments, meant that many of the potential participants were caught up in front line positions and sometimes found great difficulty in justifying time to attend the focus group discussions. To this end, a number of planned focus groups were rescheduled to allow subsequent participation. That said, a number of participants were in great demand and eventually, and understandably from a lead researcher perspective, found it impossible to dedicate themselves to the study.

Another shortcoming that was highlighted during the ethics application process when it was determined that serving NHS staff were unable to participate without obtaining NHS ethical approval. The NHS ethics coordinator also felt that this project did not fall within their service evaluation. Although NHS staff inclusion would have added much credibility to the study, as well as providing invaluable data regarding the use of TRiM in an NHS setting, especially in the midst of a global pandemic, the decision was made not to involve any serving NHS staff in the study. This disappointment was, however, offset by the fact that a number of the participants were willing to share their previous experience with using TRiM in an NHS setting. A significant strength, however, in terms of bringing new contributions to the field of

performance psychology, was the involvement of TRiM experts in study 3. The participants were considered a high-quality field of subject matter experts on the subject of using and managing TRiM and provided valuable data for analysis.

In summary, there were always going to be challenges in delivering a body of research that presents a significant contribution to the complex subject of [potential] trauma management as well as the wider field of applied performance psychology. The principal concern throughout was in ensuring the safety of all participants supporting this programme. Considerable strength and confidence were further gained with the knowledge that participants throughout the research process felt they had personally contributed towards helping others and benefitted from the experience as well as participating in a piece of work that aims to share knowledge and better support others that voluntarily place themselves in potential harm's way in CPT environments.

## 5.5 Future research directions

This thesis provides an original contribution to applied performance psychology by increasing the knowledge and understanding of operating in challenging and potentially traumatic (CPT) environments. Importantly, the first-hand information is of projected use for both the 'front line' individuals or teams that directly operate in CPT environments as well as the wider organisations that employ and seek to support their staff in the most diligent and effective way in order to maintain performance levels as well as safeguarding psychological wellbeing.

During the research, as well as on reflection, there are a number of areas or ideas that the findings of the research have uncovered that could be researched in the future in order to increase understanding of this complex and political field (Haines, 2016).

### 5.5.1 Numbers of research participants

Explanations for numbers of participants in each of the three studies has been covered within each chapter but an overall critical evaluation of the sample sizes would suggest that the data

collected could be perceived more robust with more contributors. This does not mean that the data collected, in Study 1 for instance, is inadequate but rather suggests that in future, greater numbers involved in similar studies would provide even greater understanding of the subject of Psychotraumatology, which until recently, was only seriously considered in clinical settings such the Diagnostic and Statistical Manual of Mental Disorders (Jones & Cureton, 2014).

Study 2 was another ambitious study as it not only targeted a busy operational organisation but it also aimed to study a diverse workforce within it. Although it is unrealistic to try and guarantee total participation, greater numbers at the specific time points (TPs) would have certainly been beneficial in making the study more representative (Bryman, 2016). In future research, larger numbers of participants would be preferrable as they should enable a stronger comparative study between groupings (i.e., those receiving TRiM vs. not) which should be considered with any further related studies or research. A greater number of participants in both groups within study 2 would also help achieve sufficient statistical power. For example, initial predictions suggested that up to 80 members of SFRS would participate in Study 2, which would have given sufficient statistical power. The actual ability of individuals or an organisation to participate in research is also another important factor in choosing willing and able sample group for future research.

### 5.5.2 Alternative data collection

This piece of research focused largely on the spoken and perceived experiences of the participants that operate in CPT environments using interviews, questionnaires and focus group discussions to elicit key information from participants. Other methodologies that were not used and could be considered for future research could be meta-analysis of TRiM but also with the use of bio markers. With the use of bio markers, which are characteristics of the body that you can measure such as blood pressure or levels of cortisol and adrenaline (Southwick et al, 2014). Well-known procedures such as measuring Heart Rate Variability (HRV), or taking saliva, hair

or urine samples to test for cortisol (for example), as used in a recent study involving UK Defense and Security personnel that work in volatile, uncertain, complex and ambiguous (VUCA) settings (Jones et al, 2022), could be used to measure levels of stress of participants at various TPs, as in Study 2 for instance, to increase additional data to the research.

Another line of alternative qualitative data collection could be through ethnography (Bryman, 2016). If a TRiM Team member or TRiM training provider, for instance, has an opportunity to embed themselves within an organisation for an extended period of time, there may be an opportunity to employ a wide range of alternative methods of data collection through observation and interviewing, exploring 'lives and experiences', 'in their own setting' (Taylor, 1993). Here, following strict ethical guidelines, not only individual behavioural changes can be documented but also wider cultural changes can be observed, recorded and reported upon.

### 5.5.3 Casting the net wider for other qualifying organisations / populations

There is also an opportunity to use the questionnaire, specifically designed for study 2 and that was designed to measure general health and wellbeing in risk facing organisations, in other similar organisations that may have greater capacity to provider higher numbers of participants at more predictable or consistent timelines. The RNLI, or perhaps with the right clearances, members of the NHS, are two examples that could be considered.

Furthermore, data gained from SMEs in the focus groups of study 3 was invaluable in contributing to the overall research and there is potential for wider use of such groupings both in terms facilitating and co-sharing useful information across similar organisations that would benefit those establishments that wish to employ TRiM. The anecdotal evidence gained from SFRS in the months following Study 2 showing that it may take time for TRiM to be accepted within a busy organisation could again be useful information for such organisations to share and discuss in such sessions.

## 5.6 Conclusion

In conclusion, this thesis provides an original contribution to the field of performance psychology literature by gleaning new insights into non-clinical psychosocial support and trauma and resilience management. The purpose of this thesis was to investigate whether the trauma management model known as TRiM could offer an effective option to support a wider community of risk facing professions and roles (e.g., fire and rescue services, law, international search and rescue charities, risk facing industries, etc.) that also work in challenging, potentially traumatic environments. Three specific studies were designed, conducted and analysed by the researcher in order to provide empirical evidence to shape an informed opinion as to whether the TRiM model was suitable for wider employment in settings potentially outside those that the model was originally designed for, namely the UK military.

The research crucially offers evidence provided by those that operate in CPT environments as well as from Subject Matter Experts that offer support. Combined input, using a mixed methodology approach, has allowed discovery and assessment of what is required by individuals who work in such settings to perform effectively, such as available resources (practical methods of emotional regulation and access to trusted social support). The research has also afforded the researcher the ability to offer the informed opinion that TRiM has the composite attributes to provide a solid platform for the provision of effective support in CPT environments through [proactive] biopsychosocio education, a pragmatic and flexible assessment procedure and guidelines for the provision of ongoing non-clinical / clinical (where required) support. However, this comes with a number of recommendations (Table 5.1), as TRiM is nothing more than a model that requires careful consideration, time and effort to be successful.

Finally, effective support provided for the precious people that operate in CPT environments necessitates strong and compassionate leadership to drive and guide an approach

to understanding what support is really required, to plan thoroughly and deliver diligently whilst encouraging ownership, empowerment and the provision of that ongoing support.

# CHAPTER SIX:

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https://www.nice.org.uk/guidance

https://www.ukpts.co.uk (Traumatic Stress Guidance)

(https://www.walesdenery.org)

https://www.who.int (Mental Health – WHO / World Health Organisation)

# APPENDICES:

# **APPENDIX 1:** STUDY 1 SUPPORTING DOCUMENTATION

**Appendix 1.1** Ethical Approval

**Faculty of Health Sciences**

**ETHICAL APPROVAL FEEDBACK**

| | |
|---|---|
| **Researcher name:** | Steve Eaton |
| **Title of Study:** | Developing Dynamic Resilience |
| **Status of approval:** | Approved |

Thank you for addressing the committee's comments. Your research proposal has now been approved by the Faculty's Ethics Panel and you may commence the implementation phase of your study. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site.

**Signed:** Dr Peter Kevern **Date: 28.4.17**

Chair of the Faculty of Health Sciences Ethics Panel

**Appendix 1.2** Participant Research Information Sheet (incl. Participant Consent Form, Participant Interview Guide, Participant Debrief Document)

## Participant Research Information Sheet

Steve Eaton (SN-15034179)
School of Life Sciences & Education,
Staffordshire University,
College Road,
Stoke-on-Trent.
ST4 2DE

E:
steven.eaton@research.staffs.ac.uk
M: [redacted]
E: m.slater@staffs.ac.uk
M: [redacted]

Dear … ,

I am a PhD student at Staffordshire University, conducting research in Applied Performance Psychology within the School of Life Sciences & Education. This information sheet is being sent to potential participants in line with Staffordshire University ethical considerations to provide relevant information and to avoid individuals feeling pressurised into assisting the research.

The primary aim of this research is to investigate the experiences of individuals that have experienced some form of significantly challenging / potentially traumatic event and to explore how they coped with the experience with a view to inform future trauma management strategies.

A series of interviews, which will last no longer than 90 minutes, will be conducted at a time and place of participants choosing, or via skype where absolutely necessary. Interviews will be digitally recorded (audio only) and fully transcribed; written copies will be sent back to participants after the interview via email for further comments and corrections in order to ensure accurate analysis. A summary of the final report will be sent via e-mail or recorded delivery to each participant, as requested.

To ensure confidentiality, all information obtained through interview pertaining to personal identity will be removed from transcripts and each participant will be issued a Unique Participant Number (UPN). In accordance with Staffordshire University Guidelines, all collected research data will be secured electronically and electronic devices used for storage will be password protected and locked away in a secure room when not in use.

The interview questions have been carefully considered; however, the well-being of participants is paramount to the researcher and as a duty of care the interviews can be abandoned at any time if participants do not wish to continue. Participants are able to withdraw from the study altogether and all pertaining personal information withdrawn up until two weeks following acknowledged receipt of the email containing the copy of the transcript.

It should be stated that participation in the study and the exposure to the subsequent interview questions might cause anxiety, distress and psychological discomfort. For those that have suffered with Posttraumatic Stress Disorder (PTSD) there is a potential risk to mental health and the possibility of a recurrence of previous symptoms as a result of participation. Participation in the study may also reveal facts about psychological status in relation to showing signs of PTSD, again which may cause distress and discomfort in some participants.

Although I am a trained Trauma Risk Management (TRiM) Practitioner I am not qualified to carry out formal psychological assessments or treatments so each interview will be conducted in a relaxed but safe manner, including regular breaks and refreshments as required. A debriefing will be run after each interview, giving participants the opportunity to discuss any concerns they may have.

My contact details, the researcher, and those of my research supervisor are located at the top of this page. Relevant support information will be provided in the Debrief Document, verbally prior to the interview commencing and after the interview.

Research participants can be of any gender but must be 18, or older, and not suffering from any current stress related mental illness to participate in the study. The participant's

traumatic event must have occurred at least 4 months prior to interview but less than 10 years ago. Informed consent will be required from participants prior to the interviews commencing.

If you would be willing to take part, or have any further questions, please contact me on the above e-mail address.

Yours faithfully

Steve Eaton

## Participant Research Consent Form

Steve Eaton (SN-15034179),
School of Life Sciences & Education,
Staffordshire University,
College Road,
Stoke-on-Trent.
ST4 2DE

E:
steven.eaton@research.staffs.ac.uk
M: [redacted]
E: m.slater@staffs.ac.uk
M: [redacted]

**I understand that:**

I am participating in a research project that is investigating potentially trauma related experiences in challenging settings.

I will take part in a 60-90 minute (approximately) interview that will explore my experience of a significantly challenging / potentially traumatic event.

My identity will not be revealed in any written or electronic text and my anonymity will be preserved throughout the study and final report with a Unique Participant Number (UPN). My participation is voluntary, and I may withdraw from the interview at any point without penalty or explanation.

Exposure to the questions in the study and participation may cause anxiety, distress and psychological discomfort and may reveal facts about my psychological status in relation to showing signs of Posttraumatic Stress Disorder (PTSD). If I have previously experienced PTSD there is a risk to my mental health and possibility of recurrence of symptoms as a result of participation.

The challenging / traumatic event occurred more that 4 months ago but no longer than 10 years ago.
I will be de-briefed by the researcher after the interview and receive a copy of the interview transcript via email or recorded delivery post, upon request.

The final report may be used as reference material for future research or may be presented publicly at conferences or in relevant journals.

I have the right to withdraw any personal data recorded through this research up until two weeks following receipt of the copy of the transcript.

The well-being of participants is paramount to the researcher and as a duty of care the interviews can be stopped at any time if participants do not wish to continue. Details of a suitable helpline / support details will be provided verbally at the interview and in The Debrief Document (Appendix D) in case of and adverse effect.

I am 18 or older.

I am not currently suffering from any stress related mental health illness.

**I have read and agree to the above.**

Print Name…….

Signature…….

Date…….

## Participant Research Interview Guide

Steve Eaton (SN-15034179),

School of Life Sciences & Education,
Staffordshire University,
College Road,
Stoke-on-Trent.
ST4 2DE

E:
steven.eaton@research.staffs.ac.uk
M: [redacted]
E: m.slater@staffs.ac.uk
M: [redacted]

**Participant Overview:**

- Brief outline of the research and aims (include reminder of confidentiality).
- Explain conduct of interview (include health and well-being of participant as well as practicalities such as note taking and recording).
- Talk through interview methodology (include explanation of semi-structured and open-ended questioning).

**Introduction:**

- Can you tell me about the significantly challenging / potentially traumatic event that you've been involved in?

    - Note to Researcher – Consider carefully how to ask this most appropriately.

**Identity:**

- Can you tell me if / how the event has changed you (Do you feel stronger / weaker as a result of the event)?

    - Researcher - What has been learned from the experience (about self and about others (have they identified new opportunities as a result of the event))?

**Social context:**

- Can you tell me about the support available to you? (have your relationships with others strengthened or weakened as a result of the event)?

- Can you tell me what / who helped you through the recovery process?

    - Note to researcher – Consider Before, During, After?

**Well-being:**

- Can you tell me how you are in general / specific terms since the event

    - Physically?
    - Mentally?
    - Emotionally?
    - Spiritually (has there been a significant change in your belief system)?

- Is there anything you need / rely on to get by?

**Conclusion:**

- Is there anything else that you would like to mention / talk about?

Thank you for your time.

## Participant Debrief Document

Steve Eaton (SN-15034179)
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ST4 2DE

E:
steven.eaton@research.staffs.ac.uk
M: [redacted]
E: m.slater@staffs.ac.uk
M: [redacted]

Dear … ,

Thank you for taking time to take part in this study which aims to investigate the experiences of individuals that have experienced some form of significantly challenging / potentially traumatic event and to explore how they've coped with the experience. Your invaluable participation will add to the growing body of work of research that is formulating strategies to help people manage potential trauma in high performance settings.

Once transcribed, a copy of the interview will be sent to you, via email or hardcopy, for your perusal and comment if required. If you decide that you've had a change of heart and wish to withdraw your participation from the study, then you can do so up until two weeks after you receive a copy of the transcript.

Care has been taken to ensure that the interviews have been conducted in a manner that has caused you as little distress as possible. If, on reflection, however you have any queries or concerns please contact myself or my supervisor via details below:

**Steve Eaton (researcher):**

Email: steven.eaton@research.staffs.ac.uk
Mobile: [redacted]

**Dr. Matthew Slater (research supervisor):**

Email: m.slater@staffs.ac.uk

Mobile: [redacted]

If, in the unfortunate event you do happen to suffer any adverse effects, then please consult your GP or, alternatively, you can contact Mind, which is a leading mental health charity that supports individuals with mental health concerns or problems:

Web: www.mind.org.uk
Email: supporterservices@mind.org.uk
Phone: 0208 519 2122 (England) / 0292 039 5123 (Wales)

Yours Faithfully

Steve Eaton

**Appendix 1.3** Study 1 interview guide (questions):

| Interview guide (example questions): | Notes for researcher: |
|---|---|
| | *Each interview needed to be approached in a sensitive manner and so each opening* |

| | |
|---|---|
| | *question was tailored to the individual and setting.* |
| **Can you tell me about the significantly challenging / potentially traumatic event that you've been involved in?** | |
| **Can you tell me if / how the event has changed you?** | *How did the participant feel; stronger or weaker etc, as a result of the experience?* |
| | *What had been learned from the experience (about self and about others (have they identified new opportunities as a result of the event)?* |
| **Can you tell me about the support available to you?** | *Had relationships with others altered, strengthened or weakened as a result of the event?* |
| **Can you tell me what / who helped you through the recovery process?** | *Consider before, during and / or after the event.* |
| **Can you tell me how you are in general / specific terms since the event?** | *Did the participant feel a greater appreciation of life in general?*<br>- *Physically?*<br>- *Mentally?*<br>- *Emotionally?*<br>- *Spiritually?* |
| **Is there anything you need / rely on to get by?** | |

| | |
|---|---|
| **Is there anything else that you would like to mention / talk about?** | |

**Appendix 1.4** Interviews: Data Collection and Analysis

a. **Interview 1 - SUVM01**:
   i. Interview transcription
   ii. Interview transcription (coded)
   iii. Interview transcription Codes
   iv. Interview transcription Low Order Themes
   v. Interview transcription High Order Themes
b. **Interview 2 - SUTP02**:
   i. Interview transcription
   ii. Interview transcription (coded)
   *iii.* Interview transcription Codes
   iv. Interview transcription Low Order Themes
   v. Interview transcription High Order Themes
c. **Interview 3 - SUZW03**:
   i. Interview transcription
   ii. Interview transcription (coded)
   iii. Interview transcription Codes
   iv. Interview transcription Low Order Themes
   v. Interview transcription High Order Themes
d. **Interview with SUCR04**:
   i. Interview transcription
   ii. Interview transcription (coded)
   iii. Interview transcription Codes
   iv. Interview transcription Low Order Themes
   v. Interview transcription High Order Themes
e. **Interview with SUJE05**:
   i. Interview transcription
   ii. Interview transcription (coded)
   iii. Interview transcription Codes
   iv. Interview transcription Low Order Themes
   v. Interview transcription High Order Themes
f. **Interview with SUVH06**:
   i. Interview transcription
   ii. Interview transcription (coded)
   iii. Interview transcription Codes

iv. Interview transcription Low Order Themes

v. Interview transcription High Order Themes

g. **Interview with SUEB07**:

i. Interview transcription

ii. Interview transcription (coded)

iii. Interview transcription Codes

iv. Interview transcription Low Order Themes

v. Interview transcription High Order Themes

**Appendix 1.4.1** Example Interview (SUJE05) transcription 'Coded'

Interview with SUJE05

Background

SUJE04 is a former long-standing vicar with years of experience, having presided over many weddings, funerals and services. His final role was that of a parish vicar, responsible for 8 churches in a number of villages and hamlets. Over the years he has provided comfort support to many people at times of sorrow and crisis as well as joy. Years of struggling with personal and family health issues as well as upholding the responsibility of provision of religious and practical human support led to burnout and eventual breakdown.

**Reminder:** *The primary aim of this research is to explore the experiences of individuals from high performance settings that have experienced some form of significantly challenging / potentially traumatic event and to investigate how they coped with the experience with a view to inform future trauma management studies.*

Thematic Analysis:

Each interview will be analysed by the lead researcher, firstly independently, and then collectively in order to identify Codes and key Low Order and High Order Themes in line with thematic analysis (Braun and Clarke, 2006). In this version, coding (highlighted in yellow) is used to identify key areas of interest.

Other topics of interest including the TRiM Risk Factors, which are shown in red text with the prefix T, and the Post Traumatic Growth Risk factors, which are shown in blue text with a prefix P, are also indicated within the transcribed / coded text and are for the researcher's notes and are covered in the final analysis paper.

Interview transcription (coded):

**Can you tell me about your experiences?**

Can I start by giving some background?

**Yes, of course.**

Right, so the unusual thing about being a priest is that people transfer expectations onto you and in a way, they have unrealistic expectations of what a priest can and should be, in terms of being a role model or an exemplar (1) almost leading people into a deeper understanding of their faith which is all very well, but it is being loaded onto a human being, so you are having to deal with multiple expectations that are, more often than not, unrealistic (2). People will transfer to you their expectations, their understandings of how they think a good relationship with God should work, which is quite a big thing to handle because you're dealing with people's expectations and everyone has a different expectation so there's this huge expectation upon you to be something that you're probably not as the corner stone of ministry. It's something we were introduced to as a concept in training, but you can't really understand it until you experience it (3) because more often than not, people's articulation of their expectation comes when they are in moments of crisis or in trauma; (4) when things aren't going right in their lives and then the pressure is placed on you (5). So there has always been a pressure to be something you're not (6). It is very difficult to be somebody else's ideal and inhabit somebody else's not really understood deeply emotional image of how a priest should be (7).

So, I'm not sure I can talk about specific traumas, just how it accumulates (8), and, in a way, you know, the big benchmark moments when you expect trauma to be at its greatest (9). For example, I have conducted funerals for very young children and teenagers who have died in accidents and teenagers that have committed suicide which are about as traumatic for the family as you could possibly hope (10). They are just truly awful situations by which you are truly thrust into a really deep role within that event and all the people involved with it. Those themselves, are not necessarily traumatic because I am comfortable enough in my understanding in why there is suffering in the world so when you experience it, it is horrible. You really feel, and you are caught up in the pain and question 'why'; it is because that's the way the world is, and it can't be any other way. It's horrible. A lot of people have issues of faith and question how God allows this to happen, but God isn't allowing this to happen. It's just the way the word is, and it can't be any other way (11). So, the actual individual event which people outside imagine to be deeply traumatic are actually- and I don't mean to sound callous- but they're relatively straight forward to deal with because you know what's going on (12). People are in the depths of agony and you are, as a priest, providing something that I do not understand, but it helps and you are enabling the crucial process of saying goodbye to the body in a dignified, meaningful way that they find meets a deep need in them and they feel that the goodbye has been well handled, as hideous as it is (13). So, from a personal and professional point of view, they're relatively straight forward to deal with because you know what's going on and of course, being closely involved in such pain is deeply, deeply affecting

on a very deep level but that in itself is not the problem (12). I think that as a priest, that's part of my job and I don't understand what it is I'm bringing into that situation, but I know it helps and anything that helps in that situation has to be good. I know that in a tiny way, I am helping the move through the whole process of grief and hopefully helping them to move to a healthier understanding and moving forward without carrying too much baggage and living permanently with the experience and being overshadowing of the grief (13) because we have to move on and live despite the hideous things we go through (14). And so, that actually is deeply exhausting, but you know inside that you're bringing benefit to people in crisis, so those incidents are not the turning point. The turning point is the pressure of living with a whole host of unrealisable expectations that people place on you (1). Many people understand and are deeply supportive and encouraging in the realism and reality that I am a human being and struggling with all the issues that they are struggling with (15). There are just other people that can't see that, and expect other things, and I think it's the accumulative effect of failing to meet expectations (7) because of course, as a priest, you want to be able to help and you set high standards for the way you should be performing your role (16). You can't be all things for all people and sometimes it just builds up and it's incredible how in a community that is based on a gospel of love, can be, at times, so unchristian and uncaring and just unthinkingly cruel (17) . Those experiences can just build up and build up. Now, looking back over twenty-five years and having been through a fair amount of therapeutic experiences, you can see what's been going on (18). So, I would say that having moved through these break downs and traumas, is that what you wanted, breakdowns?

**Yes, and my definition of trauma, in my book really is being overwhelmed, when your body gets to a position where you can't really function**

Yeah, well I've been through that I would say (19).

**Even if it's for a shorter period of time. Humans are designed to get through these things, as painful as it may be, and you may, in many ways, grow from them but in that moment of time, it's that overwhelming position**

I think looking back on my ministerial life, I've had four moments where it's just become too much (19). The first time, we didn't know what was happening, we just changed the job and thought everything would be OK and so there was no talking amongst those closest to me (20). I've got [redacted] who shares everything with me, she's an absolute rock in my life (21) but also in training, we were encouraged to look at the concept of 'who cares for the carers' and we were offered many models of support. My peer group, the four who did the same

course for three years at college, opted into the peer review method, and so we meet three times a year and we have done so every year for twenty-five years plus. That has been a source of huge strength once I knew what was going on (22). So, the first time with the frustration, the anger, the inability to function (23), we thought was just in the job and that if we moved job, things would be better. That way you get the whole new environment, new everything and the excitement of the thrill of something new to keep me going but four years later, it went again, big time. I wasn't in an environment where I was on my own, I was answerable to other people. The organisation was able to see what was going on and [redacted] was putting in place strategies to get me signed off, but that was all, very little therapy. The NHS psychiatrist thought that my whole problem stemmed from the fact that I believed in God. It wasn't the best place to start. That was the end of that relationship because there was nowhere to go with that one, and again I was thrown on my own resources (24). But it just about, you know, time off got me back to work, if not, aware of what was going on. I think from my own experience, you can only cope, understand and be able to move on from this cycle of traumatic breakdown if you know what's going on. So, the first time it happened, we thought nothing of it and did nothing but moved on to another job. The second time I had time off, therapy and moved on, back to work (25). It was only the third time, so about four years later, the same thing happened, and it just accumulated, and again the sense of not being able to cope with all the expectations that were placed on me. And in this environment, I was a school chaplain so as well as having all the priestly functions, I had all the pressures of being a teacher as well (19). Teaching is in itself a high stress environment, where breakdowns are quite common (26). The third time, I just found everything too much (19). I had therapy and that began to give insights into what was going on. It gave [redacted] and I, and also my peer group, a chance to talk about what was actually happening and to understand and when you look back, this is all deeply involved in who I am (27), not just a priest but a human being so it goes right back into childhood. It helps you to understand that this was shaped by the relationship with my parents that I was struggling (28) because I number two but number one was severely impacted by brain damage at birth. I mean not majorly but he was a precious child but whom I could perform at about aged four in every aspect and so there was just pressure to be better than him and knowing that I shouldn't be better than him and my mother kept worrying about him. Then as we now understand, growing up with dad who was coping with PTSD, which was completely unrecognised and untreated but was also common with his generation. So, when you look back, you find all these issues and they're not excuses but they're just a bigger picture (29). When I go into this world, I think I maybe wasn't the right person to be in this world but perhaps I was, because there's something about the damaged healer being able to touch people (13). So, the third time, we came up with a vocabulary and an awareness of what was going on and how things had gone out of control (30). It was basically, until the third

time, the coping mechanism, even with taking time off was pushing it back under the stove and forgetting about it until it goes away but of course it doesn't. The worm comes back out again, and it zaps your feeling of self-confidence and worthiness (31). How it manifests itself in an absolute overwhelming sense of failure and incompetence and just no sense of your life having any value and I suppose it's a classic scenario that the world would be improved for those around you if you weren't there making it a mess for them. So, there's always been really, really dark, dark thoughts about it.

So, I'm on this sort of cycle which I suppose is a trauma because when you're stood there seriously compensating ending your life, you know you've got the mechanism to hand and you're pretty certain you've got the will to carry it through, I think that's quite a bleak spot isn't it. I've been there, two or three times. Each of the second, third and fourth cycles have ended up with that position (32) but there's always been something small and simple that stops you. I remember once thinking, as I was tying the knot, I'd probably be found by my daughter because the way things were that day. And I can remember her anguish when she found out her rabbit had been killed by a fox and I just thought how that was going to be magnified if she found me. That was that small thing that stopped me, and I thought, you know, put the rope back and I got out of the shed (33). And then you just cope and cope. So, do you want to know about what gets you through it (34)?

**Yes, what got you through it, what made you feel stronger or weaker and the things you learnt along the way?**

Well what I learnt is a bit of why it's happening, about the way I am. It might be from upbringing or genetics, a combination of the two, nature and nurture both at work but this is how I am (35). [redacted] and I both know how I am, so she is able to make me aware when the indicators arrive because we know what they are. Before, If I was in a dark place and she was to challenge me, it would make it worse because I would have reacted incredibly badly and appallingly, and I was very cruel to her with anger and said the most awful things. You just didn't understand but at least now we know what's going on and she can see the signs and she can bring me up short and I know what she's doing (36). I don't normally fly off the handle but sometimes when it's really dark, it's incredibly difficult to cope (37). The saving mechanisms would be the therapy (27). A degree of mindfulness, of just sitting and being in the moment and thinking about how you're feeling now, and mindfulness is about not holding yourself at fault when your mind drifts away from the practices of mindfulness. You don't condemn yourself and if you don't condemn yourself at mindfulness, you don't condemn yourself for not being very good at living life. So, mindfulness is incredibly difficult, being with

yourself at times when everything is bleak and black (38). So, there's therapy to give an insight to what is going on, mindfulness but the key things are the love and support of those closest to you, and for me, that's been [redacted]. And now she's an adult and knows about these things, [redacted]. She can be bloody blunt, and she doesn't mess around (21 & 36). You have to judge your path of response from the person. The GP I had in [redacted] knew that I wanted a spade to be called a bloody shovel, so he would use really strong language and tell me I was a bloody fool for wanting to kill myself and all these other things. In his own way, I think he was giving the right response to the patient, whereas that may not have been the appropriate response for other people, but it was the right response for me (39). So, there's knowledge and understanding from those around you helps but it's the love and support. So there's my family, friends and it's amazing actually as those surprising friends come out of the woodwork and give you time when you're really, really dark. I remember one really unlikely friend came down and took me for a really long walk through the long grass it was just really good because he had come to down to see me especially and it's just that sense of giving me value. The crucial thing is that [redacted] came down and it was really lovely. Another woman who was the mother of a friend, who I would have thought wasn't the most empathetic of characters, took me off to watch an athletics event and her touch was so good because she knew why I was off work and she was just lovely and gentle. It's just those little things and I remember that always (36) (P1). It's being able to see the signs. Anyway, this last one has been the worst of all, it grew and grew because of the pressure and expectations that people had of me and there were lots of things going on all at once and it just got out of hand 19). I could see it coming, [redacted] could see it coming but we just couldn't stop it (40). It really was the bleakest, blackest, darkest one of them all, so much so that it prompted retirement (41). It was a long, long painful journey to come to an understanding of what was going on. About nineteen years ago with the first one, the culture, the climate was completely different in terms of mental illness (42). Now, it's more talked about. It's been put in the public domain. The fact that 'movember' used to just be about prostate cancer but now it's about men's psychological wellbeing because people realised (43). It's not of course, that women don't have psychological issues, it's just that something about men, and I've even seen things on building sites because you know, it's a stressful environment, there's a dangerous job, there's danger, there's deadlines there's weather and all sorts and people have to cope with it. The fact that some building companies are providing supervision to allow the people on the sight to talk about how they're feeling, so there's been a big change (44). I remember about ten or twelve years ago I gave up the pretence and I would just tell people how it was, just like any other illness, I wouldn't be ashamed of telling people (45) I had cancer, but fifty years ago, people were even ashamed of saying they had cancer. I don't know if you remember John Wayne at the Oscars. He said he was 'fighting the big C' and that was the first time anyone in

the public eye had said they had cancer. That was the late 60's. The praise he got from some reporters and also the mindless, dead response of people thinking it wasn't quite right, but he was applauded for being honest and saying what he was doing. That was the late 60's and he was the first person to say he was fighting cancer. Anyway, mental health is moving forward and you're now suffering in an environment where even if people don't understand what's going on, they're aware of what's going on (43). There's those horrible words people say, 'I know how you're feeling' and no they don't. They have an idea about my pain, but you don't 'know'. The word 'know' doesn't help anybody because everyone experiences grief and you don't know how they're feeling because there's a whole package of things and you just understand something of that (46). I know that in the funeral business, just being there and listening to them, supporting and loving them is a huge comfort. And I know there is this, almost a cultural expectation, that you're fulfilling a ritualistic purpose by the vicar coming around. You represent something that people don't understand. They may not be people of faith, they can't quite put their finger on it but they understand that the vicar coming round shows them something that they matter. The amount of people I've visited for being ill, I can tell they really appreciate it because you're not doing anything other than showing them human love, care and concern and showing them that their story matters (10/13) (P1, 2, 3). Knowing that your story matters probably helps. It's a narrow line because when you're fighting a self-annihilation, you are in such a bizarre place and the smallest things can make you stop. I mean I was standing on top of a church tower, preparing to throw myself off. I looked down at the grave of a girl who had committed suicide and I was just able to connect with the absolute devastation that her actions caused, and it was just that one thing that brought me back down the tower. If I hadn't seen that grave and remembered being with the family, I probably would have gone. That was just one little thing, it was a huge, huge thing for the family but just in the moment, just to look over and see the grave, it is sobering because when you're not in that position, it just seems incredible that anyone could be in that position. It's just the madness that swamps you with depression and coping with the pressure and stresses of life. You just crack (13). We're vulnerable human beings and you need to be aware of it, (2) although having said that being aware of it, the last one was my worst, but we crawled through (47). We just decided that probably, there was never going to be a healthy and comfortable or viable life being put in the firing line of these pressures, so we stopped and started looking and exploring new ways of living our lives (48) and finding meaning and purpose (49). I don't want to just sit there and do nothing because I think being involved with people is a vital part of living (P1, 5), not just family but the wider community. So being involved in that has always been important to me (50). The other aspect of caring for myself has been, making a connection between physical health and fitness and mental health and fitness, and so a much more focused attention on exercise. I mean I've always been fit from cycling but

now I know that there is a connection and actually, being fit helps. But It's really difficult when you're having a real struggle to be with yourself, being on a bicycle on your own is really difficult. The reasons I can't run, or anything is because of my knees but I can still ride a bicycle. That's where being a member of a bike club has been extraordinary and it's amazing how many members have been through mental issues and it's lovely that we can now talk about it. They knew why I was riding on a Sunday, I'm not prepared to hide and pretend because I think it's really important to state how you're feeling. And then you find people with something in common and they probably find it comforting to know that someone else is going through it, just to offer them a bit of TLC. I don't know (51), I hope it's made sense.
Are there any questions that you want me to cover?

**I think that's covered everything but how are you now? You made some positive changes and decisions in your life to alleviate, to remove yourself from those environments that are in some ways, toxic environments**

I suppose it has become toxic. I had been able to manage it previously, but I think this time, I've just realised that you can't keep coping with that level of stress. I'm [redacted] and I don't want to be killed by it. We don't know what's around the corner, but you don't want to carry on doing something that we know is going to shorten our life (52). Even if there is a financial cost to it, but we will cope with that as we can. The great thing is that [redacted] and I are in it together. I think that's the most important thing (53), that she's being able to learn about what's going on with me and looking back, I have always been a troubled soul. I don't know why anyone would be attracted to a troubled soul, but I suppose she's been a bit troubled as well (54). So, can you extract anything out of that as a value?

**One of the questions: Is there anything you need in life to get by? But you've just answered that. With Jo and mentioned purpose earlier, and working with people**

That's always been hugely important to my understanding of what it is to be a person. I've had a very privileged life, but I just think I've been very lucky in so many ways and I've done things to help me cope. I know that stretching and testing myself as a young person was incredibly important because it gives you a sense of how resilient you are as a human being (55). it's of huge importance, to give those experiences to young people. That's why I'm so keen with the Duke of Edinburgh, I think that's given me a focus (56) (P1-5). I might go back to work as an Uber Driver or something. Why not?

**Is there anything else you would like to mention?**

The crucial thing is being able to talk about it. Now I can talk about it with people in the wider world, like people at the bike club. You know them quite well as cyclists, but they're not people you know so well but it's incredible how much people can offer support or just a quiet word of support if you're rolling across the tarmac. I may be more vulnerable to breakdown than others but that's where I am, and you can't change that. Being free of work has been a huge blessing but I know I'm not out the woods (58).

**You said earlier, because of the expectations from others, you weren't being authentic to yourself but now you've got an opportunity to be authentic, talking to people.**

Yes, I just think about being more understanding and more aware of others because you realise that one way or another, people are coping with something (59). There's a climbing phrase, 'feeding the rat' about how everyone's got a rat inside them that needs feeding with adrenaline, and everybody has got different ways of coping. People may have hungrier rats. Whatever people are experiencing, is real for them and the crucial thing is not to belittle them but to make them understand that its absolutely OK and they're not exceptional and that there is hope afterwards (60). When you're in that absolute blackness where you've lost all sense of worth, it is a bloody difficult place. It's dark and lonely (61). Once you're there, you can't really be touched by anybody. Actions and memory and connection draw you back from that one event so maybe you don't go quite as far next time and you just stagger through and begin to realise you can get better again and you are of value and worth. It's almost bad luck when people who do kill themselves do it because they haven't been able to have that moment, that tiny flash of clarity and realisation of their value and I've been very lucky (62). Three times I've really come closest to it and each time I've been very, very lucky, different ways and different things have stopped me.

**Appendix 1.4.2** SUJE05 Transcription Codes

Interview with SUJE05

Background

SUJE05 is a former long-standing vicar with years of experience, having presided over many weddings, funerals and services. His final role was that of a parish vicar, responsible for 8 churches in a number of villages and hamlets. Over the years he has provided comfort support to many people at times of sorrow and crisis as well as joy. Years of struggling with personal and family health issues as well as upholding the responsibility of provision of religious and practical human support led to burnout and eventual breakdown.

**Reminder:** *The primary aim of this research is to explore the experiences of individuals from high performance settings that have experienced some form of significantly challenging / potentially traumatic event and to investigate how they coped with the experience with a view to inform future trauma management studies.*

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Each interview will be analysed by the lead researcher, firstly independently, and then collectively in order to identify Codes and key Low Order and High Order Themes in line with thematic analysis (Braun and Clarke, 2006). In this version, coding (highlighted in yellow) is used to identify key areas of interest.

Other topics of interest including the TRiM Risk Factors, which are shown in red text with the prefix T, and the Post Traumatic Growth Risk factors, which are shown in blue text with a prefix P, are also indicated within the transcribed / coded text and are for the researcher's notes and are covered in the final analysis paper.

Codes identified:

1. Misguided or unrealistic expectations of someone*
2. Frailties of being just a human!*
3. Identifying the realities and differences between training, often in benign conditions, to real life experiences*

4. Others asking for help and support when going through psychologically challenging times*
5. Psychological pressure applied from someone else*
6. Expectation of you to be something, that you're actually not (not being authentic – social identity) *
7. The struggle of constantly trying to live up to other's expectations*
8. Awareness of chronic and **accumulated trauma** rather than acute trauma*
9. Being in a role **expecting potentially traumatic experiences***
10. Being involved with closely supporting strangers through intimate mourning and grieving experiences, such as following the death of children – **vicarious trauma***
11. Pressure from others in expecting you to answer impossible questions … especially, to do with belief and faith*
12. Mitigating potential trauma through knowledge and understanding gained from experience of self and others*
13. Acknowledgement of providing a meaningful service in terms of **purpose***
14. Acknowledgement that sometimes life is really tough but you either get lost in past experiences or you reach acceptance and move forward with life*
15. Acknowledgement of **being human** and the associated benefits of receiving or providing **[social] support** by some*
16. Personal pride in one's own efforts in **trying to be the best one can** for the benefit of self and others*
17. Feeling of **disbelief and bewilderment** (and great sadness) at other human's behaviour – feeling of **social / group betrayal** and **loss of trust***
18. Benefits of **reflection***
19. Describing the longitudinal and accumulative (potentially) traumatic experiences as **overwhelm**ing experiences*
20. Experiencing trauma but not always recognising it in self*
21. Effective psychological support provided by loved ones*
22. Effective psychological support encouraged and provided by peers and colleagues*
23. Acute reactions to stress*
24. Overall feeling of surprise, disappointment and being let down by others – **Moral Injury***
25. Evidence of raising awareness and increasing knowledge through education and experience in order to process and move forward*
26. Acknowledging high-pressure, high-performance environment*

27. Psychological intervention, such as some form of therapy (CBT?), being a useful intervention in raising awareness and increasing understanding in an individual and group setting*
28. Suggestion of childhood trauma – evidence of complexities (complex PTSD?)*
29. Evidence of being surrounded by other stress related illnesses in family members*
30. Taking proactive steps to identify and deal with issues as they arise*
31. Showing how not allowing oneself to identify and process psychological issues means that they aren't **processed** correctly, **and acceptance** isn't reached in a timely way*
32. Despair in one's position leading to suicidal thoughts*
33. Something or someone that stops you committing suicide*
34. Denial – getting so depressed, so stressed you enter a dissociative state where human cognition doesn't allow you to figure out the rational thoughts, it wants to keep you away (and safe) so there is little / no processing conducted*
35. Awareness of why stress levels are increased and importantly how one normally reacts to it – a way of normalising situation*
36. Teaming up and using trusted family or friends to make you more aware of behaviour (signs, attitude etc.) that you may not notice yourself and to help you manage the experience, process and move forward*
37. The desperation of overwhelm (fight & Flight) that can even lead to violence in the calmest and rational of people*
38. Even practicing **mindfulness** is a challenge when the outlook is so desperate (**lack of hope**)*
39. Gauging appropriate responses for different people in different circumstances (Coaching approach to ownership and personal responsibility … only the person involved knows what they're thinking or feeling?)*
40. When you're in the midst of overwhelm caused by accumulative trauma it can be extremely difficult to alter behaviours, even when you think you should be well prepared for it. Helpless in the midst of trauma. Shutting down is one of the evolutionary natural responses to overwhelm / trauma*
41. Acknowledgement of being in a really depressed state*
42. Evidence of the accumulative effect of increased stress levels over time and the toll taken*
43. Men's mental health being in the public eye*
44. Raising the point that men often suppress emotions in order to hide or deny feelings in company of other [men]*

45. Eventually facing up to years of the effects of stress and admitting there was a problem*
46. Expressing the point that feelings are internal and that, even if they try really hard to empathise, people still can't really feel what others are feeling and can't actually know for sure*
47. Hope – it may be a struggle, but resilience can prevail, and situations can improve through being cognisant and generally more aware of self*
48. Sometimes a change of direction in life helps – **learning through adversity** (post traumatic growth?)*
49. Finding renewed purpose through 'decompressing' and making new choices*****
50. The importance of being with other 'trusted' people **(biological imperative)***
51. The benefits on overall well-being, even from the depths of despair, from exercise and generally looking after yourself (sleep, nutrition, hydration & exercise) and especially if it's in the company of others (although not always essential)
52. Realising that sometimes you just need to change what you're doing and remove yourself from the adverse situation or environment*
53. Moving forward in life, enabled by the support of people you trust and feel safe with*
54. Shared experience enabling a stronger bond between caring humans*
55. Acknowledgement of being a human and the requirement to face adversity in order to learn life lessons and build personal resilience*
56. Willingness to pass on lessons learned to others, especially the younger*
57. Evidence of 'biological imperative' and the power of talking about or sharing problems in order to aid psychological recovery*
58. Being realistic in facing life's challenges*
59. Increased understanding acknowledging that all humans are facing personal challenges all the time*
60. Normalising human struggles*
61. When consumed by trauma, the feeling of being absolutely isolated from others*

Explaining that tough as things get, the hardship most often subsides and most do get through it, often with the support from others … it will stop

**Appendix 1.4.3** SUJE05 Transcription Low Order Themes (LOTs)

Interview with SUJE05

Background

SUJE05 is a former long-standing vicar with years of experience, having presided over many weddings, funerals and services. His final role was that of a parish vicar, responsible for 8 churches in a number of villages and hamlets. Over the years he has provided comfort support to many people at times of sorrow and crisis as well as joy. Years of struggling with personal and family health issues as well as upholding the responsibility of provision of religious and practical human support led to burnout and eventual breakdown.

**Reminder:** *The primary aim of this research is to explore the experiences of individuals from high performance settings that have experienced some form of significantly challenging / potentially traumatic event and to investigate how they coped with the experience with a view to inform future trauma management studies.*

Thematic Analysis:

Each interview will be analysed by the lead researcher, firstly independently, and then collectively in order to identify Codes and key Low Order and High Order Themes in line with thematic analysis (Braun and Clarke, 2006). In this version, coding (highlighted in yellow) is used to identify key areas of interest.

Other topics of interest including the TRiM Risk Factors, which are shown in red text with the prefix T, and the Post Traumatic Growth Risk factors, which are shown in blue text with a prefix P, are also indicated within the transcribed / coded text and are for the researcher's notes and are covered in the final analysis paper.

Low Order Themes identified:

62. **The struggle to be authentic (Social identity):**

The constant tussle to be true to yourself when faced with external pressures and maintain honesty with yourself, staying true to your values and beliefs.

- Codes: 1, 2, 3, 4, 5, 6, 7, 8, 11, 13, 14, 15, 16, 17, 18, 24, 27, 28, 32, 34, 36, 39, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62

63. **Acknowledgement of existential reality – humans are fallible!**

Understanding that human beings, even the most professional or diligent, don't always get things right and they sometimes falter in the face of hardship or adversity.

- Codes: 1, 2, 3, 4, 7, 8, 9, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 28, 29, 30, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62

64. **Social Support:**

In this case realising how important trusted relationships are, in terms of continued support in the face of adversity and providing a safe environment in order to make difficult decisions regarding how one lives life or chooses not to.

- Codes: 4, 7, 10, 12, 13, 15, 16, 17, 20, 21, 22, 24, 25, 27, 29, 30, 31, 33, 35, 36, 39, 43, 44, 50, 51, 52, 53, 54, 55, 56, 57, 59, 60, 61, 62

65. **Becoming overwhelmed by the accumulation of stressors or trauma:**

The increase of stressors and other significant life factors can have a detriment effect on personal performance and in this case lead to one questioning one's religious beliefs.

- Codes: 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 16, 19, 20, 23, 26, 28, 29, 30, 31, 32, 34, 35, 37, 38, 40, 41, 42, 44, 45, 47, 51, 52, 55, 57, 58, 60, 61, 62

66. **Providing a service – having a sense of purpose:**

A key factor in leading a fulfilling life, having meaningful purpose can also be an important factor in maintaining personal resilience.

- Codes: 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 24, 25, 27, 30, 33, 38, 39, 47, 48, 49, 50, 52, 54, 55, 56, 57, 58, 59, 60, 61, 62

67. **Moral injury – Feelings associated with surprise, sadness and disappointment at the behaviour of others:**

Feeling let down and unsupported either by individuals, groups or by the organization that you 'work for'.

- Codes: 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17, 24, 31, 32, 34, 37, 39, 40, 50, 52, 53, 54, 55, 61

68. **Personal awareness of how one is coping with stress / trauma:**

Having the ability to recognise signs and symptoms of increased acute and chronic stress in oneself through biopsychosocio education is vital for modification of personal thoughts, feeling and behaviours in order to reduce overwhelm.

- Codes: 2, 3, 4, 5, 7, 8, 9, 10, 12, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 49, 50, 51, 52, 53, 54, 55, 57, 59, 60, 61

69. **Useful 'non-clinical' interventions (counselling, coaching etc):**

The use of interventions such as coaching can provide a form of support that encourages ownership and responsibility in learning lessons through challenging situations where a medical or clinical involvement is not deemed necessary.

- Codes: 4, 7, 8, 9, 10, 12, 15, 16, 18, 20, 21, 22, 25, 27, 30, 33, 35, 36, 38, 39, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62

70. **Effects of trauma on performance (including complex (childhood) issues):**

Overwhelming stress levels and the effects of psychological trauma can affect any form of performance especially in highly challenging scenarios.

- Codes: 1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 14, 15, 17, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62

71. **Loss of hope leading to despair and thoughts of suicide:**

- Codes: 1, 2, 3, 4, 6, 7, 9, 11, 17, 19, 20, 24, 26, 27, 28, 29, 32, 37, 38, 40, 41, 42, 43, 44, 46, 61

72. **Denial of own emotions and feelings (especially in men):**

In order to perform in high performance settings, it is sometimes the case where people feel they have to show a 'stiff upper lip'.

- Codes: 1, 7, 8, 9, 10, 20, 27, 28, 29, 31, 34, 38, 39, 40, 41, 42, 44, 45, 46, 55, 59, 60, 61

73. **Realisation, awareness and acceptance of factors associated with where 'you' are now:**

- Codes: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62

74. **The power of Hope:**

- Codes: 4, 9, 10, 12, 13, 14, 15, 16, 18, 21, 22, 25, 27, 30, 31, 33, 35, 36, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62

75. **Change of direction in life – doing something different:**

- Codes: 6, 7, 9, 10, 11, 13, 16, 17, 18, 24, 25, 26, 27, 36, 45, 47, 48, 49, 50, 51, 52, 53, 55, 58, 60

76. **Shared experience and learning through adversity PTG / AG):**

The benefits of peer support, especially from those with a degree of shared experience.

- Codes: 3, 4, 6, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 29, 30, 31, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62

**Appendix 1.4.4** SUJE05 Transcription High Order Themes (HOTs)

Interview with SUJE05

Background

SUJE05 is a former long-standing vicar with years of experience, having presided over many weddings, funerals and services. His final role was that of a parish vicar, responsible for 8 churches in a number of villages and hamlets. Over the years he has provided comfort support to many people at times of sorrow and crisis as well as joy. Years of struggling with personal and family health issues as well as upholding the responsibility of provision of religious and practical human support led to burnout and eventual breakdown.

**Reminder:** *The primary aim of this research is to explore the experiences of individuals from high performance settings that have experienced some form of significantly challenging / potentially traumatic event and to investigate how they coped with the experience with a view to inform future trauma management studies.*

Thematic Analysis:

Each interview will be analysed by the lead researcher, firstly independently, and then collectively in order to identify Codes and key Low Order and High Order Themes in line with thematic analysis (Braun and Clarke, 2006). In this version, coding (highlighted in yellow) is used to identify key areas of interest.

Other topics of interest including the TRiM Risk Factors, which are shown in red text with the prefix T, and the Post Traumatic Growth Risk factors, which are shown in blue text with a prefix P, are also indicated within the transcribed / coded text and are for the researcher's notes and are covered in the final analysis paper.

High Order Themes identified:

1. **Managing authenticity and maintaining meaningful purpose:**

    - LOT 1 (Codes: 1, 2, 3, 4, 5, 6, 7, 8, 11, 13, 14, 15, 16, 17, 18, 24, 27, 28, 32, 34, 36, 39, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)

- LOT 2 (  Codes: 1, 2, 3, 4, 7, 8, 9, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 28, 29, 30, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 3 (Codes: 4, 7, 10, 12, 13, 15, 16, 17, 20, 21, 22, 24, 25, 27, 29, 30, 31, 33, 35, 36, 39, 43, 44, 50, 51, 52, 53, 54, 55, 56, 57, 59, 60, 61, 62)
- LOT 5 (Codes: 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 24, 25, 27, 30, 33, 38, 39, 47, 48, 49, 50, 52, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 6 (Codes: 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17, 24, 31, 32, 34, 37, 39, 40, 50, 52, 53, 54, 55, 61)
- LOT 7 (Codes: 2, 3, 4, 5, 7, 8, 9, 10, 12, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 49, 50, 51, 52, 53, 54, 55, 57, 59, 60, 61)
- LOT 8 (Codes: 4, 7, 8, 9, 10, 12, 15, 16, 18, 20, 21, 22, 25, 27, 30, 33, 35, 36, 38, 39, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 9 (Codes: 1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 14, 15, 17, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 10 (Codes: 1, 2, 3, 4, 6, 7, 9, 11, 17, 19, 20, 24, 26, 27, 28, 29, 32, 37, 38, 40, 41, 42, 43, 44, 46, 61)
- LOT 11 (Codes: 1, 7, 8, 9, 10, 20, 27, 28, 29, 31, 34, 38, 39, 40, 41, 42, 44, 45, 46, 55, 59, 60, 61)
- LOT 12 (Codes: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 13 (Codes: 4, 9, 10, 12, 13, 14, 15, 16, 18, 21, 22, 25, 27, 30, 31, 33, 35, 36, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62)
- LOT 14 (Codes: 6, 7, 9, 10, 11, 13, 16, 17, 18, 24, 25, 26, 27, 36, 45, 47, 48, 49, 50, 51, 52, 53, 55, 58, 60)
- LOT 15 (Codes: 3, 4, 6, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 29, 30, 31, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)

2. **Having a trusted support network (social ecosystem):**

- LOT 1 (Codes:  1, 2, 3, 4, 5, 6, 7, 8, 11, 13, 14, 15, 16, 17, 18, 24, 27, 28, 32, 34, 36, 39, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 2 (Codes: 1, 2, 3, 4, 7, 8, 9, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 28, 29, 30, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)

- LOT 3 (Codes: 4, 7, 10, 12, 13, 15, 16, 17, 20, 21, 22, 24, 25, 27, 29, 30, 31, 33, 35, 36, 39, 43, 44, 50, 51, 52, 53, 54, 55, 56, 57, 59, 60, 61, 62)
- LOT 4 (Codes: 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 16, 19, 20, 23, 26, 28, 29, 30, 31, 32, 34, 35, 37, 38, 40, 41, 42, 44, 45, 47, 51, 52, 55, 57, 58, 60, 61, 62)
- LOT 5 (Codes: 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 24, 25, 27, 30, 33, 38, 39, 47, 48, 49, 50, 52, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 6 (Codes: 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17, 24, 31, 32, 34, 37, 39, 40, 50, 52, 53, 54, 55, 61)
- LOT 7 (Codes: 2, 3, 4, 5, 7, 8, 9, 10, 12, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 49, 50, 51, 52, 53, 54, 55, 57, 59, 60, 61)
- LOT 8 (Codes: 4, 7, 8, 9, 10, 12, 15, 16, 18, 20, 21, 22, 25, 27, 30, 33, 35, 36, 38, 39, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 9 (Codes: 1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 14, 15, 17, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 10 (Codes: 1, 2, 3, 4, 6, 7, 9, 11, 17, 19, 20, 24, 26, 27, 28, 29, 32, 37, 38, 40, 41, 42, 43, 44, 46, 61)
- LOT 11 (Codes: 1, 7, 8, 9, 10, 20, 27, 28, 29, 31, 34, 38, 39, 40, 41, 42, 44, 45, 46, 55, 59, 60, 61)
- LOT 12 (Codes: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 13 (Codes: 4, 9, 10, 12, 13, 14, 15, 16, 18, 21, 22, 25, 27, 30, 31, 33, 35, 36, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62)
- LOT 14 (Codes: 6, 7, 9, 10, 11, 13, 16, 17, 18, 24, 25, 26, 27, 36, 45, 47, 48, 49, 50, 51, 52, 53, 55, 58, 60)
- LOT 15 (Codes: 3, 4, 6, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 29, 30, 31, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)

3. **Being aware of being accumulative stressors and managing personal overwhelm effectively:**

- LOT 1 (Codes: 1, 2, 3, 4, 5, 6, 7, 8, 11, 13, 14, 15, 16, 17, 18, 24, 27, 28, 32, 34, 36, 39, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 2 ( Codes: 1, 2, 3, 4, 7, 8, 9, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 28, 29, 30, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)

- LOT 3 (Codes: 4, 7, 10, 12, 13, 15, 16, 17, 20, 21, 22, 24, 25, 27, 29, 30, 31, 33, 35, 36, 39, 43, 44, 50, 51, 52, 53, 54, 55, 56, 57, 59, 60, 61, 62)
- LOT 4 (Codes: 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 16, 19, 20, 23, 26, 28, 29, 30, 31, 32, 34, 35, 37, 38, 40, 41, 42, 44, 45, 47, 51, 52, 55, 57, 58, 60, 61, 62)
- LOT 6 (Codes: 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17, 24, 31, 32, 34, 37, 39, 40, 50, 52, 53, 54, 55, 61)
- LOT 7 (Codes: 2, 3, 4, 5, 7, 8, 9, 10, 12, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 49, 50, 51, 52, 53, 54, 55, 57, 59, 60, 61)
- LOT 8 (Codes: 4, 7, 8, 9, 10, 12, 15, 16, 18, 20, 21, 22, 25, 27, 30, 33, 35, 36, 38, 39, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 9 (Codes: 1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 14, 15, 17, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 10 (Codes: 1, 2, 3, 4, 6, 7, 9, 11, 17, 19, 20, 24, 26, 27, 28, 29, 32, 37, 38, 40, 41, 42, 43, 44, 46, 61)
- LOT 11 (Codes: 1, 7, 8, 9, 10, 20, 27, 28, 29, 31, 34, 38, 39, 40, 41, 42, 44, 45, 46, 55, 59, 60, 61)
- LOT 12 (Codes: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 13 (Codes: 4, 9, 10, 12, 13, 14, 15, 16, 18, 21, 22, 25, 27, 30, 31, 33, 35, 36, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62)
- LOT 14 (Codes: 6, 7, 9, 10, 11, 13, 16, 17, 18, 24, 25, 26, 27, 36, 45, 47, 48, 49, 50, 51, 52, 53, 55, 58, 60)
- LOT 15 (Codes: 3, 4, 6, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 29, 30, 31, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)

4. **Maintaining hope and finding acceptance:**

- LOT 1 (Codes: 1, 2, 3, 4, 5, 6, 7, 8, 11, 13, 14, 15, 16, 17, 18, 24, 27, 28, 32, 34, 36, 39, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 2 ( Codes: 1, 2, 3, 4, 7, 8, 9, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 28, 29, 30, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 3 (Codes: 4, 7, 10, 12, 13, 15, 16, 17, 20, 21, 22, 24, 25, 27, 29, 30, 31, 33, 35, 36, 39, 43, 44, 50, 51, 52, 53, 54, 55, 56, 57, 59, 60, 61, 62)

- LOT 5 (Codes: 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 24, 25, 27, 30, 33, 38, 39, 47, 48, 49, 50, 52, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 6 (Codes: 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17, 24, 31, 32, 34, 37, 39, 40, 50, 52, 53, 54, 55, 61)
- LOT 7 (Codes: 2, 3, 4, 5, 7, 8, 9, 10, 12, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 49, 50, 51, 52, 53, 54, 55, 57, 59, 60, 61)
- LOT 8 (Codes: 4, 7, 8, 9, 10, 12, 15, 16, 18, 20, 21, 22, 25, 27, 30, 33, 35, 36, 38, 39, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 9 (Codes: 1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 14, 15, 17, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 12 (Codes: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 13 (Codes: 4, 9, 10, 12, 13, 14, 15, 16, 18, 21, 22, 25, 27, 30, 31, 33, 35, 36, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62)
- LOT 14 (Codes: 6, 7, 9, 10, 11, 13, 16, 17, 18, 24, 25, 26, 27, 36, 45, 47, 48, 49, 50, 51, 52, 53, 55, 58, 60)
- LOT 15 (Codes: 3, 4, 6, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 29, 30, 31, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)

5. **Adversarial growth (including post traumatic):**

- LOT 1 (Codes: 1, 2, 3, 4, 5, 6, 7, 8, 11, 13, 14, 15, 16, 17, 18, 24, 27, 28, 32, 34, 36, 39, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 2 ( Codes: 1, 2, 3, 4, 7, 8, 9, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 28, 29, 30, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 3 (Codes: 4, 7, 10, 12, 13, 15, 16, 17, 20, 21, 22, 24, 25, 27, 29, 30, 31, 33, 35, 36, 39, 43, 44, 50, 51, 52, 53, 54, 55, 56, 57, 59, 60, 61, 62)
- LOT 4 (Codes: 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 16, 19, 20, 23, 26, 28, 29, 30, 31, 32, 34, 35, 37, 38, 40, 41, 42, 44, 45, 47, 51, 52, 55, 57, 58, 60, 61, 62)
- LOT 5 (Codes: 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 24, 25, 27, 30, 33, 38, 39, 47, 48, 49, 50, 52, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 6 (Codes: 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17, 24, 31, 32, 34, 37, 39, 40, 50, 52, 53, 54, 55, 61)

- LOT 7 (Codes: 2, 3, 4, 5, 7, 8, 9, 10, 12, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 49, 50, 51, 52, 53, 54, 55, 57, 59, 60, 61)
- LOT 8 (Codes: 4, 7, 8, 9, 10, 12, 15, 16, 18, 20, 21, 22, 25, 27, 30, 33, 35, 36, 38, 39, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 9 (Codes: 1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 14, 15, 17, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 10 (Codes: 1, 2, 3, 4, 6, 7, 9, 11, 17, 19, 20, 24, 26, 27, 28, 29, 32, 37, 38, 40, 41, 42, 43, 44, 46, 61)
- LOT 11 (Codes: 1, 7, 8, 9, 10, 20, 27, 28, 29, 31, 34, 38, 39, 40, 41, 42, 44, 45, 46, 55, 59, 60, 61)
- LOT 12 (Codes: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
- LOT 13 (Codes: 4, 9, 10, 12, 13, 14, 15, 16, 18, 21, 22, 25, 27, 30, 31, 33, 35, 36, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62)
- LOT 14 (Codes: 6, 7, 9, 10, 11, 13, 16, 17, 18, 24, 25, 26, 27, 36, 45, 47, 48, 49, 50, 51, 52, 53, 55, 58, 60)
- LOT 15 (Codes: 3, 4, 6, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 29, 30, 31, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)

# **Appendix 1.5** General Dimension Analysis

| Codes: | Low Order Themes: | High Order Themes: |
|---|---|---|
| 1. Misguided or unrealistic expectations of someone*<br>2. Frailties of being just a human!*<br>3. Identifying the realities and differences between training, often in benign conditions, to real life experiences*<br>4. Others asking for help and support when going through psychologically challenging times*<br>5. Psychological pressure applied from someone else*<br>6. Expectation of you to be something, that you're actually not (not being authentic – social identity)*<br>7. The struggle of constantly trying to live up to other's expectations*<br>8. Awareness of chronic and **accumulated trauma** rather than acute trauma*<br>9. Being in a role **expecting potentially traumatic experiences*** <br>10. Being involved with closely supporting strangers through intimate mourning and grieving experiences, such as following the death of children – **vicarious trauma***<br>11. Pressure from others in expecting you to answer impossible questions … especially, to do with belief and faith*<br>12. Mitigating potential trauma through knowledge and understanding gained from experience of self and others*<br>13. Acknowledgement of providing a meaningful service in terms of **purpose***<br>14. Acknowledgement that sometimes life is really tough but you either get lost in past experiences or you reach acceptance and move forward with life*<br>15. Acknowledgement of **being human** and the associated benefits of receiving or providing **[social] support** by some*<br>16. Personal pride in one's own efforts in **trying to be the best one can** for the benefit of self and others*<br>17. Feeling of **disbelief and bewilderment** (and great sadness) at other human's behavior – feeling of **social / group betrayal** and **loss of trust***<br>18. Benefits of **reflection***<br>19. Describing the longitudinal and accumulative (potentially) traumatic experiences as **overwhelm**ing experiences*<br>20. Experiencing trauma but not always recognising it in self*<br>21. Effective psychological support provided by loved ones*<br>22. Effective psychological support encouraged and provided by peers and colleagues*<br>23. Acute reactions to stress*<br>24. Overall feeling of surprise, disappointment and being let down by others – **Moral Injury***<br>25. Evidence of raising awareness and increasing knowledge through education and experience in order to process and move forward*<br>26. High pressure, high performance environment*<br>27. Psychological intervention, such as some form of therapy (CBT?), being a useful intervention in raising awareness and increasing understanding in an individual and group setting*<br>28. Suggestion of childhood trauma – evidence of complexities (complex PTSD?)*<br>29. Evidence of being surrounded by other stress related illnesses in family members*<br>30. Taking proactive steps to identify and deal with issues as they arise*<br>31. Showing how not allowing oneself to identify and process psychological issues means that they aren't **processed** correctly, **and acceptance** isn't reached in a timely way*<br>32. Despair in one's position leading to suicidal thoughts*<br>33. Something or someone that stops you committing suicide* | 1. **The struggle to be authentic (Social identity):**<br>The constant tussle to be true to yourself when faced with external pressures and maintain honesty with yourself, staying true to your values and beliefs.<br>Codes: 1, 2, 3, 4, 5, 6, 7, 8, 11, 13, 14, 15, 16, 17, 18, 24, 27, 28, 32, 34, 36, 39, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62<br><br>2. **Acknowledgement of existential reality – humans are fallible!**<br>Understanding that human beings, even the most professional or diligent, don't always get things right and they sometimes falter in the face of hardship or adversity.<br>Codes: 1, 2, 3, 4, 7, 8, 9, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 28, 29, 30, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62<br><br>3. **Social Support:**<br>In this case realising how important trusted relationships are, in terms of continued support in the face of adversity and providing a safe environment in order to make difficult decisions regarding how one lives life or chooses not to.<br>Codes: 4, 7, 10, 12, 13, 15, 16, 17, 20, 21, 22, 24, 25, 27, 29, 30, 31, 33, 35, 36, 39, 43, 44, 50, 51, 52, 53, 54, 55, 56, 57, 59, 60, 61, 62<br><br>4. **Becoming overwhelmed by the accumulation of stressors or trauma:**<br>The increase of stressors and other significant life factors can have a detriment effect on personal performance and in this case lead to one questioning one's religious beliefs.<br>Codes: 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 16, 19, 20, 23, 26, 28, 29, 30, 31, 32, 34, 35, 37, 38, 40, 41, 42, 44, 45, 47, 51, 52, 55, 57, 58, 60, 61, 62<br><br>5. **Providing a service – having a sense of purpose:**<br>A key factor in leading a fulfilling life, having meaningful purpose can also be an important factor in maintaining personal resilience.<br>Codes: 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 24, 25, 27, 30, 33, 38, 39, 47, 48, 49, 50, 52, 54, 55, 56, 57, 58, 59, 60, 61, 62<br><br>6. **Moral injury – Feelings associated with surprise, sadness and disappointment at the behaviour of others:**<br>Feeling let down and unsupported either by individuals, groups or by the organization that you 'work for'.<br>Codes: 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17, 24, 31, 32, 34, 37, 39, 40, 50, 52, 53, 54, 55, 61<br><br>7. **Personal awareness of how one is coping with stress / trauma:**<br>Having the ability to recognise signs and symptoms of increased acute and chronic stress in oneself through biopsychosocio education is vital for modification of personal thoughts, feeling and behaviours in order to reduce overwhelm.<br>Codes: 2, 3, 4, 5, 7, 8, 9, 10, 12, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 49, 50, 51, 52, 53, 54, 55, 57, 59, 60, 61 | **1. Managing authenticity and maintaining meaningful purpose:**<br>LOT 1 (Codes: 1, 2, 3, 4, 5, 6, 7, 8, 11, 13, 14, 15, 16, 17, 18, 24, 27, 28, 32, 34, 36, 39, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br><br>LOT 2 ( Codes: 1, 2, 3, 4, 7, 8, 9, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 28, 29, 30, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br>LOT 3 (Codes: 4, 7, 10, 12, 13, 15, 16, 17, 20, 21, 22, 24, 25, 27, 29, 30, 31, 33, 35, 36, 39, 43, 44, 50, 51, 52, 53, 54, 55, 56, 57, 59, 60, 61, 62)<br>LOT 5 (Codes: 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 24, 25, 27, 30, 33, 38, 39, 47, 48, 49, 50, 52, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br>LOT 6 (Codes: 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17, 24, 31, 32, 34, 37, 39, 40, 50, 52, 53, 54, 55, 61)<br>LOT 7 (Codes: 2, 3, 4, 5, 7, 8, 9, 10, 12, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 49, 50, 51, 52, 53, 54, 55, 57, 59, 60, 61)<br>LOT 8 (Codes: 4, 7, 8, 9, 10, 12, 15, 16, 18, 20, 21, 22, 25, 27, 30, 33, 35, 36, 38, 39, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br>LOT 9 (Codes: 1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 14, 15, 17, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br>LOT 10 (Codes: 1, 2, 3, 4, 6, 7, 9, 11, 17, 19, 20, 24, 26, 27, 28, 29, 32, 37, 38, 40, 41, 42, 43, 44, 46, 61)<br>LOT 11 (Codes: 1, 7, 8, 9, 10, 20, 27, 28, 29, 31, 34, 38, 39, 40, 41, 42, 44, 45, 46, 55, 59, 60, 61)<br>LOT 12 (Codes: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br>LOT 13 (Codes: 4, 9, 10, 12, 13, 14, 15, 16, 18, 21, 22, 25, 27, 30, 31, 33, 35, 36, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62)<br>LOT 14 (Codes: 6, 7, 9, 10, 11, 13, 16, 17, 18, 24, 25, 26, 27, 36, 45, 47, 48, 49, 50, 51, 52, 53, 55, 58, 60)<br>LOT 15 (Codes: 3, 4, 6, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 29, 30, 31, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br><br>**2 Having a trusted support network (social ecosystem):**<br><br>LOT 1 (Codes: 1, 2, 3, 4, 5, 6, 7, 8, 11, 13, 14, 15, 16, 17, 18, 24, 27, 28, 32, 34, 36, 39, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br>LOT 2 (Codes: 1, 2, 3, 4, 7, 8, 9, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 28, 29, 30, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br>LOT 3 (Codes: 4, 7, 10, 12, 13, 15, 16, 17, 20, 21, 22, 24, 25, 27, 29, 30, 31, 33, 35, 36, 39, 43, 44, 50, 51, 52, 53, 54, 55, 56, 57, 59, 60, 61, 62)<br>LOT 4 (Codes: 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 16, 19, 20, 23, 26, 28, 29, 30, 31, 32, 34, 35, 37, 38, 40, 41, 42, 44, 45, 47, 51, 52, 55, 57, 58, 60, 61, 62)<br>LOT 5 (Codes: 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 24, 25, 27, 30, 33, 38, 39, 47, 48, 49, 50, 52, 54, 55, 56, 57, 58, 59, 60, 61, 62) |

34. Denial – getting so depressed, so stressed you enter a dissociative state where human cognition doesn't allow you to figure out the rational thoughts, it wants to keep you away (and safe) so there is little / no processing conducted*
35. Awareness of why stress levels are increased and importantly how one normally reacts to it – a way of normalising situation*
36. Teaming up and using trusted family or friends to make you more aware of behaviour (signs, attitude etc.) that you may not notice yourself and to help you manage the experience, process and move forward*
37. The desperation of overwhelm (fight & Flight) that can even lead to violence in the calmest and rational of people*
38. Even practicing **mindfulness** is a challenge when the outlook is so desperate (**lack of hope**)*
39. Gauging appropriate responses for different people in different circumstances (Coaching approach to ownership and personal responsibility … only the person involved knows what they're thinking or feeling?)*
40. When you're in the midst of overwhelm caused by accumulative trauma it can be extremely difficult to alter behaviours, even when you think you should be well prepared for it. Helpless in the midst of trauma. Shutting down is one of the evolutionary natural responses to overwhelm / trauma*
41. Acknowledgement of being in a really depressed state*
42. Evidence of the accumulative effect of increased stress levels over time and the toll taken*
43. Men's mental health being in the public eye*
44. Raising the point that men often suppress emotions in order to hide or deny feelings in company of other [men]*
45. Eventually facing up to years of the effects of stress and admitting there was a problem*
46. Expressing the point that feelings are internal and that, even if they try really hard to empathise, people still can't really feel what others are feeling and can't actually know for sure*
47. Hope – it may be a struggle, but resilience can prevail, and situations can improve through being cognisant and generally more aware of self*
48. Sometimes a change of direction in life helps – **learning through adversity** (post traumatic growth?)*
49. Finding renewed purpose through 'decompressing' and making new choices*
50. The importance of being with other 'trusted' people **(biological imperative)***
51. The benefits on overall well-being, even from the depths of despair, from exercise and generally looking after yourself (sleep, nutrition, hydration & exercise) and especially if it's in the company of others (although not always essential)
52. Realising that sometimes you just need to change what you're doing and remove yourself from the adverse situation or environment*
53. Moving forward in life, enabled by the support of people you trust and feel safe with*
54. Shared experience enabling a stronger bond between caring humans*
55. Acknowledgement of being a human and the requirement to face adversity in order to learn life lessons and build personal resilience*
56. Willingness to pass on lessons learned to others, especially the younger*
57. Evidence of 'biological imperative' and the power of talking about or sharing problems in order to aid psychological recovery*
58. Being realistic in facing life's challenges*
59. Increased understanding acknowledging that all humans are facing personal challenges all the time*
60. Normalising human struggles*
61. When consumed by trauma, the feeling of being absolutely isolated from others*
62. Explaining that tough as things get, the hardship most often subsides and most do get through it, often with the support from others … it will stop!*

8. **Useful 'non-clinical' interventions (counselling, coaching etc):**
The use of interventions such as coaching can provide a form of support that encourages ownership and responsibility in learning lessons through challenging situations where a medical or clinical involvement is not deemed necessary.
Codes: 4, 7, 8, 9, 10, 12, 15, 16, 18, 20, 21, 22, 25, 27, 30, 33, 35, 36, 38, 39, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62

9. **Effects of trauma on performance (including complex (childhood) issues):**
Overwhelming stress levels and the effects of psychological trauma can affect any form of performance especially in highly challenging scenarios.
Codes: 1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 14, 15, 17, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62

10. **Loss of hope leading to despair and thoughts of suicide:**
Codes: 1, 2, 3, 4, 6, 7, 9, 11, 17, 19, 20, 24, 26, 27, 28, 29, 32, 37, 38, 40, 41, 42, 43, 44, 46, 61

11. **Denial of own emotions and feelings (especially in men):**
In order to perform in high performance settings, it is sometimes the case where people feel they have to show a 'stiff upper lip'.
Codes: 1, 7, 8, 9, 10, 20, 27, 28, 29, 31, 34, 38, 39, 40, 41, 42, 44, 45, 46, 55, 59, 60, 61

12. **Realisation, awareness and acceptance of factors associated with where 'you' are now:**
Codes: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62

13. **The power of Hope:**
Codes: 4, 9, 10, 12, 13, 14, 15, 16, 18, 21, 22, 25, 27, 30, 31, 33, 35, 36, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62

14. **Change of direction in life – doing something different:**
Codes: 6, 7, 9, 10, 11, 13, 16, 17, 18, 24, 25, 26, 27, 36, 45, 47, 48, 49, 50, 51, 52, 53, 55, 58, 60

15. **Shared experience and learning through adversity PTG / AG):**
The benefits of peer support, especially from those with a degree of shared experience.
Codes: 3, 4, 6, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 29, 30, 31, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62

LOT 6 (Codes: 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17, 24, 31, 32, 34, 37, 39, 40, 50, 52, 53, 54, 55, 61)
LOT 7 (Codes: 2, 3, 4, 5, 7, 8, 9, 10, 12, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 49, 50, 51, 52, 53, 54, 55, 57, 59, 60, 61)
LOT 8 (Codes: 4, 7, 8, 9, 10, 12, 15, 16, 18, 20, 21, 22, 25, 27, 30, 33, 35, 36, 38, 39, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
LOT 9 (Codes: 1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 14, 15, 17, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
LOT 10 (Codes: 1, 2, 3, 4, 6, 7, 9, 11, 17, 19, 20, 24, 26, 27, 28, 29, 32, 37, 38, 40, 41, 42, 43, 44, 46, 61)
LOT 11 (Codes: 1, 7, 8, 9, 10, 20, 27, 28, 29, 31, 34, 38, 39, 40, 41, 42, 44, 45, 46, 55, 59, 60, 61)
LOT 12 (Codes: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
LOT 13 (Codes: 4, 9, 10, 12, 13, 14, 15, 16, 18, 21, 22, 25, 27, 30, 31, 33, 35, 36, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62)
LOT 14 (Codes: 6, 7, 9, 10, 11, 13, 16, 17, 18, 24, 25, 26, 27, 36, 45, 47, 48, 49, 50, 51, 52, 53, 55, 58, 60)
LOT 15 (Codes: 3, 4, 6, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 29, 30, 31, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)

3 **Being aware of accumulative stressors and managing personal overwhelm effectively:**

LOT 1 (Codes: 1, 2, 3, 4, 5, 6, 7, 8, 11, 13, 14, 15, 16, 17, 18, 24, 27, 28, 32, 34, 36, 39, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
LOT 2 ( Codes: 1, 2, 3, 4, 7, 8, 9, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 28, 29, 30, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
LOT 3 (Codes: 4, 7, 10, 12, 13, 15, 16, 17, 20, 21, 22, 24, 25, 27, 29, 30, 31, 33, 35, 36, 39, 43, 44, 50, 51, 52, 53, 54, 55, 56, 57, 59, 60, 61, 62)
LOT 4 (Codes: 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 16, 19, 20, 23, 26, 28, 29, 30, 31, 32, 34, 35, 37, 38, 40, 41, 42, 44, 45, 47, 51, 52, 55, 57, 58, 60, 61, 62)
LOT 6 (Codes: 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17, 24, 31, 32, 34, 37, 39, 40, 50, 52, 53, 54, 55, 61)
LOT 7 (Codes: 2, 3, 4, 5, 7, 8, 9, 10, 12, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 49, 50, 51, 52, 53, 54, 55, 57, 59, 60, 61)
LOT 8 (Codes: 4, 7, 8, 9, 10, 12, 15, 16, 18, 20, 21, 22, 25, 27, 30, 33, 35, 36, 38, 39, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
LOT 9 (Codes: 1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 14, 15, 17, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)
LOT 10 (Codes: 1, 2, 3, 4, 6, 7, 9, 11, 17, 19, 20, 24, 26, 27, 28, 29, 32, 37, 38, 40, 41, 42, 43, 44, 46, 61)
LOT 11 (Codes: 1, 7, 8, 9, 10, 20, 27, 28, 29, 31, 34, 38, 39, 40, 41, 42, 44, 45, 46, 55, 59, 60, 61)
LOT 12 (Codes: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)

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| | | LOT 13 (Codes: 4, 9, 10, 12, 13, 14, 15, 16, 18, 21, 22, 25, 27, 30, 31, 33, 35, 36, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62)<br>LOT 14 (Codes: 6, 7, 9, 10, 11, 13, 16, 17, 18, 24, 25, 26, 27, 36, 45, 47, 48, 49, 50, 51, 52, 53, 55, 58, 60)<br>LOT 15 (Codes: 3, 4, 6, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 29, 30, 31, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br><br>**4 Maintaining hope and finding acceptance:**<br>LOT 1 (Codes: 1, 2, 3, 4, 5, 6, 7, 8, 11, 13, 14, 15, 16, 17, 18, 24, 27, 28, 32, 34, 36, 39, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br>LOT 2 ( Codes: 1, 2, 3, 4, 7, 8, 9, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 28, 29, 30, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br>LOT 3 (Codes: 4, 7, 10, 12, 13, 15, 16, 17, 20, 21, 22, 24, 25, 27, 29, 30, 31, 33, 35, 36, 39, 43, 44, 50, 51, 52, 53, 54, 55, 56, 57, 59, 60, 61, 62)<br>LOT 5 (Codes: 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 24, 25, 27, 30, 33, 38, 39, 47, 48, 49, 50, 52, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br>LOT 6 (Codes: 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17, 24, 31, 32, 34, 37, 39, 40, 50, 52, 53, 54, 55, 61)<br>LOT 7 (Codes: 2, 3, 4, 5, 7, 8, 9, 10, 12, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 49, 50, 51, 52, 53, 54, 55, 57, 59, 60, 61)<br>LOT 8 (Codes: 4, 7, 8, 9, 10, 12, 15, 16, 18, 20, 21, 22, 25, 27, 30, 33, 35, 36, 38, 39, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br>LOT 9 (Codes: 1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 14, 15, 17, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br>LOT 12 (Codes: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br>LOT 13 (Codes: 4, 9, 10, 12, 13, 14, 15, 16, 18, 21, 22, 25, 27, 30, 31, 33, 35, 36, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62)<br>LOT 14 (Codes: 6, 7, 9, 10, 11, 13, 16, 17, 18, 24, 25, 26, 27, 36, 45, 47, 48, 49, 50, 51, 52, 53, 55, 58, 60)<br>LOT 15 (Codes: 3, 4, 6, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 29, 30, 31, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br><br>**5 Adversarial growth (including post traumatic):**<br><br>LOT 1 (Codes: 1, 2, 3, 4, 5, 6, 7, 8, 11, 13, 14, 15, 16, 17, 18, 24, 27, 28, 32, 34, 36, 39, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br>LOT 2 ( Codes: 1, 2, 3, 4, 7, 8, 9, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 28, 29, 30, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br>LOT 3 (Codes: 4, 7, 10, 12, 13, 15, 16, 17, 20, 21, 22, 24, 25, 27, 29, 30, 31, 33, 35, 36, 39, 43, 44, 50, 51, 52, 53, 54, 55, 56, 57, 59, 60, 61, 62)<br>LOT 4 (Codes: 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 16, 19, 20, 23, 26, 28, 29, 30, 31, 32, 34, 35, 37, 38, 40, 41, 42, 44, 45, 47, 51, 52, 55, 57, 58, 60, 61, 62)<br>LOT 5 (Codes: 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 24, 25, 27, 30, 33, 38, 39, 47, 48, 49, 50, 52, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br>LOT 6 (Codes: 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17, 24, 31, 32, 34, 37, 39, 40, 50, 52, 53, 54, 55, 61) |

| | | |
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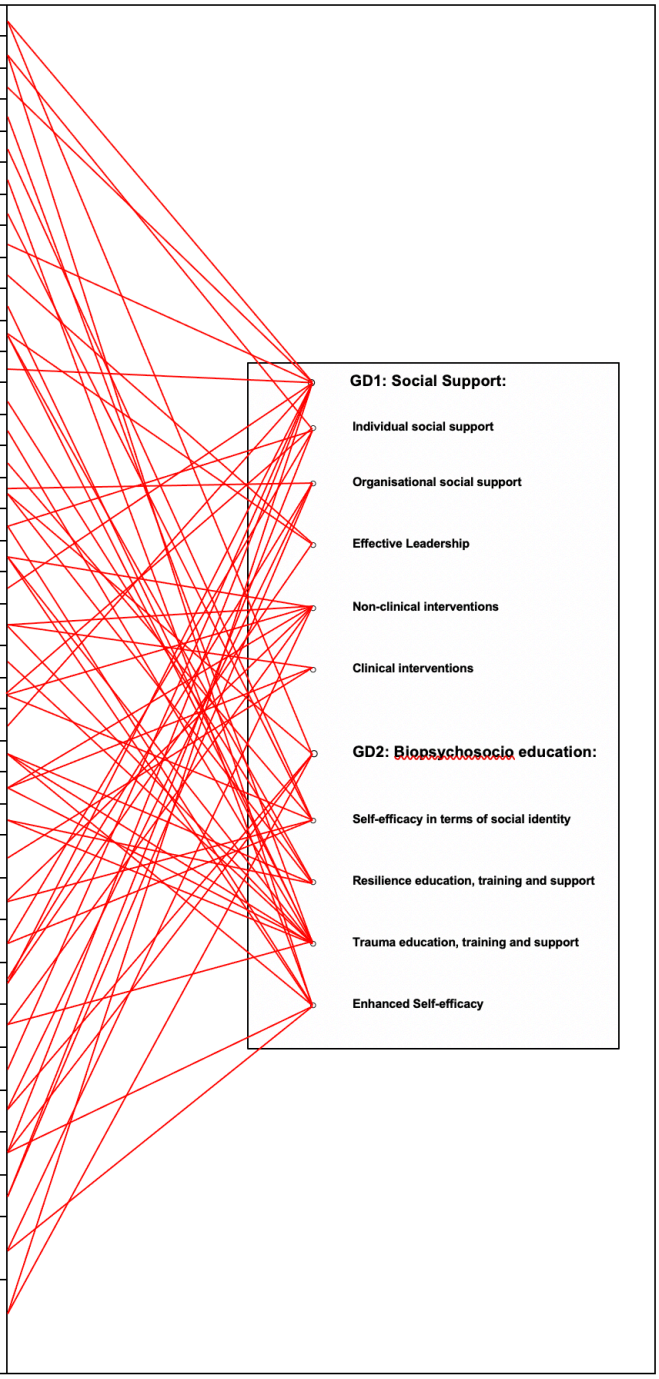
| | | LOT 7 (Codes: 2, 3, 4, 5, 7, 8, 9, 10, 12, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 49, 50, 51, 52, 53, 54, 55, 57, 59, 60, 61)<br>LOT 8 (Codes: 4, 7, 8, 9, 10, 12, 15, 16, 18, 20, 21, 22, 25, 27, 30, 33, 35, 36, 38, 39, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br>LOT 9 (Codes: 1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 14, 15, 17, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br>LOT 10 (Codes: 1, 2, 3, 4, 6, 7, 9, 11, 17, 19, 20, 24, 26, 27, 28, 29, 32, 37, 38, 40, 41, 42, 43, 44, 46, 61)<br>LOT 11 (Codes: 1, 7, 8, 9, 10, 20, 27, 28, 29, 31, 34, 38, 39, 40, 41, 42, 44, 45, 46, 55, 59, 60, 61)<br>LOT 12 (Codes: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62)<br>LOT 13 (Codes: 4, 9, 10, 12, 13, 14, 15, 16, 18, 21, 22, 25, 27, 30, 31, 33, 35, 36, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62)<br>LOT 14 (Codes: 6, 7, 9, 10, 11, 13, 16, 17, 18, 24, 25, 26, 27, 36, 45, 47, 48, 49, 50, 51, 52, 53, 55, 58, 60)<br>LOT 15 (Codes: 3, 4, 6, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 29, 30, 31, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62) |

| All interview - High Order Themes | General Dimensions |
|---|---|
| Opportunities for Learning: | |
| Self-awareness & personal regulation & well-being: | |
| Social Support (social ecosystem/biological imperative): | |
| Proactive trauma awareness (education) and management: | |
| Personal Qualities, Values & Beliefs (Sense of Purpose): | |
| Importance of self-regulation: | |
| Positive Mental Attitude: | |
| Support (social) – Biological Imperative: | |
| Effective Leadership: | |
| Post Traumatic Growth: | |
| Use of trauma management tools(such as TRiM) not always being effective: | |
| Social support (Social Ecosystems/Biological Imperative): | |
| Adaptable resilience: | |
| Post traumatic growth: | |
| Positive Mental Attitude: | |
| Biopsychosocial education, training and sustained support: | |
| Self-regulation: | |
| Avoiding overwhelm: | |
| Social Support (social ecosystems) | |
| The potential negative long-term effects of posttraumatic stress (including PTSD & CPTSD) if not processed | |
| Post adversarial / traumatic growth and positive mental attitude: | |
| Managing authenticity and maintaining purpose: | |
| Having a trusted support network (social ecosystem) | |
| Being aware of accumulative stressors and managing personal overwhelm effectively: | |
| Maintaining hope and finding acceptance: | |
| Adversarial growth (including post traumatic): | |
| Use of maladaptive coping strategies that create an unstable lifestyle that hampers psychological processing and recovery: | |
| Self-reflection to assess who you are (authenticity), where you are (psychological and general health and wellbeing) and how you wish to proceed with life: | |
| Proactively raising awareness and increasing understanding of personal resilience (biopsychosocio education): | |
| Feeling let down, hurt or ignored (morally injured (MI)) by those dear to you (family, friends, colleagues, organisations, health professionals): | |
| A desire to move forward in life (PMA); applying lessons learned through challenges in life in order to make positive, progressive changes to life (AG / PTG): | |
| The importance of trusted social support (friends, family, colleagues etc) in moving forward: | |
| The long reaching negative effects of ineffective or absent support from trusted people, such as sports coaches, especially during developmental years: | |
| The importance of having the necessary skills, knowledge and support early in training and throughout sporting career to equip individuals to face challenges: | |
| The necessity for effective social ecosystems available to support individuals (in this case younger adults) through challenging times: | |
| The importance of non-clinical interventions in high performance environments such as coaching and mentoring and how both can either positively or negatively affect individual's performance and overall health and wellbeing depending on how they are delivered: | |
| The importance of raising self-awareness and adopting a positive mindset (Attitude) to learn from past experiences and putting lessons learned into focusing on moving forward in career / life. | |



# **APPENDIX 2:** STUDY 2 SUPPORTING DOCUMENTATION

**Appendix 2.1** Ethical Approval for Study 2

**Appendix 2.2** Participant Information Pack (incl. Participant Research Consent Form, Participant Debrief Document)

**Appendix 2.3** Study 2 – Research Questionnaire

**Appendix 2.4** Table 1: Outliers

**Appendix 2.1** Ethical Approval for Study 2

STAFFORDSHIRE UNIVERSITY

**Life Sciences and Education**

**ETHICAL APPROVAL FEEDBACK**

| | |
|---|---|
| **Researcher name:** | Steve Eaton |
| **Title of Study:** | Is Trauma Risk Management (TRiM) effective in improving general well-being and reducing stress in a UK emergency service population? |
| **Status of approval:** | Approved |

Thank you for addressing the committee's comments. Your research proposal has now been approved by the Ethics Panel and you may commence the implementation phase of your study. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site.

**Signed:** Dr Roozbeh Naemi **Date: 26.10.2018**

Ethics Coordinator
School of Life Sciences and Education

**Appendix 2.2** Participant Information Sheet (incl. Participant Research Consent Form, Participant Debrief Document)

**(Study 2) - Participant Information Pack**

Steve Eaton (SN-15034179),
Dept of Sport & Exercise,
Staffordshire University,
College Road,
Stoke-on-Trent.
ST4 2DE

E: steven.eaton@research.staffs.ac.uk
M: [redacted]
E: m.slater@staffs.ac.uk
M: [redacted]

Dear …….

I am a former member of the British Forces currently completing a PhD at Staffordshire University, conducting research in Applied Performance Psychology within the Department of Sport & Exercise. This information sheet is being sent to potential participants in line with Staffordshire University ethical considerations to provide relevant information and to avoid individuals feeling pressurised into assisting the research.

The primary aim of this longitudinal study is to conduct a series of anonymous questionnaires (4 in total) over a twelve-month period in order to explore if Trauma Risk Management (TRiM) is effective in improving general well-being and reducing stress in a UK Emergency Service population, in this case (Shropshire Fire & Rescue Service – SFRS).

The study aims to involve approximately 100 personnel from SFRS, broken down into two distinct groups; one that has conducted the TRiM training (Group 1) and

one that has not (Group 2). The 100 participants will be chosen randomly from within SFRS ensuring a wide representation of skills and positions. All participants will be sent this Information Sheet (Appendix A) to read and a Consent Form (Appendix B) to agree to prior to commencing the study questionnaire. Each questionnaire should take approximately 20 minutes to complete. The itinery is as follows:

- **Round 1** – Questionnaire completed on paper or online by all participants (Groups 1 & 2) prior to attending any TRiM training.
- **Round 2** – Questionnaire completed by Group 1 within one month of completing a TRiM training course. Participants that have not attended the TRiM training (Group 2) will complete the second questionnaire between the end of the first TRiM course (preliminary dates of 7-8 June 18) and the end of the last TRiM course (preliminary date of 2-3 July 18).
- **Round 3** – Questionnaire completed by Groups 1 & 2, 6 months after Round 1.
- **Round 4** – Questionnaire completed by Groups 1 & 2, 12 months after Round 1.

The research questionnaire has been designed to encompass a broad range of general health questions to explore how people consider their own personal experiences, what support they receive from or provide others and how connected they feel towards others and the organisation they are part of.

As a duty of care, it must be stated that participation in the study and the exposure to the subsequent questionnaire might cause anxiety, distress and psychological discomfort. For those that have suffered with Post Traumatic Stress Disorder (PTSD) there is a potential risk to mental health and the possibility of a recurrence of previous symptoms as a result of participation. Participation in the study may also reveal facts about psychological status in relation to showing signs of PTSD, again which may cause distress and discomfort in some participants.

Research participants can be of any gender but must be 18, or older, and not suffering from any current stress related mental illness to participate in the study. Informed consent (Appendix B) will be required from participants prior to the questionnaire commencing.

Shropshire Fire & Rescue Service have agreed in principle to the voluntary participation of their staff in this study as it sees the research as an opportunity to further support their people to the best of their ability and both Human Resources (HR)

and Occupational Health Departments are available to provide support at any time should it be required. Details of an alternative suitable helpline / support details will be provided in The Debrief Document (Appendix D) in case of and adverse effect.

It should be stressed that the wellbeing of participants is paramount to the researcher and SFRS and as a duty of care the questionnaire can be stopped at any time if participants do not wish to continue without penalty or explanation. Participants are able to withdraw from the study altogether, and all pertaining personal information withdrawn, up until two weeks following acknowledged receipt of the completed questionnaire by emailing the researcher (Steve Eaton) or the supervisor (Dr Matt Slater) by using their UPN and asking to be withdrawn from the study. On receiving any such instruction, any 'withdrawn' questionnaires that were completed by hand will be destroyed and relevant electronic questionnaires completed on Qualtrics will be deleted.

My contact details, as the lead researcher, and those of my research supervisor are located at the top of this page. Relevant support information will be provided in the Debrief Document (Appendix D).

Yours faithfully

**Participant Research Consent Form**

Steve Eaton (SN-15034179),
Dept of Sport & Exercise,
Staffordshire University,
College Road,
Stoke-on-Trent.
ST4 2DE

E: steven.eaton@research.staffs.ac.uk
M: [redacted]
E: m.slater@staffs.ac.uk
M: [redacted]

**I understand that:**

I am participating in a research project that aims to explore if Trauma Risk Management (TRiM) is effective in improving general well-being and reducing stress in a UK Emergency Service population, in this case (Shropshire Fire & Rescue Service – SFRS).

I will take part in 4 questionnaires, each taking approximately 20 minutes to complete, over a 12-month period that aim to explore my experiences as a member of SFRS.

My participation is voluntary, and I understand that I may withdraw from the questionnaire at any point (including removal of all data) and up to 2 weeks following the completion of the questionnaire without penalty or explanation. If I wish to withdraw during a questionnaire, I can stop at any time. If I do wish to withdraw from the study questionnaires at any time I will contact the primary researcher, Steve Eaton (contact details above).

I understand that the data, received through this questionnaire may be used as reference material for future research, or may be presented publicly at conferences or in relevant journals, however, my identity will not be revealed in any written or electronic text and my anonymity will be preserved throughout the study and final report with a Unique Participant Number (UPN).

I understand that exposure to the questions in the study and participation may cause anxiety, distress and psychological discomfort and may reveal facts about my psychological status in relation to showing signs of Post-Traumatic Stress Disorder (PTSD). If I have previously experienced PTSD I understand that there is a potential risk to my mental health and possibility of recurrence of symptoms as a result of participation.

The well-being of participants is paramount to the researcher and SFRS and as such I understand that I can stop the questionnaire at any time if I do not wish to continue. Details of a suitable helpline / support details will be provided in The Debrief Document (Appendix D) in case of and adverse effect.

I am 18 or older.

I am not currently suffering from any stress related mental health illness.

**I have read and agree to the above.**

Print Name…….

Signature……

Date……

**Participant Debrief Document**

Steve Eaton (SN-15034179)
Dept of Sport & Exercise,
Staffordshire University,
College Road,
Stoke-on-Trent.
ST4 2DE

E: steven.eaton@research.staffs.ac.uk
M: [redacted]

Dear …….

Thank you for taking time to complete this series of questionnaires, which aim to explore if Trauma Risk Management (TRiM) is effective in improving general well-being and reducing stress in a UK Emergency Service population, in this case Shropshire Fire & Rescue Service (SFRS).

Your invaluable participation will add to the growing body of work of research that is formulating strategies to best support people in managing stress and / or trauma in high performance settings.

As a reminder, participants have the right to withdraw from the study altogether, and all pertaining personal information withdrawn, up until two weeks following acknowledged receipt of the completed questionnaire. This can be done by either deciding that you no longer wish to continue with the study and stopping the population of the questionnaire at any time without obligation or by emailing the researcher (Steve Eaton) or the supervisor (Dr Matt Slater) and using their UPN ask to be withdrawn from the study. On receiving any such instruction, any 'withdrawn' questionnaires completed by hand will be destroyed and relevant electronic questionnaires completed on Qualtrice will be deleted.

A duty of care has been taken to ensure that the questionnaire causes you as little distress as possible but if, on reflection, you have any queries or concerns please contact myself or my supervisor via details below:

**Steve Eaton (researcher):**

Email: steven.eaton@research.staffs.ac.uk
Mobile: [redacted]

**Dr. Matthew Slater (research supervisor):**

Email: m.slater@staffs.ac.uk
Mobile: [redacted]

Or alternatively speak to a member of your HR or Occupational Health Department at SFRS.

If in the unfortunate event you do happen to suffer any adverse effects then please consult your GP or, alternatively, you can contact Mind, which is a leading mental health charity that supports individuals with mental health concerns or problems:

Web: www.mind.org.uk
Email: supporterservices@mind.org.uk
Phone: 0208 519 2122 (England) / 0292 039 5123 (Wales)

Yours Faithfully

**Appendix 2.3** Study 2 – Research Questionnaire

# Study 2 - Research Questionnaire

Steve Eaton (SN-15034179)
Dept of Sport & Exercise,
Staffordshire University,
College Road,
Stoke-on-Trent.
ST4 2DE
E: steven.eaton@research.staffs.ac.uk
M: [redacted]
E: m.slater@staffs.ac.uk
M: [redacted]

**Study Group: Shropshire Fire & Rescue Service (SFRS)**

Generic questions?

- Age … (DOB)?
- Where you work (front line, clerical staff, control room …
- Male/female/other
- **Did you attend TRiM training?**

## 1. General Health Questionnaire (GHQ12) (Goldberg D., 1978)

(1) Better than usual
(2) Same as usual
(3) Less than usual
(4) Much less than usual

How have you been feeling over the past few weeks?
Have you recently:

| | | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| A | Been able to concentrate on what you're doing? | | | | |
| B | Lost much sleep over worry? | | | | |
| C | Felt you were playing a useful part in things? | | | | |
| D | Felt capable of making decisions about things? | | | | |
| E | Felt constantly under strain? | | | | |
| F | Felt you couldn't overcome your difficulties? | | | | |
| G | Been able to enjoy your normal day-to-day activities? | | | | |
| H | Been able to face up to your problems? | | | | |
| I | Been feeling unhappy and depressed? | | | | |
| J | Been losing confidence in yourself? | | | | |
| K | Been thinking of yourself as a worthless person? | | | | |
| L | Been feeling reasonably happy, all things considered? | | | | |
| | | | | | |

**2. Warwick-Edinburgh Mental Well-being Scale (WEMWBS)** (University of Warwick & University of Edinburgh, 2006)

(1) None of the time
(2) Rarely
(3) Some of the time
(4) Often
(5) All of the time

Over the past month:

| | | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| A | I've been feeling optimistic about the future | | | | |
| B | I've been feeling useful | | | | |
| C | I've been feeling relaxed | | | | |
| D | I've been feeling interested in other people | | | | |
| E | I've had energy to spare | | | | |
| F | I've been dealing with problems well | | | | |
| G | I've been thinking clearly | | | | |
| H | I've been feeling good about myself | | | | |

| | | | | | |
|---|---|---|---|---|---|
| I | I've been feeling close to other people | | | | |
| J | I've been feeling confident | | | | |
| K | I've been able to make up my own mind about things | | | | |
| L | I've been feeling loved / cared for | | | | |
| M | I've been interested in new things | | | | |
| N | I've been feeling cheerful | | | | |
| | | | | | |

**3. Perceived Stress Scale** (Cohen S., 1994)

(0) Never
(1) Almost never
(2) Sometimes
(3) Fairly often
(4) Very often

In the last month:

| | | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|
| A | How often have you been upset because of something that happened unexpectedly? | | | | | |
| B | How often have you felt that you were unable to control the important things in your life? | | | | | |
| C | How often have you felt nervous and stressed? | | | | | |
| D | How often have you felt confident about your ability to handle your personal problems? | | | | | |
| E | How often have you felt that things were going your way? | | | | | |
| F | How often have you found that you could not cope with all things that you had to do? | | | | | |
| G | How often have you been able to control irritations in your life? | | | | | |
| H | How often have you felt that you were on top of things? | | | | | |
| I | How often have you been angered because of things that happened that were outside of your control? | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| J | How often have you felt difficulties were piling up so high that you could not overcome them? | | | | | |
| | | | | | | |

**4. Resilience Scale R14 (RS5 & RS12)** (Gail M., Young W. & Young H., 1993)

(1) Strongly disagree
(2) Disagree
(3) More or less disagree
(4) Undecided
(5) More or less agree
(6) Agree
(7) Strongly agree

| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|---|
| A | I usually manage one way or the other. | | | | | | | |
| B | I feel proud that I have accomplished things in life. | | | | | | | |
| C | I usually take things in my stride. | | | | | | | |
| D | I am friends with myself. | | | | | | | |
| E | I feel that I can handle many things at a time. | | | | | | | |
| F | I am determined. | | | | | | | |
| G | I can get through difficult times because I've experienced difficulty before. | | | | | | | |
| H | I have self-discipline. | | | | | | | |
| I | I keep / remain interested in things. | | | | | | | |
| J | I can usually find something to laugh about. | | | | | | | |
| K | My belief in myself gets me through hard times. | | | | | | | |
| L | In an emergency, I'm someone people can rely on. | | | | | | | |
| M | My life has meaning. | | | | | | | |
| N | When I'm in a difficult situation, I can usually find my way out of it. | | | | | | | |
| | | | | | | | | |

**5. Berlin Social Support Scale (BSSS)** (Schwarzer R. & Schulz U., 2013; Measurement Instrument Database for the Social Sciences)

a. Perceived Emotional Support, Perceived Instrumental Support, Need for support and support seeking

*Endorsements (for all BSSS scales)*

(1) Strongly disagree
(2) Somewhat disagree
(3) Somewhat agree
(4) Strongly agree

| | | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| | ***Perceived emotional support*** | | | | |
| A | There are some people who truly like me. | | | | |
| B | Whenever I am not feeling well, other people show me that they are fond of me. | | | | |
| C | Whenever I am sad, there are people that cheer me up. | | | | |
| D | There is always someone there for me when I need comforting. | | | | |
| | | | | | |
| | ***Perceived Instrumental Support*** | | | | |
| A | I know some people upon whom I can always rely. | | | | |
| B | When I am worried, there is someone who helps / supports me. | | | | |
| D | There are people who offer me help / support when I need it. | | | | |
| E | When everything becomes too much for me to handle, others are there to help / support me. | | | | |
| | | | | | |
| | ***Need for support*** | | | | |
| A | When I am down, I need someone who boosts my spirits. | | | | |
| B | It is important for me always to have someone who listens to me. | | | | |
| C | Before making any important decisions, I absolutely need a second opinion. | | | | |
| D | I get along best without any outside help. | | | | |
| | | | | | |
| | ***Support Seeking*** | | | | |

| | | | | | |
|---|---|---|---|---|---|
| A | In critical situations, I prefer to ask others for their advice. | | | | |
| B | Whenever I am down, I look for someone to talk to. | | | | |
| C | When I am worried, I reach out to someone to talk to. | | | | |
| D | If I do not know how to handle a situation, I ask others what they would do. | | | | |
| E | Whenever I need help / support I ask for it. | | | | |
| | | | | | |

b. Actually Received Support Recipient

*Think about the person who is closest to you, such as your colleague, spouse, partner, child or friend (and so on). How did <u>this person react to you</u> during the past week?*

| | | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| A | The person showed me that he / she loves and accepts me. | | | | |
| B | This person comforted me when I was feeling bad. | | | | |
| C | This person left me alone. | | | | |
| D | This person did not show much empathy for my situation. | | | | |
| E | This person criticised me. | | | | |
| F | This person made me feel valued and important. | | | | |
| G | This person expressed concern about my condition. | | | | |
| H | This person assured me that I can rely completely on them. | | | | |
| I | This person encouraged me not to give up. | | | | |
| J | This person was there when I needed them. | | | | |
| K | This person took care of many things for me. | | | | |
| L | This person took care of things that I couldn't manage on my own. | | | | |
| M | This person helped me find something positive in my situation. | | | | |
| N | This person suggested activities that might distract me. | | | | |
| | | | | | |

c. Actually Provided Support

*Think about the same person who is closest to you, such as your colleague, spouse, partner, child or friend (and so on). How did <u>you interact with them</u> during this week?*

| | | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| A | I showed them how much I cherish / care about and accept them. | | | | |
| B | I comforted them when they were feeling bad. | | | | |
| C | I left them alone. | | | | |
| D | I did not have much empathy for them | | | | |
| E | I criticized them. | | | | |
| F | I made them feel valued and important. | | | | |
| G | I expressed my concern about their condition. | | | | |
| H | I reassured them that he / they can rely completely on me. | | | | |
| I | I encouraged them not to give up. | | | | |
| J | I was there when they needed me. | | | | |
| K | I did a lot for them. | | | | |
| L | I took care of daily duties that they could not fulfill on their own. | | | | |
| M | I helped them find something positive in their situation. | | | | |
| N | I suggested an activity that might distract them. | | | | |
| | | | | | |

**6. Group Identification Scale** (Slater, Turner, Evans & Jones 2017; Leadership Quarterly)

As a member of the Shropshire Fire & Rescue Service (SFRS):

(1) Strongly disagree
(2) Disagree
(3) More or less disagree
(4) Undecided
(5) More or less agree
(6) Agree
(7) Strongly agree

| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|---|
| A | You identify strongly with SFRS | | | | | | | |
| B | You feel a strong connection with SFRS | | | | | | | |
| C | You feel no connection with SFRS | | | | | | | |
| | | | | | | | | |

**7. Relational Identification** (Slater et al., 2017)

As a member of Shropshire Fire Service (SFS):

(1) Strongly disagree
(2) Disagree
(3) More or less disagree
(4) Undecided
(5) More or less agree
(6) Agree
(7) Strongly agree

| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|---|
| A | You identify strongly with your colleagues at SFS | | | | | | | |
| B | You feel a strong connection with your colleagues at SFS | | | | | | | |
| C | You feel no connection with your colleagues at SFS | | | | | | | |
| | | | | | | | | |

**8. Presenteeism and Absenteeism** (Stanford Presenteeism Scale (SPS-6); 2001. Stanford University School of Medicine and Merck & Co.)

Please describe your work experiences **in the past month**. These experiences may be affected by many environmental as well as personal factors and may change from time to time. For each of the following statements, please check one of the following responses to show your agreement or disagreement with this statement in describing your work experiences **in the past month**.

*Note *health problems* can include physical and mental health.

Please use the following scale:

(1) I strongly disagree with the statement.
(2) I somewhat disagree with the statement
(3) I am uncertain about my agreement with the statement
(4) I somewhat agree with the statement
(5) I strongly agree with the statement

| | | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| A | Because of health problem, the stresses of my job were much harder to handle | | | | | |
| B | Despite health problems, I was able to finish hard tasks in my work | | | | | |
| C | My health problem distracted me from taking pleasure in my work | | | | | |
| D | I felt hopeless about finishing certain work tasks, due to my health problem. | | | | | |
| E | At work, I was able to focus on achieving my goals despite my health problems. | | | | | |
| F | Despite my health problem, I felt energetic enough to complete all my work. | | | | | |
| | | | | | | |

**Appendix 2.4** Table 1: Outliers

Table 1: Outliers

| Participant: | Time Point (TP) & Questionnaire: | Remarks & Action: |
|---|---|---|
| **UPN:02031069** | TP4 - Resilience | scored at 1.07 and increased it to 3.79 (next point that isn't an outlier) |
| **UPN:01070472** | TP1 – Received Social Support | scored at 1.43 and increased it to 2.21 (next point that isn't an outlier) |
| | TP2 - Received Social Support | scored at 2.07 and increased it to 2.71 (next point that isn't an outlier) |
| | TP1 - Provided Social Support | scored at 1.5 and increased it to 2.21 (next point that isn't an outlier) |
| | TP2 - Provided Social Support | scored at 2.21 and increased it to 2.86 (next point that isn't an outlier) |
| | TP1 – Relational identification | scored at 2.33 and increased it to 3.67 (next point that isn't an outlier) |
| **UPN:01070171** | TP4 - Provided Social Support | scored at 1.93 and increased it to 2.29 (next point that isn't an outlier) |
| | TP4 - Group Identification | scored at 1.33 and increased it to 5 (next point that isn't an outlier) |

# **APPENDIX 3:** STUDY 3 SUPPORTING DOCUMENTATION

**Appendix 3.1** Ethical Approval for Study 3

**Life Sciences and Education**

**ETHICAL APPROVAL FEEDBACK**

| | |
|---|---|
| **Researcher name:** | Steve Eaton |
| **Title of Study:** | A qualitative analysis exploring the perceived effectiveness of the trauma management programme 'TRiM', across multiple organisations that operate in challenging, potentially traumatic, environments. |
| **Status of approval:** | Approved – Please see the Note below. |

**NOTE: Please note that this approval does not include participation of volunteers from organisations for which NHS ethical approval is required. Also advertising thestudy to the potential participants for recruitment requires prior agreement from the organisation (that deliver TRiM) to which the individuals are affiliated.**

Thank you for addressing the committee's comments. Your research proposal has now been approved by the Ethics Panel and you may commence the implementation phase ofyour study. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site.

**Signed:** Prof. Roozbeh Naemi **Date: 04.11.2021**

Ethics Coordinator
School of Life Sciences and Education

**Appendix 3.2** Supporting Information Document (incl. Participant Information Sheet, Participant Consent Form, Participant Debrief Document and Focus Group Questions)

Steve Eaton

Department of Life Sciences and Education

Sport and Exercise

Brindley Building

Staffordshire University

Stoke-on-Trent

ST4 2DF

E: steven.eaton@research.staffs.ac.uk

PARTICIPANT INFORMATION SHEET

**Title of Study: A qualitative analysis exploring the perceived effectiveness of the trauma management programme 'TRiM', across multiple organisations that operate in challenging, potentially traumatic, environments.**

I am conducting research study for my PhD in Applied Performance Psychology within the Department of Life Sciences and Education at Staffordshire University. As the lead researcher I would like to invite you to take part in this research study as you have valuable experience in using TRiM. Before you decide, I would like you to understand why the research is being done and what it would involve for you. This information sheet is being sent to all potential participants in line with Staffordshire University ethical considerations so please take time to read the information and discuss

it with others if you wish. Please contact me, using the email address above, if there is anything that is not clear or if you would like more information. Thank you for reading this.

**What is the purpose of the study?**

Currently there is a lack of credible studies regarding the efficacy of TRiM outside the UK military. The primary aim of this study is therefore to conduct an exploratory study that involves a series of online group discussions, known as Focus Groups, with other professionals that have trained in, use and deliver TRiM support across a wide range of settings that are routinely challenging and potentially traumatic, in order to explore the actual effectiveness of TRiM. Secondly, through openly discussing personal and organisational experiences of using TRiM, it is hoped that strengths and shortcomings of the TRiM methodology can be identified and, where suitable, enhancements can be made to its implementation and long-term utility, to better support staff and colleagues that regularly put themselves in potential harms way.

**Why have I been asked to take part in this research?**

You have been invited to take part in our research because you are either currently or have been previously involved in the delivery of TRiM either as a practitioner, manager / coordinator or leader and as such have valuable, real-life experience of its use and effectiveness. As such we are keen to explore personal experiences of TRiM to discover what informed people genuinely think of TRiM as a programme and as a methodology for effectively supporting staff and colleagues that operate in challenging, potentially traumatic, environments such as yours. A working knowledge and understanding of TRiM are required for you to participate in the study.

**Do I have to take part?**

It is up to you to decide whether or not you would like to take part in our research. If you decide to take part, you will be given a copy of this information sheet to keep, and you will need to sign an informed consent sheet, which accompanies this document.

**What will happen to me if I take part?**

In line with university guidelines, all willing participants will be required to sign a Consent Form and return it electronically to me, the lead researcher, at steven.eaton@research.staffs.ac.uk. Once consent has been obtained, you will receive an email containing a number of short questions about basic demographics and a further email inviting you to attend one of the online Focus Groups via an MS Teams link. The lead researcher will explain how things will run during the session before facilitating the discussion. As a participant of the group discussion, you will be encouraged to share your experiences and ideas of TRiM, from an individual and organisational perspective, via a number of general and open questions offered to the group. Each focus group is expected to last around 60 minutes and no longer than 90 minutes.

For those of you that request it, anonymity can be provided through the online sessions with the use of an alias name (chosen by the you the participant) and deactivated camera. All subsequent data that is collected through the study will be coded and any personal details removed or redacted to protect the identity of those participating.

Your well-being is paramount to the researcher and as a duty of care any participant may leave the Focus Group Discussions at any time if they no longer wish to continue. Participants can withdraw from the study altogether and all pertaining personal information will be either withdrawn or redacted from subsequent transcriptions by emailing the lead researcher (Steve Eaton) or research supervisor (Dr Matt Slater) asking to be withdrawn from the study.

Participants should, however, note that it is difficult to withdraw individual data given the nature of the focus group discussions, therefore please take this into consideration before giving consent.

**What are the possible risks and disadvantages of taking part in the research?**

Although there is no intention to discuss any trauma related subjects in detail, it should be stated that participation in the study may cause anxiety, distress and psychological discomfort. For those that have suffered with Post Traumatic Stress Disorder (PTSD) there is a potential risk to mental health and the possibility of a recurrence of previous symptoms as a result of participation. Participation in the study may also reveal facts about psychological status in relation to showing signs of PTSD, again which may cause distress and discomfort in some participants.

**What are the possible benefits of taking part?**

By taking part you have the opportunity to make a contribution to our scientific understanding of the use and effectiveness of TRiM and assist with the wider ongoing provision of effective support for staff, colleagues and organisations that routinely operate in challenging environments.

**Will my taking part be kept confidential?**

Yes. All information that is collected about you during the research will be kept confidential and will only be accessible to the research team. To reiterate, if you wish to remain anonymous during the study you can choose a pseudonym to use during the Focus Groups and personally ensure that your camera is turned off or covered. This can be discussed in detail with the lead researcher prior to the study commencing.

**Data handling and confidentiality**

In accordance with Staffordshire University guidelines, all collected research data will be secured electronically on secure, password protected devices. Your data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR).

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the Staffordshire University Data Protection Officer. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

**Data Protection Statement**

The data controller for this project will be the lead researcher and Staffordshire University. The lead researcher will process your personal data for the purpose of the research outlined above, and for no other reason. The legal basis for processing your personal data for research purposes under the data protection law is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.

**What will happen to the results of the study?**

The results of this study will go into the final thesis of my PhD in Performance Psychology looking at how best to support the wellbeing of people and organisations that operate in challenging, potentially traumatic, environments. We may also publish the results of this study in a scientific journal, book, or book chapter, present the research at a conference, and/or share our findings via blogs and social media. Any research publication would not identify you individually. If you wish to obtain a copy of the published results, please inform the lead researcher. We would be delighted to send them to you when they are available.

**Who has reviewed this study?**

This study has been reviewed by my PhD supervisors and approved by the Staffordshire University Research Ethics Committee.

**Further information and contact details**

If you have any concerns or would like to make a complaint about this research, please contact the Chair of the University Research Ethics Committee:

Dr. Tim Horne,

Research, Innovation and Impact Services,

Cadman Building,

Staffordshire University,

College Road,

Stoke-on-Trent,

ST4 2DF

E: Tim.horne@staffs.ac.uk

If you have any further questions about this study, please contact Steve Eaton using the email address:

steven.eaton@research.staffs.ac.uk

Steve Eaton

**Thank you for taking the time to read this information**

Steve Eaton

Department of Life Sciences and Education
Sport and Exercise
Brindley Building
Staffordshire University
Stoke-on-Trent
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E: steven.eaton@research.staffs.ac.uk

PARTICPANT CONSENT FORM

**Title of Study: A qualitative analysis exploring the perceived effectiveness of the trauma management programme 'TRiM', across multiple organisations that operate in challenging, potentially traumatic, environments.**

Please initial to confirm your agreement:

| | |
|---|---|
| I confirm that I have read and understood the Participant Information Sheet for the study: **A qualitative analysis exploring the perceived effectiveness of the trauma management programme 'TRiM', across multiple organisations that operate in challenging, potentially traumatic, environments.** | |
| I understand that I am participating in a research project that is exploring the experiences of TRiM practitioners, managers / leaders, and coordinators from a variety of organisations that routinely employ TRiM as part of its organisational procedures, to conduct a form of evaluation. | |
| I understand that my participation in the study is completely voluntary, and I may withdraw from the Focus Group at any point and withdraw my input / data up to two weeks following the Focus Group without penalty or explanation. If I do choose to withdraw from the study any data collected from me will be redacted by the researcher in conducting the study. | |
| I understand that exposure to the questions in the study and participation may cause anxiety, distress and psychological discomfort and may reveal facts about my psychological status in relation to showing signs | |

| | |
|---|---|
| of Post-Traumatic Stress Disorder (PTSD). If I have previously experienced PTSD there is a risk to my mental health and possibility of recurrence of symptoms as a result of participation. | |
| I understand that the data will be used for research only. All data will be anonymised, where requested, and stored safely in a password-protected device. After 10 years all study data will be destroyed. | |
| I agree that all data collected can be used for publication in scientific journals, presented at scientific forums (e.g., conferences, seminars, workshops), and the findings of the research can be shared using social media. I understand that all data will be presented anonymously. | |
| The well-being of participants is paramount to the researcher and as a duty of care the focus group can be stopped at any time to allow a participant to leave if they do not wish to continue. Details of a suitable helpline / support details will be provided verbally before each Focus Group and in The Debrief Document (Attached) in case of and adverse effect. | |
| I agree to take part in this study. | |

Name of Participant:

Signature: Date:

Steve Eaton

Department of Life Sciences and

Education

Sport and Exercise

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Staffordshire University

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ST4 2DF

E: steven.eaton@research.staffs.ac.uk

PARTICPANT DEBRIEF DOCUMENT

**Title of Study: A qualitative analysis exploring the perceived effectiveness of the trauma management programme 'TRiM', across multiple organisations that operate in challenging, potentially traumatic, environments.**

Thank you for taking time to participate in the Focus Group discussions which form a vital part of this ongoing research exploring the trauma management programme known as TRiM.

Your invaluable participation will add to the growing body of work of research that is formulating strategies to help people, such as you, your staff and your colleagues, maintain health and wellbeing whilst operating in challenging and potentially traumatic environments.

Care has been taken to ensure that the Focus Groups have been conducted in a manner that causes as little distress as possible and have been facilitated in a sensitive but constructive manner, to mitigate potential effects on individuals participating. If, however, and on reflection you have any queries or concerns about any part of the study, please contact myself, lead researcher, or Dr. Matt Slater, my supervisor, via details below:

**Steve Eaton (lead researcher):**

Email: steven.eaton@research.staffs.ac.uk

**Dr. Matthew Slater (research supervisor):**

Email: m.slater@staffs.ac.uk

If, in the unfortunate event, you do happen to suffer any adverse effects then please also consult your Occupational Health representative or, alternatively your GP or Mind, which is a leading mental health charity that supports individuals with mental health concerns or problems:

Web: www.mind.org.uk

Email: supporterservices@mind.org.uk

Phone: 0208 519 2122 (England) / 0292 039 5123 (Wales)

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FOCUS GROUP QUESTIONS

**Title of Study: A qualitative analysis exploring the perceived effectiveness of the trauma management programme 'TRiM', across multiple organisations that operate in challenging, potentially traumatic, environments.**

1. What would you say are the biggest strengths or benefits of the TRiM programme? Discuss
2. What would you say are the biggest drawbacks or weaknesses of the TRiM programme? Discuss
3. Would you say that TRiM is an accepted methodology within your organisation and if so or not, why is that so? Discuss
4. Can you say how the implementation of TRiM has led to a positive or negative cultural change within your organisation? Discuss
5. In your opinion, how would you describe your experience of delivering TRiM in terms of whether you perceive it as a proactive or reactive tool or methodology? Discuss
6. Do you think that regular TRiM / trauma awareness sessions would benefit your colleagues / organisation and if so, how and why? Discuss

7. Given technical and online advances, how do you feel a blended approach to delivering TRiM could be used more effectively in providing effective support to your colleagues and organisation, i.e., part online self-directed learning and part face to face? Discuss
8. What advice would you give to other organisations that were thinking of implementing a TRiM programme to others that work in psychologically or physically challenging, potentially traumatic environments?
9. How else do you think the TRiM programme could be improved?
10. Is there anything else that you would like to add that you think is important and may aide this focus group and further research?

**Appendix 3.3** Focus Group Guide / Questions

| | |
|---|---|
| 1. | What would you say are the biggest strengths of the TRiM programme? Discuss |
| 2. | What would you say are the biggest weaknesses of the TRiM programme? Discuss |
| 3. | Would you say that TRiM is an accepted methodology within your organisation and if so or not, why is that so? Discuss |
| 4. | Can you say how the implementation of TRiM has led to a positive or negative cultural change within your organisation? Discuss |
| 5. | In your opinion, how would you describe your experience of delivering TRiM in terms of whether you perceive it as a proactive or reactive tool or methodology? Discuss |
| 6. | Do you think that regular TRiM / trauma awareness sessions would benefit your colleagues / organisation and if so, how and why? Discuss |
| 7. | Given technical and online advances, how do you feel a blended approach to delivering TRiM could be used more effectively in providing effective support to your colleagues and organisation, i.e., part online self-directed learning and part face to face? Discuss |
| 8. | What advice would you give to other organisations that were thinking of implementing a TRiM programme to others that work in psychologically or physically challenging, potentially traumatic environments? |
| 9. | How else do you think the TRiM programme could be improved? |
| 10. | Is there anything else that you would like to add that you think is important and may aide this focus group and further research? |

**Appendix 3.4.1** Example Focus Group (FG4) transcription 'Coded'

**Focus Group 4: Coded Transcription**

Participants: Karen, Rebecca, Pamela

Date: 170222

**Steve:**

1. So, happy for us to start, guys? Yeah, so I'm just going to go through these questions because, it does make it far easier for me when I'm looking for themes and general dimensions so first thing then what would you say then are the biggest strengths or drawbacks, from your perspective, of the TRiM program and either of you, one of you can kick off.

**Karen:**

It's been clearly a very challenging time [redacted] over the last couple of years, but also the last, very many years and I think well-being has only really more recently been started.

Nothing in [redacted], though, I started with working wellbeing 5 1/2 years ago and I think more recently for a year and a half TRiM and I think, the biggest strength is support following a PTE (1) but also staff feeling that we care about them, which we do (2). You know this for me isn't a tick box exercise (3), actually when we do the interventions, I think that they realise that we do care, and we do offer structured support within a framework. And so, I think it sounds a bit woolly really, but I think that the strengths are that that we can support people and we can help keep them at work and they do feel cared about (3).

I think that really matters so much. Lovely. Thank you, Karen.

**Pamela:**

So I think the biggest strengths are that it's a process that that can be followed by anyone they don't have to be professionally qualified (4). You know, health, qualified, mental health. It's a process that can be rolled out in any environment basically. As long as the process is followed (5).

So, it it's not looking for professionals or qualified people.

It's looking for people that will buy into it basically so that for me is the first strength (6).

So, there's two there, isn't there cause it's about process and that you don't have to have a qualification. It's not a bespoke process for just one discipline. So, you know it, it's got a wide, universal language because of that whereas if something is, you know, let's say it' s aimed at medics or teachers or, you know, a particular discipline, then it will be in their language, which automatically excludes, or potentially excludes, people outside (7).

To me, it's the universal part of it.

**Steve:**
And do you mean medical qualification?

**Pamela:**
Any really. So, I've seen it in. You absolutely wouldn't have needed to have a medical qualification. Obviously, I come from that background, but they don't need any of those.

No person-centred type of qualification: shall we say it? You know it, it could be an engineer that’s not used to working with people at all. So that's the beauty of it for me that.

**Rebecca:**
So, my thing is really that this is a … it's a peer led program (8).

And in the 2015 data for our well-being at the bar research, which was replicated in 2021 and again came through as a really, strong protective factor is the collegiate working environment that we have as practitioners (9). So, to have a program which falls within the safety net of where we know our people get the most support, when we asked them in our empirical surveys. Where do you find support? Where do you feel is most you know; this safety can be found? It was often amongst colleagues, and that's not to say there is a distrust of regulator or outside, but because of the status or because of the stigma (10).

The value of trend is that it is peer Led and it's about having a conversation where those,

indicators can be travelled through in a in a natural way without feeling that there's too much critical analysis because one of the risk factors with barristers is that they have very high levels of rumination and perfectionism (11).

So, there will be actually thinking about what they should be saying and not really saying what they're feeling or thinking truly. So that process or that structured conversation with a peer is actually very valuable (12).

**Steve:**

2. Excellent, thank you. So conversely then what do you think are the biggest drawbacks or weaknesses with the TRiM program and I know that you're at both at different stages of sort of implementation, if you like, but just as you see it now, so what would you say then is the biggest weaknesses of the of a TRiM program?

**Pamela:**

It's almost the fact that it can be used as a, it becomes a tick box exercise (13).

So maybe if you look at what I've just said, if it was aimed at a discipline, you, I guess, you can assume that by buying straight away, because that discipline is interested in a certain subject, hope, because this is universal risk that might just be a tick box. So, I think that is a potential weakness, not every time, because again that comes back to how it's introduced, how it's sold as a as a process (13) and the outcome. I'm not saying that there is a real potential, like everything, it just becomes a yes, we've done that. We're covering something about psychological well-being which is very in vogue moment (14).

**Karen:**

I think they're challenges rather than weaknesses, maybe challenges come in a bit. I can't remember. I think, at the moment, there are two challenges here, people who have signed up to be TRiM practitioners, and we've had 63 now, and sign up to be TRiM practitioners. They complete the training, complete the peer review assessments, which we do.

We do insist that we have to do practice sessions and then, or real events, but we peer review and then they're assessed as competent. And so, there's a lack of time for the TRiM practitioners (15).

People aren't reporting PTE's, even though we know we have numerous PTE's. Weekly, and I'd say, some more, bigger ones. But people aren't referring them in as I think they should. So that's been a real, real challenge (16).

We know stuff has happened that should have been referred and hasn't been, so it's been a very slow cultural shift, because people often think, oh well, I'm a nurse or doctor, it's part of my job (16), you know, I'm thinking, actually, no, that was quite tough, actually, you know, to see.

Maybe there was something, so it's those kinds of things. And the other thing I feel is it's been a real challenge trying to get senior staff to engage with it (17). And there was a bit of an incident yesterday which poor [redacted], I have ranted off to [redacted] about yesterday because I feel senior staff aren't really in engaging with it. So that's been a real challenge.

Is that a weakness? I think that's probably a different question. So, I'm sorry if it is.
It'll always be there slightly, so I think it is with this.

**Steve:**
Uh, but just on that one, Karen, just taking you back then. So, do you do you think though that the fact that people don't shout up there, about the PTE's or acknowledge something as a as a potentially traumatic experience. Do you think that's a lack of education or just lack of awareness or just testing it? Stubbornness?

**Karen:**
I think it's a cultural shift and we're not there yet with our cultural shift (18). So, I think we've never really offered this before, and we've only been running it for well under a year really and it's taking a while for it to ripple out (19). It's starting to happen actually, but it's a whole cultural shift about accepting TRiM when something happens (18).
So I think that's that.

I'd be interested in seeing in a year or two years' time whether the culture has changed. I think it will. I think it will. But we're not, we're not there yet.

**Steve:**

Great. Thank you, Karen.

**Rebecca:**

My, well, I think the question is posed about it to what weakness does TRiM have? And it's the fitness for purpose for us because unlike the scenario with the blue light type of trigger, barristers are rarely involved in an incident where there will be that appropriate categorisation. Ours is much more of a slow drip secondary vicarious experience where we may be dealing with terrorism incidents, we may be dealing with war crimes, or we may be dealing with immigration when we're expected to challenge the integrity of the account and scrutinise, repeat, and seek to qualify, to undermine potentially the validity of the horror that that person is trying to actually explain. So, you are visiting the types of TRiM incident that we wouldn't recognise with a 999 blue light type of scenario (19).

But our experiences of how we have come to that doesn't really fit sort of the TRiM definition and the way in which the structure questions will presented or to talk about the incident, which has an anchor?

You know the anchor to being outside the embassy when the bomb went off being in the accident and emergency department when someone came in with a gun and was trying to harm people and you were in the throes of that and that part, that doesn't fit.

We really like what TRiM has, so the weakness is its fitness for purpose really that's how I would sort of describe it and with that sort of qualification of an explanation (19).

That said, when you when you read, when you read the papers and the underlying factors of what those core issues reveal, both for the psychological and the factual experience in the individual, we all know different, which is why I believe that TRiM is a good model.

But it just needs to be slightly adapted, which I think you'll come onto in your next questions (20).

**Karen:**

Can I just add to that point? Really, it's just kind of jolted me to think what weakness is and will always be. In implementing TRiM in our organisation and I always said it's like trying to

fit a square peg into a round hole. We're having to shave the edges off really. And so, I think with the TRiM model was clearly set up in the military and it's been adapted for other areas. So that's one of the biggest challenges we have had with TRiM, and incident say happens in emergency department. Lots of people will come from different areas at the hospital to support with that emergency (21).

So, as specialist cardiac nurses, you'll have a 12-20 people working on a patient and then very quickly disappear once the emergency is finished as they've gone back to their departments. They work shifts. They work different, you know, rotors, different times of the day, night, and so for us to then try and coordinate a TRiM session is very logistically difficult (22), so, you know the last incident? It's like they're all from six different departments involved, you know? So, it's very logistically difficult then. And so, you're filtering, you know, we sat down to try and filter yesterday and it's very logistically difficult to filter something where also you don't even know the dynamics, but you don't know the BIOS. You don't. You can't have a proper planning session, for various reasons. So, I think that, you know, we're having to do the best that we can. We really do try and do the best we can with a model that wasn't really geared up for our kind of type of organisation (22).

**Steve:**

3. Right. Would you say that TRiM is an accepted methodology within your organisation? If so, or not, why is that so?

**Rebecca:**

I think the short answer is yes (23). I think it has a solid history of longevity research and it has a multi factoral application into different professions (24).

**Karen:**

I definitely think so, and it is a structured way (25). So, when something would happen before, there'd be a procedural debrief, which still would happen in alongside TRiM, different with a different meeting. But I think we were always struggling to know how do we support people psychologically (26)? And I think the TRiM methodology really does fit actually. This is what we do, and this is how we split people. You know structurally. So, I think yes, I think it does, is (27).

**Pamela**:

So yes, if I if I look at my MOD background absolutely (28), and particularly from the Royal Marine aspect and Royal Navy actually. You know, I'm talking back years now. I was aware of TRiM and obviously became involved in it, but it wasn't accepted vocabulary and particularly because we were in a time of conflict, so trauma was more spoken about maybe expected absolutely happening and this training was always say around before the conflicts and talking about which mainly Afghanistan. TRiM became like a natural part of that discussion (29).

You know, if, and when I was working in the mental health arena anyway, if we were talking about an incident, one of the automatic questions would be; were you TRiMed which to me is really valuable because that that shows it's embedded (30). So, I'm talking about it as a clinician to a service person, I wouldn't then have to explain what TRiM was. Which you know that shows a culture change to me because it's part of the language, it's part of the expectation (31). And it's a proven under almost an expectation of it's what happens when something goes wrong (32).

Yeah, I think that's a real positive and it was embedded (33).

**Steve:**

Yeah. So, the key thing there was that it was embedded, but also the fact that it was accepted and would you, would you say accepted from sort of top to bottom and left to right, so it was just a common theme as opposed to common practice.

**Pamela**:

Saying with most Royal Marines that it was more because of the amount of trauma they were experiencing. So, you know, if we think of a time of conflict and the many years of Afghanistan. From the tempo that marines were operational in Afghanistan.
Alright through natural events or events that happened out there, the natural course was there was more trauma experienced by Royal Marines, supposed to maybe well Navy people that I'd be seeing at the time. So, it became very evident that situations incidents were part off (34).

For most of the marines at this time, therefore TRiM is very much a part of life. So, when I think about, I think very much about the war Marines at that time (35). The Navy, I think it was more sporadic and maybe even personality driven (36).

**Steve:**

Yeah. OK. And I suppose that goes back to your point, isn't it? The fact that the Navy, even though it deployed out there, they didn't see, I suppose they weren't embroiled in that space and its aspects it's dangerous to think that, you know, trauma is caused by simply combat, you know. But clearly when there's more combat type stuff around, then it does make a difference, doesn't it? You know, and if the if the ships were being attacked or, you know, then there might be might have been a different, you know, but uh, but OK, so the war Marines are really good example, but, you know, accepted methodology across the border.

**Pamela**:

Yeah, but I do recall some of the survivors' people from the Navy side, you know, we were kind of, I can't remember the correct term they were flying the drones. Yeah, I mean, obviously by computer and that was traumatic for many. In its own way, and quite a unique way (37).

So, I don't remember TRiM conversations about that. So that brings in and another element really that when is, when is it identified as a traumatic experience? (38)

**Steve:**

4. So, would you say the implementation of TRiM led to positive or negative cultural change within your organisation? And again, I suppose that's quite difficult if there's any form of resistance to the implementation? I suppose in there, but I don't know it. Would you say that the implementation of TRiM, even if it's so far, has led to a sort of positive change or even in raising awareness of something that's needed? Perhaps that over to you?

**Rebecca:**

I'm not. I'm not at Karen or Pamela's stage but I can say that the conversations around TRiM the as you know presenting the work at the ones for law forum that has really improved our conversation around potential trauma and an appreciation of many of the behavioural traits

and response (39). Some issues to our ethics and our practice and our risks. So yes, is the answer, but we're not, we're not sort of down the line as much as Karen.

**Karen:**

I'd definitely say yes, I think. You know, even if it was a very slow (40).

I think that there are many variables over the last year, but I think it's definitely a cultural shift definitely for positive (41), you know, and I've even just as we're talking and just before you came on, Rebecca, I notice there's an email saying someone attended a TRiM session last year and their sister in Ireland wants to start doing it because they've been singing the praises so much and can I contact her sister in Ireland to talk about what we've done.

Now I didn't get any feedback from that person about the TRiM, at the time, but clearly she's been sitting there saying how great it was. So, for me it's things like that that I'm hearing because we never formally evaluated it, but it's just like, wow (42). So, this is, this is my, you know. It's working and having a cultural shift. And I do think it's as simple as that (43).

This sounds it's because they feel cared for, and that really matters. I think people need to feel valued and supported, and this is the one of the ways we're supporting them and valuing them. I think so, yeah (44).

**Steve:**

That type of stuff is Golden, isn't it? You know, hearing that, but sadly you only hear it almost by accident. Don't you know that? Uh, you know, it's not coming forward, but yeah, OK.

**Pamela:**

So, I think that the culture started to shift about being looked after and invested in (45).
I still believe that that's true with TRiM as an investment in people and you could say that it went from a very masculine, non-emotional environment to where we're allowed to talk openly about things that have happened (46). You know how we fail type thing which is quite a shift for the Royal Marines who were at the time, you know, in one of the biggest conflicts of all times.

So, I think that was an absolute positive. That we are we are OK to talk about things that don't feel OK (47).

**Steve**:

Yeah. They've been looked after, they've been invested in. Great. Thank you, Pamela.

5. In your opinion, then, how would you describe the experience of delivering TRiM? I suppose delivering or running TRiM in terms of whether you perceived it as a proactive or reactive, but just how you see it? So, in your opinion from your perspective would you say you know in your delivery or in your running of TRiM which you see it's proactive or reactive.

**Pamela:**

I think that at its base, it's a reaction to an incident or incidents, but it's a proactive method of merging psychoeducation and self-awareness and it's proactive in it hopes to maybe prevent things from going wrong as well (48). I guess it raises self-awareness and if you know what's happening it can de-escalate things (49).

Yeah. So, it's very active because it happens because of something, but it's proactive because it's looking at normalising through psychoeducation really and signposting and also that containment again (50). So that's why it's proactive rather than waiting for somebody to become potentially unwell or confused because they don't know what's happening to them (51).

**Steve**:

Great, because I'm, you know, as we all know, some organisations just use it. They say it's almost more of a reactive tool for when things go wrong. They, as we said before, you know they pull it off the shelves, but it's the key bit, there's the, you know, some of the real value is in that goes back to that cultural check box. You know the cultural changes in organisations and forgetting it's embedded. So, it becomes the norm, you know, almost.

That awareness, as you say, you know, can almost de-escalate some things yourself. You know, having that which again empowers people, it, you know, make some more aware and they look out for each other, don't they? So, it becomes that sort of upward cycle or the self-fulfilling prophecies you know, it's like, you know, looking after each other, you spot it in somebody. Recognising yourself, you're able to recognise it in others.

**Pamela**:

I think it decreases the potential isolation as well that sometimes trauma can cause because if you if you're aware of a process that is happening around you and it's not just about you, being may be unable to sleep or you know, ruminating about the issues then I think it can help decrease that feeling of isolation, which in turn would potentially de-escalate any issues becoming bigger than there needs to be? (52)

**Rebecca:**

I think in my experience at the stage of the work I'm doing with it. It's proactive because we are not alive to the same issues of an incident like in some of the other forums where it's delivered, and they are either targeted individuals (53). So, I have deployed TRiM, and I have TRiMed people who I can see from my experience as a practitioner they may be, in one particular example, they were very, very big household name who was in a certain type of work that you would expect to have needed TRiM and their [redacted]. And so, I went in and used TRiM proactively and it worked. And he's just such a powerful advocate with me. Still doesn't talk about his experience of TRiM, but very, very powerful tool from his personal experience of it. So, I'm not. I'm not. I'm at that stage really of trying to be proactive and I communicate it proactively even though I absolutely get that it has reactive methodology and where I I've shifted it into using this as a protective factor (54).

How we anticipate this sort of distribution of it and that mentoring capacity of people in chambers, it will hopefully just be normalised as a proactive peer review progress development, continuing professional development conversation in the same way that service is connected to social services and the programs around supervision work. And so, I put it in that sort of proactive, even though they may well be talking about it in that retrospective and past tense language, it's still being. It's still being communicated by me as a proactive methodology (55).

**Karen:**

So, I just, I agree. I think it's proactive in our organisation (56), so I think. Clearly, stuff happens in [redacted]. You know you can't prevent stuff. You can't prevent young people coming in, you know with heart attacks and all those kinds of things that might trigger a TRiM response (57). So, you were not going to be up to prevent it, but we tried to be proactive quite quickly. So, we didn't wait till we heard that people were struggling with it. What we did

if we heard of something or someone got referred, we very quickly offered the TRiM proactively (58). So, when we we're not just yeah like I say waiting for people who may be struggling with something that happened. We would try and on that day or the next couple of days contact them and have a sort of chat or offer them TRiM. So unfortunately, like I say it's not nearly as many incidents as we know what happened. But when we did hear about them, we tried to be proactive (59).

**Steve:**

And I suppose in in advertising it and trying to push out. The fact that you're running TRiM you know, even if it's behind the scenes, if you like or you know, yeah, it's your plans. I suppose. You're doing that in a proactive and productive way anyway, aren't you? So, you're trying to sort of get the stuff out there anyway, before it's even potentially used, I suppose, or needed. The information is getting out there, isn't it? So, people knowing that they've got something there. You know, the organisation has got something in place in case things do happen. Having that out there so, OK.

6. Uhm, do you think quite short one then? Do you think that regular TRiM or TRiM awareness sessions would be beneficial for your organisation or present ties into the last question? I suppose in trying to spread I suppose the TRiM informing you know because you're both working environments where you know trauma, there is potential trauma involved in what it whatever you do, whether it's vicarious or, you know, or first hand.

So, do you think regular awareness sessions would benefit you? So rather than just rolling TRiM out when things happen, do you think getting stuff out there early on would be useful within your organisation?

**Karen:**

I definitely think so. So, we put some online sessions on for the organisation and bite sized training for managers, which are hour long sessions on Teams so managers can just join any of them (60).

So, we're putting one on about TRiM. We've also got a people panel where I think that's a half an hour session where people just come along and ask (61).

So, we've got one on TRiM, we've got leaflets that we did distribute and we were also in the process of making a short video about TRiM which two of the directors, I'm hoping, I certainly hope at least one of them is going to get involved in making and that will put on our extranet site so that people can just find out about TRiM so we were, are trying to raise people's awareness or it, which I'm hoping will help make that cultural shift as well (62).

**Pamela:**

Yes, I do. But I think there's a risk of overkill (63).

So again, and I think I like you know, I experienced this in my current role. If you roll out the message too often it can, sometimes fall on deaf ears because it's just another Oh yeah, it's that lecture again (64). But that brief that education. Whereas I think if you time it carefully to Keep it fresh. In my experience, that works much better (65). You know, I think it's probably picking up my theme as we need to not make our messages tick box. It's about balance (66).

**Steve**:

Yeah. OK. And that's so it's about balance, isn't it really meant to keeping that balance. You know if we don't if you don't need to overdo it then. Don't you know just yet, but you just need to keep it current. Keep it up to date.

**Pamela**:

Yeah, it's fresh and not just the same message every time, you know, obviously the key points are the same but it's about keeping people engaged in the message (67).

**Rebecca:**

Yeah, I agree. For me, having regular refreshers and advertisements normalises and supports this, the destigmatising of the negative, whether that's cognitive dissonance of those in leadership that they don't understand what they say or whether it's the individual who's afraid of the addressing those issues or talking about them (68). So, the more regular normalisation of those programs and the advertisement of it, is pretty key (69).

So, we have done a lot of soundings around how that learning is best developed in our in our profession and it is through those regular continuous professional development updates (70). It's by having quarterly practice management reviews with your colleague or your peers

or where that will form a part of the process. Just as in the same way that clinical supervision would work (71).

**Steve:**

Brilliant. Excellent. Thank you all.

7. OK, given the technical and online advances, then that we've gone through saying there's a couple of years, do you see a benefit, and this is it's not really an open question is that you know, but it turns in terms of a blended approach to delivering TRiM? Obviously, historically we've always delivered it face to face but since, or prior to COVID really. So, do you feel that blended approach delivering TRiM could be more effectively used for providing effective support to your colleagues and organisations? Or part online part face to face. What do you think about Blending the online learning side of things?

**Karen:**

So I think for us it generally worked that we had the blended approach each time we did a cohort as you know we've flexed how we've rolled it out (72). I think the last cohort was probably the best that we did. So, we then did the online learning and then we met with you in a room and did the practice session. So, for me that was probably the best way I think in [redacted] over the last year we could have run it (73).

Well, I think some [redacted] organisations did, but certainly I don't think we could have run it two days either online or in a classroom, certainly not any classroom but maybe online, but we wouldn't have been able to spare the staff. I think the disadvantage of the blended approach is that people can do it when they want. So, we've had a lot of people that signed up, started it and then never finished it or a few that stall it if I'm honest and so I think that's been tricky (74). But if you're in a room for two days or all online for two days, you've finished the course (75) whereas we, as you know, we've got several that haven't yet finished. So that that's that's the downside, I think.

**Pamela**:

I think it's a way to get more engagement because, if we think of the organisations that are likely to benefit from TRiM, they tend to be big, busy, pressured, and high stress environments (76). So, to release people for training is a is a big issue so I think to do the blended learning as in do the basics online to the, you know, the basic framework, not in a basic way and quite a comprehensive way that people can (77). Engaging so not just a

PowerPoint slide by slide, but they're interactive and different ways of delivering online followed by a follow up session that consolidates everything, gives a bit of practical experience. Followed by a further follow up (78). It's very hard to talk timescales, isn't it? But within a reasonable timeframe. You do the first follow up, so it's still fresh and you do another follow up (79). Hopefully when people have maybe had a chance to either practice or deliver because to me that that can help create confidence. So, I'm very keen that people get the opportunity to practice and then under still feel held by other people's experience so blended, absolutely (80). I think there's more opportunity to get buy in (81). I mean not put more stress on people because once you say OK, you need three days out for training (82).

**Rebecca:**

We've got 17,000 barristers on the role of registers, so unlike organisations that have control to some degree over there people, ours are very desperate and the nature of our practitioners means that they're not employed. So, whilst they've got regulatory responsibilities of CPD and keeping up to date and doing certain things come, there is it's not as if we have a, you know, an ability to put them in a room and make them do some mandatory training and so the on-site has always been a challenge and it's always been very London centric (83). I'm getting out to those circuits as being difficult. So for me and I can tell you that the blended learning approach with our mental health first aid has been phenomenal in lockdown and the numbers that we've seen, we've trained 600 people just through lockdown in mental health first aid and we never had anything like that coming to the London (84) even when we were offering to go to Chambers aren't on circuits to access people, there was an interest, but trying to find them available at 5:30 to 7:30 on a Tuesday night when they might be doing a case here or there or in principle say yes, but then actually you turn up and there would be 5 people not 15. And it was problematic, whereas the online worked better so. Sure, accessibility, you know, accessing both practitioners and practitioners accessing the content that blended learning approaches is much more useful (85). Hey look there are the same drawbacks as Karen said, about commitment and continuity, that learning and the ways in which people learn is always better when you've got their undivided attention and then they're in a room and you've got the collaborations and the conversations that you get with that, and you can't really emanate that. But it's a hybrid model for me (86). What we're hoping to achieve where they can go through some of that core stuff online and then we can actually get together people together to do the practical, to have those conversations, to talk about the challenges that they think they're going to have (87).

**Steve:**

Awesome. Thank you. Great.

8. What advice, then, would you give to other organisations that we're thinking of implementing a TRiM program?

**Karen:**

OK, so I think, even though I knew that TRiM was right from beginning, we've never achieved senior managers buying into support for it and understanding it. It became clear to me that my senior managers don't really know what it is, which is disappointing. So senior management engagement is key (88). Recruit practitioners quite carefully (89). So, we did, I thought I had a fairly robust recruitment procedure, but on in retrospect it could have been more robust (90). So, I think it's think carefully about the people. Who are the right people but also who have enough time to do it? That's a big thing. So, recruitment of practitioners (91).

Think about how you're going to advertise it and how you going to roll it out and change that culture? (92) So, think about ways of trying to embed it and getting the right people on your side (93). Really. I think have people who are well connected, you know, and feel passionately about it on your side (94).

Also make sure that you have good support from the company (training provider) (95), as if it wasn't for [redacted], I'm not sure I would still be sitting here because it has been quite a challenge and they have really supported me through that. And I think that for me was really important because it was very lonely for me. I was the only one doing it and for well over a year and that was really hard and lonely and it and the best thing I've ever done. But it was really hard and lonely setting it up as well, so you need that kind of support (96), so I'd say don't you know, don't do it on your own if you can. Two is always better than one. I think just to bite that richness you can get from just discussing things so that that (97). Yeah, I'm sure there's lots more, but I let Rebecca and Pamela say their bit now.

**Steve:**

Thank you, Karen.

**Pamela**:

The people at the top, you need to buy into the process and understand the process and value the team stuff like providing time to do the training and give the time to the coordinator (98). They appreciate this is very difficult in certain environments to work out how the process would work with shift patterns within pressured environments again. So, I think it has to be a cascade approach to, not just the learning but committing at any level and should be at all levels (99).

The endorsement comes from the top because then that starts the message, the culture shift. If it starts at any level without the top buying, it's difficult and it's the potential to get lost 100).

**Steve**:

Uhm. Well, clearly in in some of the biggest struggle bigger organisations, you know, you've got this sort of people at the top, but within that you've got these sort of mini triangles And with many departments and you know and all those need to be a similar way then they in all of those you know the senior management, the senior and whoever the senior people are you know whether it's HR as well and you know they need to be involved (101). You know, once it's nurtured, it just becomes it. It becomes its own beast, isn't it? Because it feeds itself. It looks after itself, you know, once it's up and running, doesn't it, you know, but I think it's almost the biggest failing in management not understanding (102).

**Rebecca:**

Yeah, I echo a lot of what Pamela and Karen have said, leadership of leaders. Yeah, and my tip for that is train them, take them to a training session (103). Let them wear the green beret. That was a big experience for one of my very senior chairman of the board, so that they actually get it (103).

Peer support. I am absolutely, as you know, I am part of the DNA family so I can't underestimate the value of that in so many respects because I'm never lonely and I'm never afraid and I'm never struggling for somewhere or someone to go to for support because I've got DNA and every single time I feel that that any of those people, whatever time of the day or night, would respond if they got a text message or an email (104), and then I saw it. And so that form of courage and empowerment of an individual is something back I would think to embed when, as part of the setup package, that if you're someone who's going to advise

an organisation that would be, you know, the leadership is one aspect, but then it's obviously it's care of yourself. We talk about caring for others. But then as part of our own self-care (105). That is key because it is the signposting and the support for you and then again (106).

The third is choose. Choose your champions carefully because they are not just the champion of your work, but they are a reflection of what it represents (107) and some of our individuals have the motivation for people volunteering (108). Sometimes it needs to be sifted and filtered, and so using the experience of others in have been doing the police works. So, [redacted] was fantastic in the [redacted] Police Service and others come around volunteering and making sure that your processes that you put in place also have half that and that is just a brutal, you know, reputational perspective but really necessary to safeguard the individual and those that they might encounter as well as the system you're trying to put in place (109).

**Steve:**
Brilliant. Thank you guys.

9. OK, in your very relative experiences, how do you say in the TRiM program could be improved, just from, you know, very individual, very personal ways? You know, organisationally clearly two quite different organisations, but how do you think, you know you mentioned earlier Rebecca, about certain things that you know where TRiM doesn't fit. You mentioned about this, the square peg.

**Pamela**:
I guess coming from a former mental health nurse perspective, I'm quite keen on the self-cure bit so, I think that there's potentially more room for talking about that in the process because there's a risk of people getting very fixed in the process and forgetting to be human (110). And you know, just having a bit of a human conversation with somebody and saying, you know, look after yourself, just maybe do this, that and the other because people can get very caught up in. I've got to say this, I've got to say that I forget in the. It's a very normal conversation that they, you know, have a conversation with purpose. To make sure people just tend to leave some of those good things rather than seeing it as an add-on at the end (111).

**Rebecca:**

I think that's a really difficult question steve because I know the challenges that I've had with it, but applying TRiM more flexibly is problematic (112) because, where and how? And so, it is structured in the way it is because that it's a process (113). We all, the TRiM team, as it were in the leadership TRiM leaders are already beginning to see and do their own adaptions. I'm being supported in that process (114), so I think for example my work come as you know, you know I'm doing some stuff with judges internationally and another country and there are real cultural issues of that to manage with that group (115). In the UK, obviously we've got 17,000 barristers so you know they're always going to be different types of organisational challenges and learning and so I think having an expected approach to its flexibility because at the moment when you look at it and all the papers that are written and the empirical foundation for the work and the systems that are in place for its delivery, our quite military based or are quite structured and I think potentially a better strap line that you know we you can fill, this can be flexed and we know that people are doing that in the way that they're dealing with it in the police who do have the same sort of slow drip exposures and behavioural issues as we do but just may, maybe that that being communicated or studied so that we start to get up some research around where and how TRiM has been used when it has been flexed a little bit (116).

**Steve:**

So you're saying that., yeah, actually the model itself is good, but it's how it's used and it's whether it's used, you know, as in a rigid format or whether it's used, I suppose creativity with an adaptable mindset, I suppose that they can use it in different ways.

**Rebecca:**

Yeah, I have a mantra, Steve, and that is practice can inform research and research can inform practice (117). And you know there have always been this, uhm, osmosis, really, of how you apply something. So, whether you're looking at sociology or psychology, we're always looking at the application of these principles or these foundations, or even or penology. Even if you're trying to stop people getting into trouble, you know what theories you can use to look at how behaviours can be shifted, changed, modified, managed (118). So, I think the same approach to TRiM can be applied and the same learning and the same advocacy can be used to highlight all its virtues and its strength. We just need to be more open about the flexibility and the applicator value of that approach in its application (119).

**Karen:**

So, I think, on a general level, I agree with Rebecca that we have built in some flexibility. And if that worries me, I know that you, Steve and Nigel do reassure me that that's OK (120). What we're doing that we are flexing it and people, you know, we're not going to do a formal or not formal by trend session and but we might just have a chat actually anything is better than nothing. So, I think it is that flexibility is or what can we do and what can we do within that model but varying it slightly (121). I think if we bring it back more locally to the actual training online training but that you run I think there could be a few tweaks if I'm honest to that actually TRiM program.

And I think one of those is for each sector is having a TRiM assessment that is relevant to their, that section, that sector (122). So, for us it would be a MedTRiM type scenario would I think we would relate to and also watching how a group session could be done. So, I think a video of a group session would be really handy and just kind of a summary of going through it from start to finish up but so some tweaks to the on you know to the online training and just to each sector (123), I think.

And also, maybe somehow I don't know how you would do this, but for us we've certainly built in this kind of peer review, so people can't or shouldn't really practice as a TRiM practitioner until one of us, there's two or three of us who can peer review, until they've been assessed and passed as competent, good, you know, and for that (124). And so, for me, that's quite important because. I've watched, you know, I've done some practice sessions with people and think, oh my God, you actually, you haven't really grasped this. And so, it takes two or three sessions to go through it with them and, you know, they're going to be fine in the end, but it just worries me. that maybe some people are just do the training and then they're qualified and away they go, and it might be fine, but sometimes it might not be fine. So, I think the accreditation then needs to be I suppose, robust and carefully considered as well (125).

I think someone came up with a really good idea, which I was going to talk to you about and it was maybe the training provider doesn't issue the certificates until we've assessed them. But until we've assessed them as competent, they don't get their certificate. And actually, I think that's a really good because we've had lots of people who finished your training but have not come forward to the practice and competent, you know peer review but they've got their certificate for their portfolio and their CPD and all of that. But actually, if we didn't issue the certificates until they've done that, they wouldn't finished and say we'll catch up that

about like a later date. But I think for me it was like a light bulb moment. Yes that's really what they could do (126).

**Steve:**

I said it's a really useful point actually. That's the beauty with these processes that it's two way, isn't it? The actual reality and practice and how you do it in the real world is the most important thing isn't, you know? And I think that's an absolutely great idea. So great. Well, that's really useful.

10. Finally, then, it's the good old one. Is there anything else I've missed? And I'm sure there is but is anything else that you'd like to add in terms of the sort of, whether it's LawTRiM or MedTRiM or anything at all that you would like to add that you think is important either for this, this research or for other people, and going forward, I think.

**Pamela**:

So not necessarily something you've forgotten, but I think I keep going on about tick box then I think when it's first introduced to organisations as a concept, it's really good to get people that are interested. Interested because if you need to change a culture, you need and trust people.

So, I think the only way you can start some cultural change is with people who are passionate about it. We've seen it when we've gone through the training but how many of them actually do it? They'll be absolutely up for putting it on their CV. But actually, not very up for actually doing it? So, there's, I suppose that there's that personal bit isn't there, but there's the organisational bit, making sure that they send the right people. But uh, but there will always be those individuals, so I suppose it's stressing to the individual that, you know, if you're going to be going to be part of this, you know, this growing cultural change, then, you know, you need to take your active part in it rather than just being a passive member, you know (127).

**Rebecca:**

So with my view on that, and again, you know, I'm still very early stages, but I can only speak in other contacts well, I found really helpful, has been the community that TRiM has created which through my professional association with DNA I've had access to other organisations or other individuals who are leading the TRiM work may not have that luxury of being able

to have those points of reference (128). One of the things we did with our Wellness for Law programme, that's not profit that I've set up to support our sharing of knowledge and gathering of people who are interested in helping us was that the value of having their those education days or putting on that conference once a year with a particular topic meant that all of the people who were part of the network came together and the value the coffee cough conversations or the lunch, UM, introductions that people made or learning that exchange that occurred was in some respects more valuable than the keynote or the person who was speaking in a presentation, so I'd like to see a forum for TRiM practitioners and for the for the TRiM leads or a yearly conference where the trend developments or the TRiM challenges can be shared to connect that community a bit more (129).

**Steve:**

That's a great idea, Rebecca.

**Rebecca:**

The other thought was confidentiality is a real issue (130) about barristers, didn't want to on senior people, they were very concerned about who they were going to be talking to and sharing all of this information with. And I think there's a real potential for being able to parachute people in who are from somewhere else (131). So, I'm not suggesting though it's a hierarchy aspect, but there's a lot to be sad from having, you know, Karen, for instance, to do an afternoon and a set of chambers and a quid pro quo of me going to wherever. But you know, just having or most people probably terrified because. I'm often seen acting for the trust. But you know that level of the exchange of leaders to do TRiM in in alternative environments, because that was that has and I'm afraid it is a bit of a barrier that I even though people are being or going to potentially be TRiMed, I'm not sure that there's that safety factor, they're not psychologically safe (132) in the same way as they are when we've had people like fabulous [redacted] or [redacted] and who comes from the Foreign Office to do my mental health training. There's a lot more psychological safety and having a separation of TRiM practitioners and coming to do the work. So, I don't know how that could be a facilitated and but that's certainly something that as a service I think worth considering building in because Chambers will be looking into by some of this expertise and whether that can be done on a consultancy basis to make it more efficient (133). And that's my last like my last word, hopefully Steve.

**Steve:**

Brilliant. Excellent. Thank you, Rebecca. Anything else you'd like to add that list?

**Rebecca:**

So, we've got a regulatory and one of the challenges in fact it's a point I forgot to mention Steve. But so we have uh we've got the codes of conduct and they're a bit like the GMC we have they bar Standards Board and so there is a potential barrier where if TRiM practitioners are practitioners practicing barristers who through serious misconduct is reported to them as part of that conversation. So, if someone says yes, you know I'm what's your alcohol consumption like? How are you drinking? When are you drinking? I'm drinking all the time and you know that person still practicing and their potentially then being exposed to members of the public whilst they're drinking that will breach potentially their code of conduct require you as a practitioner to report them for serious misconduct it's the same as ever does the doctor becomes aware of a professional ethics issue, so that. Sorry, Steve, but that's a massive issue for us, is the ethics. So, we've got to manage the ethics, which means that we can deal with that's because I had it in the early days and I still have it. I've got exemption from reporting (134). I put more people in the priority or pick them up on route to court and take them to the Priory than I can tell you.

But the reality of that is that there's safety mechanisms that we need to put in place from, from regular regulatory purpose. So, with the mental health training, it's been brilliant to have both (135).

Uh, because I'm a not for profit and uhm, I need to actually be a bit more commercial about things to be able to hire people more professionally to support the development of things. But the reality of that is that we, you know, you were light on the ground. And so, deploying people is done on volunteer, peer to peer volunteer basis and that that kicks into all the challenges we've been discussing as part of this review on the priority of those people then motivations for why they're volunteering in the first place and the practical efficacy of their skills, and it always much better when you know the best results we've had and all of our training (136). Yes, there's a combination. So, a combination what both stone and this is a lady who's a psychologist who works for an office in the deep, the [redacted]. She basically is freelance, but she comes towards. But I had her. I sent her off to Chambers. She spent time in Chambers. She spent time going to court with barristers. She spent time marshalling with judges and she's just invested in understanding our organisation and our

quirky people. And overtime she was sufficiently really engaged in in what we were trying to do because she's that type of a person that she's been absolutely buzzing with developing our mental health awareness and training programs and leading that sort of pretty much single handedly. So, you've got to have those people as part of your core and yeah that's I'm yeah that be a good conversation to have at some point.

**Steve**:

Of course. Well, that's fine. That's all of my questions over. Really. So massive. Massive. Thank you all. And I think just to two things, the peer support bit, I'd say one of the bigs peer support things from my perspective, it's not just about peers, but I think peer support for me. The fact is there that it's almost the shared experience. It's coming from people that have that bit of knowledge it's not coming from a clinical psychologist or psychiatrist. It's coming from people that have an understanding and care for each other. I think that's the real thing. So, I think the peer support, I think some people can cling onto it. But I think that for me is more about the shared experience and I think the confidentiality, MedTRiM management, Rachel, that for me is a really good example there of the of the flexible approach. You know each organisation has their little quirks, and little requirements and I think you know in terms of the intro or the exit brief, whatever you know in terms of this, you know that is a really good example of where you can just go look.

From a confidentiality perspective, these things might be red flags. Now, clearly you've managed it in another way, but I think it this is where it gives you the ability to flex it, to be creative with it, but to still deliver something which is really straightforward, really quite sensible, but it's done. For you guys, you know it's a bespoke package for your guys, for your requirement, for meeting your requirement you know. So, I think they were really excellent points, yeah.

**Karen:**

Adding to that part because I know you've got to go right to the confidentiality. I mean that clearly is a huge issue for doctors and nurses and what you know what they may or may not disclose inner TRiM session and how much you know because it's a confidential and I'm very hot on that. But we do get challenged by our governance about well you know where the parameters are around like. It's, you know we have TRiM consultants and doctors, nurses, and we you know there are potential issues that emerged around the confidentiality and where do we stand about patient safety? (137)

**Rebecca:**

Thank you so much for all your sharing and Steve thanks for putting this all together.

**Steve:**

It's been really valuable I think, you know, having the conversations I've had with people, it's been fantastic. And of course, once I've got it all done, I'll share it with everyone. So you know, and this is what we dream of really is being able to, you know, get great people like you together to talk about it, you know, and I and I think you know in an ideal world, we'd be able to support each other more, and you know and care about because you know you guys are at the front line, you care about what you do, you're helping people all the time and it's fantastic. So, I think this is this is to dream really. So, thank you, honestly. Thank you so much for sparing the time.

OK, guys. Thank you.

**Appendix 3.4.2** FG4 Transcription Codes

## Focus Group 4 (FG4): Transcription Codes

Participants: Karen, Rebecca and Pamela

Date:

Questions asked during each Focus Group.

11. What would you say are the biggest strengths of the TRiM programme? Discuss
12. What would you say are the biggest weaknesses of the TRiM programme? Discuss
13. Would you say that TRiM is an accepted methodology within your organisation and if so or not, why is that so? Discuss
14. Can you say how the implementation of TRiM has led to a positive or negative cultural change within your organisation? Discuss
15. In your opinion, how would you describe your experience of delivering TRiM in terms of whether you perceive it as a proactive or reactive tool or methodology? Discuss
16. Do you think that regular TRiM / trauma awareness sessions would benefit your colleagues / organisation and if so, how and why? Discuss
17. Given technical and online advances, how do you feel a blended approach to delivering TRiM could be used more effectively in providing effective support to your colleagues and organisation, i.e., part online self-directed learning and part face to face? Discuss
18. What advice would you give to other organisations that were thinking of implementing a TRiM programme to others that work in psychologically or physically challenging, potentially traumatic environments?
19. How else do you think the TRiM programme could be improved?
20. Is there anything else that you would like to add that you think is important and may aide this focus group and further research?

Codes identified within FG4 Transcript.

Q1. So, happy for us to start, guys? Yeah, so I'm just going to go through these questions because, it does make it far easier for me when I'm looking for themes and general dimensions so first thing then what would you say then are the biggest strengths or benefits, from your perspective, of the TRiM program and either of you, one of you can kick off.

1. … the biggest strength is support following a PTE (1) *

2. … staff feeling that we care about them, which we do (2) *

3. … this for me isn't a tick box exercise (3) *

   … I think that the strengths are that that we can support people and we can help keep them at work and they do feel cared about (3) *

4. the biggest strengths are that it's a process that that can be followed by anyone they don't have to be professionally qualified (4).*

5. It's a process that can be rolled out in any environment basically. As long as the process is followed (5).*

6. It's looking for people that will buy into it basically so that for me is the first strength (6). *

7. … it's got a wide, universal language because of that whereas if something is, you know, let's say it' s aimed at medics or teachers or, you know, a particular discipline, then it will be in their language, which automatically excludes, or potentially excludes, people outside (7). *

8. … it's a peer led program (8). *

9. …again, came through as a really, strong protective factor is the collegiate working environment that we have as practitioners (9). *
10. … to have a program which falls within the safety net of where we know our people get the most support, when we asked them in our empirical surveys. Where do you find support? Where do you feel is most you know; this safety can be found? It was often amongst colleagues, and that's not to say there is a distrust of regulator or outside, but because of the status or because of the stigma (10). *

11. … it's about having a conversation where those, indicators can be travelled through in a in a natural way without feeling that there's too much critical analysis because one of the risk factors with barristers is that they have very high levels of rumination and perfectionism (11). *

12. … that process or that structured conversation with a peer is actually very valuable (12). *

Q2. Excellent, thank you. So conversely then what do you think are the biggest drawbacks or weaknesses with the TRiM program and I know that you're at both at different stages of sort of implementation, if you like, but just as you see it now, so what would you say then is the biggest weaknesses of the of a TRiM program?

13. … the fact that it can be used as a, it becomes a tick box exercise (13).

    … I think that is a potential weakness, not every time, because again that comes back to how it's introduced, how it's sold as a as a process (13)

14. … it just becomes a yes, we've done that. We're covering something about psychological well-being which is very in vogue moment (14).

15. … there's a lack of time for the TRiM practitioners (15).

16. … People aren't reporting PTE's, even though we know we have numerous PTE's. Weekly, and I'd say, some more, bigger ones. But people aren't referring them in as I think they should. So that's been a real, real challenge (16).

    … it's been a very slow cultural shift, because people often think, oh well, I'm a nurse or doctor, it's part of my job (16)

17. … the other thing I feel is it's been a real challenge trying to get senior staff to engage with it (17).\

18. I think it's a cultural shift and we're not there yet with our cultural shift (18).

    … I think we've never really offered this before, and we've only been running it for well under a year really and it's taking a while for it to ripple out (19). It's starting to happen actually, but it's a whole cultural shift about accepting TRiM when something happens (18).

19. … it's the fitness for purpose for us because unlike the scenario with the blue light type of trigger, barristers are rarely involved in an incident where there will be that appropriate categorisation. Ours is much more of a slow drip secondary vicarious experience where we may be dealing with terrorism incidents, we may be dealing with war crimes, or we may be dealing with immigration when we're expected to challenge the integrity of the account and scrutinise, repeat, and seek to qualify, to undermine potentially the validity of the horror that that person is trying to actually explain. So, you are visiting the types of TRiM incident that we wouldn't recognise with a 999 blue light type of scenario (19).

    We really like what TRiM has, so the weakness is its fitness for purpose really that's how I would sort of describe it and with that sort of qualification of an explanation (19).

20. … it just needs to be slightly adapted, which I think you'll come onto in your next questions (20).

21. … it's just kind of jolted me to think what weakness is and will always be. In implementing TRiM in our organisation and I always said it's like trying to fit a square peg into a round hole. We're having to shave the edges off really. And so, I think with the TRiM model was clearly set up in the military and it's been adapted for other areas. So that's one of the biggest challenges we have had with TRiM, and incident say happens in emergency department. Lots of people will come from different areas at the hospital to support with that emergency (21).

22. So, as specialist cardiac nurses, you'll have a 12-20 people working on a patient and then very quickly disappear once the emergency is finished as they've gone back to their departments. They work shifts. They work different, you know, rotors, different times of the day, night, and so for us to then try and coordinate a TRiM session is very logistically difficult (22)

    We really do try and do the best we can with a model that wasn't really geared up for our kind of type of organisation (22).

Q3. Right. Would you say that TRiM is an accepted methodology within your organisation? If so, or not, why is that so?

23. I think the short answer is yes (23).

24. I think it has a solid history of longevity research and it has a multi factoral application into different professions (24).

25. I definitely think so, and it is a structured way (25).

26. I think we were always struggling to know how do we support people psychologically (26)?

27. … I think the TRiM methodology really does fit actually. This is what we do, and this is how we split people. You know structurally. So, I think yes, I think it does, is (27).

28. … yes, if I if I look at my MOD background absolutely (28)

29. You know, I'm talking back years now. I was aware of TRiM and obviously became involved in it, but it wasn't accepted vocabulary and particularly because we were in a time of conflict, so trauma was more spoken about maybe expected absolutely happening and this training was always say around before the conflicts and talking about which mainly Afghanistan. TRiM became like a natural part of that discussion (29).

30. … I was working in the mental health arena anyway, if we were talking about an incident, one of the automatic questions would be; were you TRiMed which to me is really valuable because that that shows it's embedded (30).

31. … I wouldn't then have to explain what TRiM was. Which you know that shows a culture change to me because it's part of the language, it's part of the expectation (31).

32. … it's a proven under almost an expectation of it's what happens when something goes wrong (32).

33. Yeah, I think that's a real positive and it was embedded (33).

34. … it was more because of the amount of trauma they were experiencing. So, you know, if we think of a time of conflict and the many years of Afghanistan. From the tempo that marines were operational in Afghanistan. Alright through natural events or events that happened out there, the natural course was there was more trauma experienced by Royal Marines, supposed to maybe well Navy people that I'd be seeing at the time. So, it became very evident that situations incidents were part off (34).

35. For most of the marines at this time, therefore TRiM is very much a part of life. So, when I think about, I think very much about the war Marines at that time (35).

36. The Navy, I think it was more sporadic and maybe even personality driven (36).

37. … I do recall some of the survivors' people from the Navy side, you know, we were kind of, I can't remember the correct term they were flying the drones. Yeah, I mean, obviously by computer and that was traumatic for many. In its own way, and quite a unique way (37).
38. … I don't remember TRiM conversations about that. So that brings in and another element really that when is, when is it identified as a traumatic experience? (38)

Q4. So, would you say the implementation of TRiM led to positive or negative cultural change within your organisation? And again, I suppose that's quite difficult if there's any form of resistance to the implementation? I suppose in there, but I don't know it. Would you say that the implementation of TRiM, even if it's so far, has led to a sort of positive change or even in raising awareness of something that's needed? Perhaps that over to you?

39. TRiM the as you know presenting the work at the ones for law forum that has really improved our conversation around potential trauma and an appreciation of many of the behavioural traits and response (39).

40. I'd definitely say yes, I think. You know, even if it was a very slow (40).

41. I think that there are many variables over the last year, but I think it's definitely a cultural shift definitely for positive (41)

42. … there's an email saying someone attended a TRiM session last year and their sister in Ireland wants to start doing it because they've been singing the praises so much and can I contact her sister in Ireland to talk about what we've done.

    Now I didn't get any feedback from that person about the TRiM, at the time, but clearly she's been sitting there saying how great it was. So, for me it's things like that that I'm hearing because we never formally evaluated it, but it's just like, wow (42).

43. It's working and having a cultural shift. And I do think it's as simple as that (43).

44. This sounds it's because they feel cared for, and that really matters. I think people need to feel valued and supported, and this is the one of the ways we're supporting them and valuing them. I think so, yeah (44).

45. … I think that the culture started to shift about being looked after and invested in (45).

46. I still believe that that's true with TRiM as an investment in people and you could say that it went from a very masculine, non-emotional environment to where we're allowed to talk openly about things that have happened (46).

47. … I think that was an absolute positive. That we are we are OK to talk about things that don't feel OK (47).

Q5. In your opinion, then, how would you describe the experience of delivering TRiM? I suppose delivering or running TRiM in terms of whether you perceived it as a proactive or reactive, but just how you see it? So, in your opinion from your perspective would you say you know in your delivery or in your running of TRiM which you see it's proactive or reactive.

48. I think that at its base, it's a reaction to an incident or incidents, but it's a proactive method of merging psychoeducation and self-awareness and it's proactive in it hopes to maybe prevent things from going wrong as well (48).

49. I guess it raises self-awareness and if you know what's happening it can de-escalate things (49).

50. … it's very active because it happens because of something, but it's proactive because it's looking at normalising through psychoeducation really and signposting and also that containment again (50)

51. it's proactive rather than waiting for somebody to become potentially unwell or confused because they don't know what's happening to them (51).

52. I think it decreases the potential isolation as well that sometimes trauma can cause because if you if you're aware of a process that is happening around you and it's not just about you, being may be unable to sleep or you know, ruminating about the issues then I think it can help decrease that feeling of isolation, which in turn would potentially de-escalate any issues becoming bigger than there needs to be? (52)

53. It's proactive because we are not alive to the same issues of an incident like in some of the other forums where it's delivered, and they are either targeted individuals (53)

54. I have deployed TRiM, and I have TRiMed people who I can see from my experience as a practitioner they may be, in one particular example, they were very, very big household name

who was in a certain type of work that you would expect to have needed TRiM and their [redacted]. And so, I went in and used TRiM proactively and it worked. And he's just such a powerful advocate with me. Still doesn't talk about his experience of TRiM, but very, very powerful tool from his personal experience of it. So, I'm not. I'm not. I'm at that stage really of trying to be proactive and I communicate it proactively even though I absolutely get that it has reactive methodology and where I I've shifted it into using this as a protective factor (54).

55. How we anticipate this sort of distribution of it and that mentoring capacity of people in chambers, it will hopefully just be normalised as a proactive peer review progress development, continuing professional development conversation in the same way that service is connected to social services and the programs around supervision work. And so, I put it in that sort of proactive, even though they may well be talking about it in that retrospective and past tense language, it's still being. It's still being communicated by me as a proactive methodology (55).

56. I agree. I think it's proactive in our organisation (56)

57. You can't prevent young people coming in, you know with heart attacks and all those kinds of things that might trigger a TRiM response (57).

58. … we didn't wait till we heard that people were struggling with it. What we did if we heard of something or someone got referred, we very quickly offered the TRiM proactively (58).

59. I say it's not nearly as many incidents as we know what happened. But when we did hear about them, we tried to be proactive (59).

Q6. Uhm, do you think quite short one then? Do you think that regular TRiM or TRiM awareness sessions would be beneficial for your organisation or present ties into the last question? I suppose in trying to spread I suppose the TRiM informing you know because you're both working environments where you know trauma, there is potential trauma involved in what it whatever you do, whether it's vicarious or, you know, or first hand.

60. I definitely think so. So, we put some online sessions on for the organisation and bite sized training for managers, which are hour long sessions on Teams so managers can just join any of them (60).

61. So, we're putting one on about TRiM. We've also got a people panel where I think that's a half an hour session where people just come along and ask (61).

62. … we've got one on TRiM, we've got leaflets that we did distribute and we were also in the process of making a short video about TRiM which two of the directors, I'm hoping, I certainly hope at least one of them is going to get involved in making and that will put on our extranet site so that people can just find out about TRiM so we were, are trying to raise people's awareness or it, which I'm hoping will help make that cultural shift as well (62).

63. Yes, I do. But I think there's a risk of overkill (63).

64. … I experienced this in my current role. If you roll out the message too often it can, sometimes fall on deaf ears because it's just another Oh yeah, it's that lecture again (64).

65. … I think if you time it carefully to Keep it fresh. In my experience, that works much better (65).

66. I think it's probably picking up my theme as we need to not make our messages tick box. It's about balance (66).

67. … it's fresh and not just the same message every time, you know, obviously the key points are the same but it's about keeping people engaged in the message (67).

68. For me, having regular refreshers and advertisements normalises and supports this, the destigmatising of the negative, whether that's cognitive dissonance of those in leadership that they don't understand what they say or whether it's the individual who's afraid of the addressing those issues or talking about them (68).

69. So, the more regular normalisation of those programs and the advertisement of it, is pretty key (69).

70. So, we have done a lot of soundings around how that learning is best developed in our in our profession and it is through those regular continuous professional development updates (70)

71. It's by having quarterly practice management reviews with your colleague or your peers or where that will form a part of the process. Just as in the same way that clinical supervision would work (71).

Q7. OK, given the technical and online advances, then that we've gone through saying there's a couple of years, do you see a benefit, and this is it's not really an open question is that you know, but it turns in terms of a blended approach to delivering TRiM? Obviously, historically we've always delivered it face to face but since, or prior to COVID really. So, do you feel that blended approach

delivering TRiM could be more effectively used for providing effective support to your colleagues and organisations? Or part online part face to face. What do you think about Blending the online learning side of things?

72. … I think for us it generally worked that we had the blended approach each time we did a cohort as you know we've flexed how we've rolled it out (72).

73. … we then did the online learning and then we met with you in a room and did the practice session. So, for me that was probably the best way I think in [redacted] over the last year we could have run it (73).

74. … I don't think we could have run it two days either online or in a classroom, certainly not any classroom but maybe online, but we wouldn't have been able to spare the staff. I think the disadvantage of the blended approach is that people can do it when they want. So, we've had a lot of people that signed up, started it and then never finished it or a few that stall it if I'm honest and so I think that's been tricky (74).

75. … if you're in a room for two days or all online for two days, you've finished the course (75)

76. I think it's a way to get more engagement because, if we think of the organisations that are likely to benefit from TRiM, they tend to be big, busy, pressured, and high stress environments (76).

77. … to release people for training is a is a big issue so I think to do the blended learning as in do the basics online to the, you know, the basic framework, not in a basic way and quite a comprehensive way that people can (77)

78. Engaging so not just a PowerPoint slide by slide, but they're interactive and different ways of delivering online followed by a follow up session that consolidates everything, gives a bit of practical experience. Followed by a further follow up (78)

79. It's very hard to talk timescales, isn't it? But within a reasonable timeframe. You do the first follow up, so it's still fresh and you do another follow up (79)

80. … I'm very keen that people get the opportunity to practice and then under still feel held by other people's experience so blended, absolutely (80)

81. I think there's more opportunity to get buy in (81)

82. … not put more stress on people because once you say OK, you need three days out for training (82).

83. We've got 17,000 barristers on the role of registers, so unlike organisations that have control to some degree over there people, ours are very desperate and the nature of our practitioners means that they're not employed. So, whilst they've got regulatory responsibilities of CPD and keeping up to date and doing certain things come, there is it's not as if we have a, you know, an ability to put them in a room and make them do some mandatory training and so the on-site has always been a challenge and it's always been very London centric (83).

84. … for me and I can tell you that the blended learning approach with our mental health first aid has been phenomenal in lockdown and the numbers that we've seen, we've trained 600 people just through lockdown in mental health first aid and we never had anything like that coming to the London (84)

85. … accessing both practitioners and practitioners accessing the content that blended learning approaches is much more useful (85).

86. … there are the same drawbacks as Karen said, about commitment and continuity, that learning and the ways in which people learn is always better when you've got their undivided attention and then they're in a room and you've got the collaborations and the conversations that you get with that, and you can't really emanate that. But it's a hybrid model for me (86).

87. … we're hoping to achieve where they can go through some of that core stuff online and then we can actually get together people together to do the practical, to have those conversations, to talk about the challenges that they think they're going to have (87).

Q8. What advice, then, would you give to other organisations that we're thinking of implementing a TRiM program?

88. It became clear to me that my senior managers don't really know what it is, which is disappointing. So senior management engagement is key (88).

89. Recruit practitioners quite carefully (89).

90. … I thought I had a fairly robust recruitment procedure, but on in retrospect it could have been more robust (90).

91. … think carefully about the people. Who are the right people but also who have enough time to do it? That's a big thing. So, recruitment of practitioners (91).

92. Think about how you're going to advertise it and how you going to roll it out and change that culture? (92)

93. … think about ways of trying to embed it and getting the right people on your side (93).

94. I think have people who are well connected, you know, and feel passionately about it on your side (94).

95. … make sure that you have good support from the company (training provider) (95)

96. I was the only one doing it and for well over a year and that was really hard and lonely and it and the best thing I've ever done. But it was really hard and lonely setting it up as well, so you need that kind of support (96)

97. … I'd say don't you know, don't do it on your own if you can. Two is always better than one. I think just to bite that richness you can get from just discussing things so that that (97).

98. The people at the top, you need to buy into the process and understand the process and value the team stuff like providing time to do the training and give the time to the coordinator (98).

99. They appreciate this is very difficult in certain environments to work out how the process would work with shift patterns within pressured environments again. So, I think it has to be a cascade approach to, not just the learning but committing at any level and should be at all levels (99).

100. The endorsement comes from the top because then that starts the message, the culture shift. If it starts at any level without the top buying, it's difficult and it's the potential to get lost 100).

101. … clearly in in some of the biggest struggle bigger organisations, you know, you've got this sort of people at the top, but within that you've got these sort of mini triangles And with many departments and you know and all those need to be a similar way then they in all of those you know the senior management, the senior and whoever the senior people are you know whether it's HR as well and you know they need to be involved (101).

102. … once it's nurtured, it just becomes it. It becomes its own beast, isn't it? Because it feeds itself. It looks after itself, you know, once it's up and running, doesn't it, you know, but I think it's almost the biggest failing in management not understanding (102).

103. … I echo a lot of what Pamela and Karen have said, leadership of leaders. Yeah, and my tip for that is train them, take them to a training session (103).

    That was a big experience for one of my very senior chairman of the board, so that they actually get it (103).

104. Peer support. I am absolutely, as you know, I am part of the DNA family so I can't underestimate the value of that in so many respects because I'm never lonely and I'm never afraid and I'm never struggling for somewhere or someone to go to for support because I've got DNA and every single time I feel that that any of those people, whatever time of the day or night, would respond if they got a text message or an email (104)

105. … that form of courage and empowerment of an individual is something back I would think to embed when, as part of the setup package, that if you're someone who's going to advise an organisation that would be, you know, the leadership is one aspect, but then it's obviously it's care of yourself. We talk about caring for others. But then as part of our own self-care (105).

106. … it is the signposting and the support for you and then again (106).

107. Choose your champions carefully because they are not just the champion of your work, but they are a reflection of what it represents (107)

108. … some of our individuals have the motivation for people volunteering (108).

109. … making sure that your processes that you put in place also have half that and that is just a brutal, you know, reputational perspective but really necessary to safeguard the individual and those that they might encounter as well as the system you're trying to put in place (109).

Q9. OK, in your very relative experiences, how do you say in the TRiM program could be improved, just from, you know, very individual, very personal ways? You know, organisationally clearly two quite different organisations, but how do you think, you know you mentioned earlier Rebecca, about certain things that you know where TRiM doesn't fit. You mentioned about this, the square peg.

110. … I'm quite keen on the self-cure bit so, I think that there's potentially more room for talking about that in the process because there's a risk of people getting very fixed in the process and forgetting to be human (110).

111. … just having a bit of a human conversation with somebody and saying, you know, look after yourself, just maybe do this, that and the other because people can get very caught up in. I've got to say this, I've got to say that I forget in the. It's a very normal conversation that they, you know, have a conversation with purpose. To make sure people just tend to leave some of those good things rather than seeing it as an add-on at the end (111).

112. … applying TRiM more flexibly is problematic (112)

113. … it is structured in the way it is because that it's a process (113).

114. … the TRiM team, as it were in the leadership TRiM leaders are already beginning to see and do their own adaptions. I'm being supported in that process (114)

115. … I think for example my work come as you know, you know I'm doing some stuff with judges internationally and another country and there are real cultural issues of that to manage with that group (115).

116. … I think having an expected approach to its flexibility because at the moment when you look at it and all the papers that are written and the empirical foundation for the work and the systems that are in place for its delivery, our quite military based or are quite structured and I think potentially a better strap line that you know we you can fill, this can be flexed and we know that people are doing that in the way that they're dealing with it in the police who do have the same sort of slow drip exposures and behavioural issues as we do but just may, maybe that that being communicated or studied so that we start to get up some research around where and how TRiM has been used when it has been flexed a little bit (116).

117. … practice can inform research and research can inform practice (117).

118. … whether you're looking at sociology or psychology, we're always looking at the application of these principles or these foundations, or even or penology. Even if you're trying to stop people getting into trouble, you know what theories you can use to look at how behaviours can be shifted, changed, modified, managed (118).

119. … TRiM can be applied and the same learning and the same advocacy can be used to highlight all its virtues and its strength. We just need to be more open about the flexibility and the applicator value of that approach in its application (119).

120. … I think, on a general level, I agree with Rebecca that we have built in some flexibility. And if that worries me, I know that you, Steve and Nigel do reassure me that that's OK (120).

121. … we are flexing it and people, you know, we're not going to do a formal or not formal by trend session and but we might just have a chat actually anything is better than nothing. So, I think it is that flexibility is or what can we do and what can we do within that model but varying it slightly (121).

122. …I think if we bring it back more locally to the actual training online training but that you run I think there could be a few tweaks if I'm honest to that actually TRiM program and I think one of those is for each sector is having a TRiM assessment that is relevant to their, that section, that sector (122).

123. … for us it would be a MedTRiM type scenario would I think we would relate to and also watching how a group session could be done. So, I think a video of a group session would be really handy and just kind of a summary of going through it from start to finish up but so some tweaks to the on you know to the online training and just to each sector (123)

124. … for us we've certainly built in this kind of peer review, so people can't or shouldn't really practice as a TRiM practitioner until one of us, there's two or three of us who can peer review, until they've been assessed and passed as competent, good, you know, and for that (124).

125. … I think the accreditation then needs to be I suppose, robust and carefully considered as well (125).

126. I think someone came up with a really good idea, which I was going to talk to you about and it was maybe the training provider doesn't issue the certificates until we've assessed them. But until we've assessed them as competent, they don't get their certificate. And actually, I think that's a really good because we've had lots of people who finished your training but have not come forward to the practice and competent, you know peer review but they've got their certificate for their portfolio and their CPD and all of that. But actually, if we didn't issue the certificates until they've done that, they wouldn't finished and say we'll catch up that about like a later date. But I think for me it was like a light bulb moment. Yes that's really what they could do (126).

Q10. Finally, then, it's the good old one. Is there anything else I've missed? And I'm sure there is but is anything else that you'd like to add in terms of the sort of, whether it's LawTRiM or MedTRiM or anything at all that you would like to add that you think is important either for this, this research or for other people, and going forward, I think.

127. … I think the only way you can start some cultural change is with people who are passionate about it. We've seen it when we've gone through the training but how many of them actually do it? They'll be absolutely up for putting it on their CV. But actually, not very up for actually doing it? So, there's, I suppose that there's that personal bit isn't there, but there's the organisational bit, making sure that they send the right people. But uh, but there will always be those individuals, so I suppose it's stressing to the individual that, you know, if you're going to be going to be part of this, you know, this growing cultural change, then, you know, you need to take your active part in it rather than just being a passive member, you know (127).

128. … I found really helpful, has been the community that TRiM has created which through my professional association with [redacted] I've had access to other organisations or other individuals who are leading the TRiM work may not have that luxury of being able to have those points of reference (128).

129. … the value of having their those education days or putting on that conference once a year with a particular topic meant that all of the people who were part of the network came together and the value the coffee cough conversations or the lunch, UM, introductions that people made or learning that exchange that occurred was in some respects more valuable than the keynote or the person who was speaking in a presentation, so I'd like to see a forum for TRiM practitioners and for the for the TRiM leads or a yearly conference where the trend developments or the TRiM challenges can be shared to connect that community a bit more (129).

130. The other thought was confidentiality is a real issue (130)

131. … I think there's a real potential for being able to parachute people in who are from somewhere else (131).

132. … that level of the exchange of leaders to do TRiM in in alternative environments, because that was that has and I'm afraid it is a bit of a barrier that I even though people are being or going to potentially be TRiMed, I'm not sure that there's that safety factor, they're not psychologically safe (132)

133. There's a lot more psychological safety and having a separation of TRiM practitioners and coming to do the work. So, I don't know how that could be a facilitated and but that's certainly something that as a service I think worth considering building in because Chambers will be looking into by some of this expertise and whether that can be done on a consultancy basis to make it more efficient (133).

134. … we have uh we've got the codes of conduct and they're a bit like the GMC we have they bar Standards Board and so there is a potential barrier where if TRiM practitioners are practitioners practicing barristers who through serious misconduct is reported to them as part of that conversation. So, if someone says yes, you know I'm what's your alcohol consumption like? How are you drinking? When are you drinking? I'm drinking all the time and you know that person still practicing and their potentially then being exposed to members of the public whilst they're drinking that will breach potentially their code of conduct require you as a practitioner to report them for serious misconduct it's the same as ever does the doctor becomes aware of a professional ethics issue, so that. Sorry, Steve, but that's a massive issue for us, is the ethics. So, we've got to manage the ethics, which means that we can deal with that's because I had it in the early days and I still have it. I've got exemption from reporting (134).

135. … the reality of that is that there's safety mechanisms that we need to put in place from, from regular regulatory purpose. So, with the mental health training, it's been brilliant to have both (135).

136. … to be able to hire people more professionally to support the development of things. But the reality of that is that we, you know, you were light on the ground. And so, deploying people is done on volunteer, peer to peer volunteer basis and that that kicks into all the challenges we've been discussing as part of this review on the priority of those people then motivations for why they're volunteering in the first place and the practical efficacy of their skills, and it always much better when you know the best results we've had and all of our training (136).

137. Adding to that part because I know you've got to go right to the confidentiality. I mean that clearly is a huge issue for doctors and nurses and what you know what they may or may not disclose inner TRiM session and how much you know because it's a confidential and I'm very hot on that. But we do get challenged by our governance about well you know where the parameters are around like. It's, you know we have TRiM consultants and doctors, nurses, and we you know there are potential issues that emerged around the confidentiality and where do we stand about patient safety? (137)

**Appendix 3.4.3** FG 1 - 4 Transcription Low Order Themes (LOTs)

## Focus Groups (1, 2, 3 & 4): Low Order Themes

Participants: Thematic analysis was conducted across all four Focus Groups to identify Low Order Themes.

Questions asked during each Focus Group.

21. What would you say are the biggest benefits of the TRiM programme? Discuss
22. What would you say are the biggest drawbacks of the TRiM programme? Discuss
23. Would you say that TRiM is an accepted methodology within your organisation and if so or not, why is that so? Discuss
24. Can you say how the implementation of TRiM has led to a positive or negative cultural change within your organisation? Discuss
25. In your opinion, how would you describe your experience of delivering TRiM in terms of whether you perceive it as a proactive or reactive tool or methodology? Discuss
26. Do you think that regular TRiM / trauma awareness sessions would benefit your colleagues / organisation and if so, how and why? Discuss
27. Given technical and online advances, how do you feel a blended approach to delivering TRiM could be used more effectively in providing effective support to your colleagues and organisation, i.e., part online self-directed learning and part face to face? Discuss
28. What advice would you give to other organisations that were thinking of implementing a TRiM programme to others that work in psychologically or physically challenging, potentially traumatic environments?
29. How else do you think the TRiM programme could be improved?
30. Is there anything else that you would like to add that you think is important and may aide this focus group and further research?

Low Order Themes identified across all four FGs.

Q1. What would you say are the biggest strengths or benefits associated with the TRiM programme? Discuss

1. The implementation / use of TRiM makes staff feel valued, invested in, cared for and supported.

   (FG1:1,2), (FG2: 1, 7), (FG3: 3, 6, 7, 9, 10, 11), (FG4: 1, 2, 3, 9, 10, 12)

2. Increased trauma awareness, both individual and organisational, through provision of effective trauma informing (overwhelming stress) education, knowledge and skills in order to identify signs and symptoms of potential trauma.

   (FG1: 3, 4), (FG2: 5), (FG3: 8, 12), (FG4: 11)

3. Normalises effects of potential / actual trauma.

   (FG1: 5, 6), (FG2: 2, 5), (FG3: 1, 5, 8, 11)

4. Offers and encourages peer / non-clinical support to staff and colleagues:

   (FG1: 3, 5, 6, 7, 9), (FG2: 2, 3, 4, 5, 6, 7), (FG3: 3, 5, 6, 7, 10, 11, 12), (FG4: 3, 4, 6, 7, 8, 9, 10, 11, 12)

5. Reduces Stigma:

   (FG1: 5, 6), (FG2: 4, 6, 7), (FG3: 1, 2, 3, 11, 12), (FG4: 10, 11)

6. Inclusive and impartial:

   (FG1: 1, 2, 4, 5, 6, 7), (FG2: 1, 2, 4, 7), (FG3: 2, 3, 7, 8, 9, 10, 11, 12), (FG4: 1, 2, 3, 4, 6, 7, 8, 9, 11, 12)

7. Provides a well-structured and straight forward approach for individuals and organisations that work in challenging (potentially traumatic) environments:

   (FG1: 4, 5, 6, 7, 8, 9, 10), (FG2: 2, 3, 4, 5, 6, 7), (FG3: 2, 3, 4, 5, 7, 8, 9, 10, 11, 12), (FG4: 4, 5, 7, 8, 9, 10, 11, 12)

8. It has credibility and proven efficacy:

   (FG1: 10), (FG2: 2, 3, 6), (FG3: 4), (FG4: 5)

9. The TRiM Model allows for considered adaptation to afford effective integration within organisations:

   (FG1: 3, 4, 5, 6, 7, 8, 9, 10), (FG2: 1, 2, 4, 7), (FG3: 2, 3, 7), (FG4: 5, 7, 8)

10. Fosters effective leadership and teamship:

    (FG1: 1, 2, 4, 5, 6), (FG2: 1, 2, 5, 6, 7), (FG3: 1, 2, 3, 6, 7, 8, 10, 11, 12), (FG4: 2, 3, 7, 8, 9, 11, 12)

11. Can be used in conjunction with other interventions such as Mental Health First Aide:

    (FG1: 9, 10), (FG2: 4, 5, 6, 7), (FG3: 1, 2), (FG4: 4, 5, 7, 9, 10, 12)

## Q2. What would you say are the biggest drawbacks or weaknesses associated with the TRiM programme? Discuss

1. Trained TRiM Practitioners not adhering to TRiM protocol (ie. offering counselling for example):

   (FG1: 11)

2. The requirement for trained practitioners to maintain their TRiM skills through regular use and / or regular and thorough refresher training:

   (FG1: 12), (FG4: 15)

3. Time pressures (individually and organisationally) associated with TRiM:

   (FG1: 14), (FG2: 9, 13), (FG3: 17), (FG4: 15, 16, 18, 22)

4. Poor or inconsistent communication impairs the effective role out / employment of TRiM:

(FG1: 10, 11, 13), (FG2: 8, 10, 12, 13, 14), (FG3: 13, 16, 17, 18, 21, 22, 23), (FG4: 13, 16, 18)

5. Nomenclature / education around using the word ‘Trauma’ and managing perception:

   (FG2: 13), (FG3: 13, 14, 16, 17, 18, 19, 20, 21, 23), (FG4: 13)

6. Organisational / management ‘Buy-in’:

   (FG2: 11, 13), (FG3: 14, 15, 16, 17, 18, 21, 22), (FG4: 13, 14, 17, 18)

7. Lack of understanding requiring general / focused education on key elements of TRiM:

   (FG1: 11, 12), (FG2: 10, 13), (FG3: 13, 14, 16, 18, 19, 20, 21, 23), (FG4: 16, 17, 18)

8. The TRiM Model is not fit for purpose in certain organisations (it’s perceived as the wrong model):

   (FG4: 13, 19, 20, 21, 22)

9. TRiM can be perceived as a ‘box ticking’ exercise (implementing a mental health initiative because ‘they’ should be seen to be doing something) and thus the approach is not taken seriously by organisations and / or individuals:

   (FG1: 13), (FG2: 11, 12, 13, 14, 15), (FG3: 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23), (FG4: 13, 14, 16, 17, 18, 19, 21, 22)

## Q3. Would you say that TRiM is an accepted methodology within your organisation and if so or not, why is that so? Discuss

1. Yes, because the organisation bought into it:

   (FG1: 15, 16, 17), (FG2: 21, 22, 25, 26), (FG3: 24, 25, 26, 28, 29, 30, 31, 32, 33, 35, 36), (FG4: 23, 27, 28, 29, 30, 31, 33, 34, 35)

2. Yes, because of TRiMs credibility and proven efficacy:

   (FG4: 24, 29, 30, 32, 35)

3. Yes, because of the structure it provides:

   (FG1: 17), (FG3: 44, 45, 46), (FG4: 25, 27, 31, 32, 35)

4. Yes, because it gets people talking:

   (FG2: 21), (FG3: 25, 26, 29, 31, 32, 33, 35), (FG4: 29, 31)

5. Yes, but the effect of TRiM has been diluted by the use of other interventions:

   (FG2: 16, 18, 19, 20, 23), (FG3: 37)

6. Yes, but sadly in some organisations you need a major event to jolt an organisation into action (to react rather being proactive):

   (FG2: 24)

7. Yes, it's useful as a filter to signposting colleagues to other, more appropriate support:

   (FG2: 17, 18, 19, 20, 21, 24)

8. Yes, because it's encouraged conversations around the subjects of psychological issues / injuries between members of staff (colleagues, peers, leaders etc.

   (FG1: 15), (FG2: 20, 21, 23, 24, 25, 26), (FG3: 2526, 29, 30, 31, 32, 33, 35, 36), (FG4: 29, 30, 31, 32, 35, 38)

9. No, not at the moment:

   (FG2: 27, 28), (FG3: 37)

Q4. Can you say how the implementation of TRiM has led to a positive or negative cultural change within your organisation? Discuss

1. Positive: Gave staff and organisations confidence that it's 'ok not be ok' ('normalising) and to ask for support:

   (FG1: 18, 19, 21, 22), (FG2: 29, 30, 31, 32, 34, 36), (FG3: 43, 47, 48, 50, 52, 54), (FG4: 39, 41, 42, 44, 45, 46, 47)

2. Positive: Staff feel invested in and supported:

   (FG1: 18), (FG2: 29, 30, 31, 32, 34), (FG3: 39, 40, 41, 42, 43, 47, 49, 50), (FG4: 39, 44, 45, 46, 47)

3. Positive: The implementation of TRiM raised general trauma / resilience awareness:

   (FG1: 18, 19), (FG2: 29, 30, 31, 32, 34, 36), (FG3: 41, 43, 47, 50, 51), (FG4: 39, 46, 47)

4. Positive: Effective implementation and running of a TRiM programme requires ongoing support from others, importantly including senior management and other key departments such as HR:

   (FG1: 20), (FG2: 29, 31, 32, 33, 34, 36), (FG3: 45, 47, 50, 51, 52, 53)

5. Positive: Implementation of the TRiM programme can take time but once it becomes accepted, the positive effects are clear to see:

   (FG1: 18, 19, 20, 21, 22), (FG2: 31, 32, 36), (FG3: 43, 48, 49, 50, 52, 53, 54), (FG4: 39, 40, 45)

6. Positive: TRiM is most effective when it's used proactively, and becomes part of daily routine (education, debriefing etc.) rather than used when something goes wrong:

   (FG1: 18, 19, 21, 22), (FG2: 29, 30, 31, 32, 34, 35, 36), (FG3: 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54), (FG4: 39, 44, 45, 46, 47, 62)

*Negative (possibly): The need to have the right person / department running the TRiM implementation / programme (ie. with credibility and who is trustworthy):

## Q5. In your opinion, how would you describe your experience of delivering TRiM in terms of whether you perceive it as a proactive or reactive tool or methodology? Discuss

1. Proactive:

   (FG1: 23), (FG2: 37, 38), (FG3: 55, 56, 57, 58, 60, 61, 62), (FG4: 50, 51, 53, 54, 55, 56, 58, 59)

2. Proactive and reactive:

   (FG1: 24), (FG2: 39, 40, 41, 43, 49, 54), (FG3: 56, 57, 59, 61), (FG4: 48,

3. Reactive (perceived box ticking!):

   (FG3: 61)

   *Need for departments such as OH or HR to run and support … not to get rid of them because 'we now have TRiM'! (FG2: 45, 46, 47), (FG3: 56)

Q6. Do you think that regular TRiM / trauma awareness sessions would benefit your colleagues / organisation and if so, how and why? Discuss

1. Yes: to create a normalising cultural effect with a well-considered approach (not taking up too much time etc.):

   (FG1: 25, 26), (FG2: 54, 55, 56, 57, 58, 59), (FG3: 63, 64, 65, 66), (FG4: 60, 61, 62, 65, 67, 68, 69

2. Yes: as part of wellbeing programmes, such as during probationary periods of someone's career, Continuous Professional Development (CPD) or annually:

   (FG1: 25, (FG2: 59, 62, 63), (FG4: 70, 71)

3. Yes: to include all staff, in particular senior leaders / managers:

   (FG1: 26), (FG4: 60)

4. Yes: but be mindful not to be too overbearing with TRiM:

   (FG1: 25), (FG2: 50, 51, 53), (FG4: 63, 64, 66 (not tick box),

5. Yes: to include significant others (families / partners etc.):

(FG2: 61, 62, 63, 64)

*Not using TRiM but just demonstrating good practice: (FG2: 63, 64)

Q7. Given technical and online advances, how do you feel a blended approach to delivering TRiM could be used more effectively in providing effective support to your colleagues and organisation, i.e., part online self-directed learning and part face to face? Discuss

1. A blended approach can help relieve individual / organisational time pressures:

   (FG1: 27, 30, 32), (FG2: 77, 78), (FG3: 67), (FG4: 74, 76, 77, 79, 83, 84)

2. A blended approach allows flexibility in training TRiM practitioners / managers as well as allowing trained personnel to 'dip in and out' at a time of their choosing to maintain currency:

   (FG1: 27, 28, 29, 30), (FG2: 66, 70, 78), (FG3: 67), (FG4: 72, 73, 74, 76, 77, 78, 80, 81, 82, 83, 84, 85, 86, 87)

3. A blended approach to using TRiM allows a wider, more flexible provision of support to individuals and organisations:

   (FG1: 32, 33), (FG2: 75, 77, 78), (FG3: 76), (FG4: 72, 73, 76, 77, 78, 79, 80, 81, 83, 84, 85)

4. A blended approach may hinder the purpose and / or ability to hold face to face meaningful conversations:

   (FG1: 31), (FG2: 65, 67, 68, 69, 70, 71, 72, 73, 74, 76), (FG3: 69, 70, 71, 72, 74, 75, 76, 77)

5. TRiM sessions using virtual / online resources, as part of the blended approach, do not work / work less well:

   (FG3: 70, 71, 72, 74, 75, 77), (FG4: 74 (you do not necessarily have the ability to hold people to account, you relinquish responsibility to the individual with risk of them not completing the TRiM training)

6. A blended approach may work, but face to face training / interventions / conversations with purpose are the preferred options (not ruling out virtual sessions in extremis):

   (FG1: 30, 31, 32, 33), (FG2: 65, 66, 67, 68, 69, 70, 72, 73, 74, 75, 76, 77, 78), (FG3: 68, 73, 77), (FG4: 86, 87)

Q8. What advice would you give to other organisations that were thinking of implementing a TRiM programme to others that work in psychologically or physically challenging, potentially traumatic environments?

1. Find the right person / people / department to lead the TRiM coordination within the organisation that can find sufficient time, can influence at all levels and has the credibility and skills to build a positive trauma informing culture:

   (FG1: 35, 36), (FG2: 81, 84, 85, 86, 88, 89, 91, 94, 95), (FG3: 81, 87, 88), (FG4: 88, 91, 92,, 93, 94, 96, 97, 98, 99, 100, 101, 102, 103, 107, 108, 109)

2. Put considerable thought into recruiting the right people to be TRiM practitioners in terms of time available, experience, position, role, motivations, etc. and brief them thoroughly beforehand on the realities of being a TRiM practitioner.

   (FG1: 35), (FG2: 85, 86), (FG3: 78, 79, 80, 81, 82, 84, 86, 87, 88), (FG4: 89, 90, 91, 92, 93, 94, 99, 107, 108)

3. Where possible try to create a TRiM team to lead and coordinate the TRiM implementation rather than relying on a single person as the sole lead:

   (FG1: 36), (FG2: 89), (FG3: 84), (FG4: 89, 96, 97, 98, 104, 105, 107, 109)

4. Don’t train too many TRiM practitioners too early (and beware of the ones that are only looking to enhance their CV):

   (FG1: 37), (FG2: 82), (FG3: 79, 80, 81, 82, 83, 84, 86, 87, 88), (FG4: 89, 90, 91, 92, 107, 109)

5. Ensure you research and get the right service provider for you that can provide ongoing support during the TRiM setup / implementation phase:

(FG4: 95, 96, 104)

6. Ensure your organisation creates a robust and reliable TRiM structure from the outset to look after all interests including welfare of TRiM practitioners, TRiM management systems / IT programmes and databases etc:

   (FG1: 38), (FG2: 81, 82, 83, 84, 87, 88, 89, 92, 93, 94), (FG3: 84, 85, 86, 88), (FG4: 90, 92, 96, 97, 98, 99, 101, 102, 105, 106, 109)

7. Ensure you have organisational buy in, including senior (very importantly) leadership / management and include them in the process wherever possible / suitable:

   (FG1: 36), (FG2: 79, 81, 82, 83, 84, 88, 91, 92, 93, 94, 95), (FG3: 84, 85, 88), (FG4: 88, 92, 93, 94, 95, 98, 99, 100, 101, 102, 103, 105, 107, 109)

8. Identify other similar organisations that have implemented TRiM and where suitable, ask to learn from them (many Trusts in the NHS and police forces have done this successfully):
   (FG1: 34), (FG2: 89, 90, 91, 92), (FG3: 84)

9. It takes time, effort and dedication to implement the TRiM process fully and effectively into an organisation:

   (FG2: 82, 92, 95), (FG3: 79, 81, 83, 84, 85, 86, 87, 88), (FG4: 92, 96, 98, 99, 100, 101, 102, 104, 109)

10. Successful implementation of TRiM often requires long term investment in methods of support, often involving cultural change around education, dialogue and practices:

    (FG1: 34, 35, 36, 38), (FG2: 79, 80, 81, 82, 84, 88, 92, 93, 95), (FG3: 81, 84, 85, 86, 87, 88), (FG4: 88, 92, 93, 94, 98, 99, 100, 101, 102, 103, 105, 107, 109)

## Q9. How else do you think the TRiM programme could be improved?

1. TRiM training needs to be sector specific so that language used, for instance, is constant:

   (FG1: 39, 42, 44), (FG4: 122)

2. TRiM should be regularly shared cross-sector, at training or annual events, for instance (sharing good practice):

   (FG1: 41, 44), (FG2: 96), (FG4: 129)

3. Ideally the TRiM programme should fit around an organisation's needs rather than an organisation bending itself out of shape to fit around the TRiM process:

   (FG1: 39, 40, 42, 43), (FG2: 97, 98, 100, 101, 102, 104), (FG3: 89, 91, 92, 93, 96), (FG4: 110, 111, 112, 114, 115, 116, 117, 118, 119, 120, 121, 124, 125, 126)

4. There are cultural issues both within certain organisations and also internationally that often need addressing in order to find acceptance of both the philosophy and fundamental employment of TRiM:

   (FG1: 40, 41, 42, 43, 44), (FG2: 96, 97, 98, 99, 100, 101, 102, 103, 104), (FG3: 92, 93, 95, 96, 97), (FG4: 110, 111, 112, 113, 114, 115, 116, 118, 119, 120, 121, 122, 124, 126)

5. The way TRiM is delivered needs to be carefully considered. Some suggest TRiM model needs to be flexible in terms of delivery methods and usage and conversely, some suggest that the strength of TRiM is it provides structure, which is needed, and when not followed can lead to complications:

   (FG1: 41, 42, 43, 44), (FG2: 96, 97, 98, 99, 100, 102, 103, 104), (FG3: 89, 95, 97, 99, 100), (FG4: 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126)

6. TRiM could be rebranded in order to reduce the potential stigma often associated with trauma:

   (FG2: 96, 98, 100, 101, 102, 103), (FG4: 110, 111, 114, 116, 118, 119, 120, 121)

7. The TRiM programme philosophy / programme could be used to distribute trauma focused education to the wider community, following incidents for example:

   (FG1: 40, 43), (FG2: 96, 98, 99, 100, 101, 102, 103), (FG4: 110, 111, 114, 115, 116, 117, 118, 119, 120, 121, 122)

8. TRiM practitioners shouldn't be allowed to practice as TRiM Practitioners until they've been peer assessed by their TRiM Lead:

   (FG1: 39), (FG3: 90), (FG4: 124, 126)

## Q10. Is there anything else that you would like to add that you think is important and may aide this focus group and further research?

1. Use TRiM 'experiences' as a useful way to influence others (leadership, managers, staff and wider community:

   (FG1: 45), (FG2: 105, 108, 109, 110), (FG3: 101, 102, 103, 106, 107), (FG4: 127, 128, 129)

2. Volunteers or people chosen to have a TRiM role, should ideally come with some form of relevant 'life' experience:

   (FG1: 45), (FG2: 105, 110), (FG3: 104, 105), (FG4: 133, 136)

3. Taking into account Point 1, confidentiality and codes of conduct also requires important organisational consideration and provision of psychological safety:

   (FG1: 45), (FG4: 130, 132, 134, 135, 136, 137)

4. TRiM allows for trauma informing education to be delivered and shared, resulting in greater understanding and less stigma attached to the subject across the community through normalisation and appropriate guidance / support:

   (FG1: 45), (FG2: 105, 106,108, 109), (FG3: 101, 102, 103, 107), (FG4: 128, 129, 131, 133, 136)

5. Care needs to be taken to ensure TRiM isn't misused; not bing considered as the silver bullet to fixing all personnel issues but it can be used in conjunction with other interventions

   (FG2: 107, 108, 110), (FG4: 127, 135, 136)

**Appendix 3.4.4** FG 1 - 4 Transcription High Order Themes (HOTs)

## Focus Groups (1, 2, 3 & 4): High Order Themes

Participants: Thematic analysis was conducted across all four Focus Groups to identify How Order Themes.

Questions asked during each Focus Group.

Q1. What would you say are the biggest strengths or benefits of the TRiM programme? Discuss
Q2. What would you say are the biggest drawbacks or weaknesses of the TRiM programme? Discuss
Q3. Would you say that TRiM is an accepted methodology within your organisation and if so or not, why is that so? Discuss
Q4. Can you say how the implementation of TRiM has led to a positive or negative cultural change within your organisation? Discuss
Q5. In your opinion, how would you describe your experience of delivering TRiM in terms of whether you perceive it as a proactive or reactive tool or methodology? Discuss
Q6. Do you think that regular TRiM / trauma awareness sessions would benefit your colleagues / organisation and if so, how and why? Discuss
Q7. Given technical and online advances, how do you feel a blended approach to delivering TRiM could be used more effectively in providing effective support to your colleagues and organisation, i.e., part online self-directed learning and part face to face? Discuss
Q8. What advice would you give to other organisations that were thinking of implementing a TRiM programme to others that work in psychologically or physically challenging, potentially traumatic environments?
Q9. How else do you think the TRiM programme could be improved?
Q10. Is there anything else that you would like to add that you think is important and may aide this focus group and further research?

How Order Themes identified across all four FGs.

Q1. What would you say are the biggest strengths or benefits of the TRiM programme? Discuss

| Low Order Themes | High Order Themes |
|---|---|
| 12. The implementation / use of TRiM makes staff feel valued, invested in, cared for and supported.<br><br>(FG1:1,2), (FG2: 1, 7), (FG3: 3, 6, 7, 9, 10, 11), (FG4: 1, 2, 3, 9, 10, 12)<br><br>13. Increased trauma awareness, both individual and organisational, through provision of effective trauma informing (overwhelming stress) education, knowledge and skills in order to identify signs and symptoms of potential trauma.<br><br>(FG1: 3, 4), (FG2: 5), (FG3: 8, 12), (FG4: 11)<br><br>14. Normalises effects of potential / actual trauma.<br><br>(FG1: 5, 6), (FG2: 2, 5), (FG3: 1, 5, 8, 11)<br><br>15. Offers and encourages peer / non-clinical support to staff and colleagues:<br><br>(FG1: 3, 5, 6, 7, 9), (FG2: 2, 3, 4, 5, 6, 7), (FG3: 3, 5, 6, 7, 10, 11, 12), (FG4: 3, 4, 6, 7, 8, 9, 10, 11, 12)<br><br>16. Reduces Stigma:<br><br>(FG1: 5, 6), (FG2: 4, 6, 7), (FG3: 1, 2, 3, 11, 12), (FG4: 10, 11)<br><br>17. Inclusive and impartial:<br><br>(FG1: 1, 2, 4, 5, 6, 7), (FG2: 1, 2, 4, 7), (FG3: 2, 3, 7, 8, 9, 10, 11, 12), (FG4: 1, 2, 3, 4, 6, 7, 8, 9, 11, 12)<br><br>18. Provides a well-structured and straight forward approach for individuals and organisations that work in challenging (potentially traumatic) environments: | 1. The use of TRiM within an organisation can lead staff to feeling supported (by peers, leadership etc) whilst working within challenging environments:<br><br>(LOT 1, LOT 2, LOT 4, LOT 5, LOT 6, LOT 7, LOT 10, LOT 11)<br><br>2. The TRiM programme provides trauma and resilience informing education to raise individual and organisational awareness and understanding, in terms of the effects of potential 'trauma' and knowing how to best look after themselves and support their colleagues, whilst working in challenging environments:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9, LOT 10, LOT 11)<br><br>3. TRiM provides a credible, structured and pragmatic support programme for individuals and organisations that operate in physically and psychologically challenging environments that can also be used in conjunction with other interventions such as Mental Health First Aide:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9, LOT 10, LOT 11)<br><br>4. With care, TRiM can be used flexibly to suit individual / organisational requirements as long as it remains safe and sits within the parameters of doing no-harm:<br><br>(LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 9, LOT 10, LOT 11) |

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| (FG1: 4, 5, 6, 7, 8, 9, 10), (FG2: 2, 3, 4, 5, 6, 7), (FG3: 2, 3, 4, 5, 7, 8, 9, 10, 11, 12), (FG4: 4, 5, 7, 8, 9, 10, 11, 12)<br><br>19. It has credibility and proven efficacy:<br><br>(FG1: 10), (FG2: 2, 3, 6), (FG3: 4), (FG4: 5)<br><br>20. The TRiM Model allows for considered adaptation to afford effective integration within organisations:<br><br>(FG1: 3, 4, 5, 6, 7, 8, 9, 10), (FG2: 1, 2, 4, 7), (FG3: 2, 3, 7), (FG4: 5, 7, 8)<br><br>21. Fosters effective leadership and teamship:<br><br>(FG1: 1, 2, 4, 5, 6), (FG2: 1, 2, 5, 6, 7), (FG3: 1, 2, 3, 6, 7, 8, 10, 11, 12), (FG4: 2, 3, 7, 8, 9, 11, 12)<br><br>22. Can be used in conjunction with other interventions such as Mental Health First Aide:<br><br>(FG1: 9, 10), (FG2: 4, 5, 6, 7), (FG3: 1, 2), (FG4: 4, 5, 7, 9, 10, 12) | |

## Q2. What would you say are the biggest drawbacks or weaknesses of the TRiM programme? Discuss

| Low Order Themes | High Order Themes |
|---|---|
| 10. Trained TRiM Practitioners not adhering to TRiM protocol (ie. offering counselling for example):<br><br>(FG1: 11)<br><br>11. The requirement for trained practitioners to maintain their TRiM skills through regular use and / or regular and thorough refresher training: | 1. As part of an effective TRiM programme, TRiM practitioners need to be managed effectively both in terms of what and how they deliver (professional conduct and standards, etc.) as well as looking after their general health and wellbeing (regular supervision / check ins etc):<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 9) |

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| (FG1: 12), (FG4: 15)<br><br>12. Time pressures (individually and organisationally) associated with TRiM:<br><br>(FG1: 14), (FG2: 9, 13), (FG3: 17), (FG4: 15, 16, 18, 22)<br><br>13. Poor or inconsistent communication impairs the effective role out / employment of TRiM:<br><br>(FG1: 10, 11, 13), (FG2: 8, 10, 12, 13, 14), (FG3: 13, 16, 17, 18, 21, 22, 23), (FG4: 13, 16, 18)<br><br>14. Nomenclature / education around using the word 'Trauma' and managing perception:<br><br>(FG2: 13), (FG3: 13, 14, 16, 17, 18, 19, 20, 21, 23), (FG4: 13)<br><br>15. Organisational / leadership / management 'Buy-in':<br><br>(FG2: 11, 13), (FG3: 14, 15, 16, 17, 18, 21, 22), (FG4: 13, 14, 17, 18)<br><br>16. Lack of understanding requiring general / focused education on key elements of TRiM:<br><br>(FG1: 11, 12), (FG2: 10, 13), (FG3: 13, 14, 16, 18, 19, 20, 21, 23), (FG4: 16, 17, 18)<br><br>17. The TRiM Model is not fit for purpose in certain organisations (it's perceived as the wrong model):<br><br>(FG4: 13, 19, 20, 21, 22)<br><br>18. TRiM can be perceived as a 'box ticking' exercise (implementing a mental health initiative because | 2. Time constraints: The TRiM programme takes time to set up, manage and run effectively, which can impact heavily on staff, especially if their TRiM role is voluntary and on top of their day job:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 9)<br><br>3. In order for a TRiM programme to be accepted and effective, implementation and daily running requires organisational 'buy in' by leadership / management and workforce alike. If TRiM is considered as a 'box ticking exercise', it is unlikely to work effectively, if at all:<br><br>(LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9)<br><br>4. Lack of organisational and individual trauma and resilience awareness and understanding:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 9)<br><br>5. TRiM has reduced credibility with some organisations:<br><br>(LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9) |

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| 'they' should be seen to be doing something) and thus the approach is not taken seriously by organisations and / or individuals:<br><br>(FG1: 13), (FG2: 11, 12, 13, 14, 15), (FG3: 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23), (FG4: 13, 14, 16, 17, 18, 19, 21, 22) | |

## Q3. Would you say that TRiM is an accepted methodology within your organisation and if so or not, why is that so? Discuss

| Low Order Themes | High Order Themes |
|---|---|
| 10. Yes, because the organisation bought into it:<br><br>(FG1: 15, 16, 17), (FG2: 21, 22, 25, 26), (FG3: 24, 25, 26, 28, 29, 30, 31, 32, 33, 35, 36), (FG4: 23, 27, 28, 29, 30, 31, 33, 34, 35)<br><br>11. Yes, because of TRiM's credibility and proven efficacy:<br><br>(FG4: 24, 29, 30, 32, 35)<br><br>12. Yes, because of the structure it provides:<br><br>(FG1: 17), (FG3: 44, 45, 46), (FG4: 25, 27, 31, 32, 35)<br><br>13. Yes, because it gets people talking:<br><br>(FG2: 21), (FG3: 25, 26, 29, 31, 32, 33, 35), (FG4: 29, 31)<br><br>14. Yes, but the effect of TRiM has been possibly diluted by the use of other interventions:<br><br>(FG2: 16, 18, 19, 20, 23), (FG3: 37) | 1. Yes, <u>because</u> an organisation has taken time and effort to carefully embed the TRiM programme providing effective support to it's workforce:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT7, LOT 8)<br><br>2. Yes, <u>because</u> TRiM has proven efficacy:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 6, LOT 7, LOT 8)<br><br>3. Yes, <u>but</u> it's potential is hindered by easier / cheaper methodologies such as mental heath first aide training etc:<br><br>(LOT 4, LOT 5, LOT 6)<br><br>4. Yes, <u>but</u> it sometimes takes a major event to jolt an organisation into acting (*often influencing a workforce into associating TRiM with negative connotations ie. something's gone wrong):<br><br>(LOT 6, LOT 7, LOT 8)<br><br>5. No, not at the moment: |

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| 15. Yes, but sadly in some organisations you need a major event to jolt an organisation into action (to react rather being proactive):<br><br>(FG2: 24)<br><br>16. Yes, it's useful as a filter to signposting colleagues to other, more appropriate support:<br><br>(FG2: 17, 18, 19, 20, 21, 24)<br><br>17. Yes, because it's encouraged conversations around the subjects of psychological issues / injuries between members of staff (colleagues, peers, leaders etc.<br><br>(FG1: 15), (FG2: 20, 21, 23, 24, 25, 26), (FG3: 2526, 29, 30, 31, 32, 33, 35, 36), (FG4: 29, 30, 31, 32, 35, 38)<br><br>18. No, not at the moment:<br><br>(FG2: 27, 28), (FG3: 37) | (LOT 9) |

## Q4. Can you say how the implementation of TRiM has led to a positive or negative cultural change within your organisation? Discuss

| Low Order Themes | High Order Themes |
|---|---|
| 7. Positive: Gave staff and organisations confidence that it's 'ok not be ok' ('normalising') and to ask for support:<br><br>(FG1: 18, 19, 21, 22), (FG2: 29, 30, 31, 32, 34, 36), (FG3: 43, 47, 48, 50, 52, 54), (FG4: 39, 41, 42, 44, 45, 46, 47)<br><br>8. Positive: Staff feel invested in and supported: | 1. In organisations that operate in challenging environments, TRiM can proactively reassure workforces by 'normalising' potential reactions to potentially traumatic experiences through ongoing education whilst providing ongoing supporting where necessary:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6) |

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|---|---|
| (FG1: 18), (FG2: 29, 30, 31, 32, 34), (FG3: 39, 40, 41, 42, 43, 47, 49, 50), (FG4: 39, 44, 45, 46, 47)<br><br>9. Positive: The implementation of TRiM raised general trauma / resilience awareness:<br><br>(FG1: 18, 19), (FG2: 29, 30, 31, 32, 34, 36), (FG3: 41, 43, 47, 50, 51), (FG4: 39, 46, 47)<br><br>10. Positive: Effective implementation and running of a TRiM programme requires ongoing support from others, importantly including senior management and other key departments such as HR:<br><br>(FG1: 20), (FG2: 29, 31, 32, 33, 34, 36), (FG3: 45, 47, 50, 51, 52, 53)<br><br>11. Positive: Implementation of the TRiM programme can take time but once it becomes accepted, the positive effects are clear to see:<br><br>(FG1: 18, 19, 20, 21, 22), (FG2: 31, 32, 36), (FG3: 43, 48, 49, 50, 52, 53, 54), (FG4: 39, 40, 45)<br><br>12. Positive: TRiM is most effective when it's used proactively, and becomes part of daily routine (education, debriefing etc.) rather than used when something goes wrong:<br><br>(FG1: 18, 19, 21, 22), (FG2: 29, 30, 31, 32, 34, 35, 36), (FG3: 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54), (FG4: 39, 44, 45, 46, 47, 62)<br><br>13. Negative (possibly): The need to have the right person / department running the TRiM implementation / programme (ie. with credibility and who is trustworthy):<br><br>(FG3: 58) | 2. Positive: TRiM can create a positive cultural change if time is taken to firstly carefully consider all that's needed to ensure successful implementation and secondly to maintain all the necessary parts to make it work efficiently and confidently (TRiM lead / manger / team, IT database, regularly refresher training, etc):<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7)<br><br>3. Positive: TRiM needs to be seen and used as a proactive tool, not just as a reactive one and requires involvement of all relevant parties such as senior leadership, HR and Occupational Health etc):<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6)<br><br>4. The TRiM lead / team need to be carefully appointed:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7) |

## Q5. In your opinion, how would you describe your experience of delivering TRiM in terms of whether you perceive it as a proactive or reactive tool or methodology? Discuss

| Low Order Themes | High Order Themes |
|---|---|
| 4. Proactive:<br><br>(FG1: 23), (FG2: 37, 38), (FG3: 55, 56, 57, 58, 60, 61, 62), (FG4: 50, 51, 53, 54, 55, 56, 58, 59)<br><br>5. Proactive and reactive:<br><br>(FG1: 24), (FG2: 39, 40, 41, 43, 49, 54), (FG3: 56, 57, 59, 61), (FG4: 48,<br><br>6. Reactive (perceived box ticking!):<br><br>(FG3: 61)<br><br>*Need for departments such as OH or HR to run and support … not to get rid of them because 'we now have TRiM'! (FG2: 45, 46, 47), (FG3: 56) | 1. The majority of people that participated in the Focus Groups considered their successful experience of TRiM down to a proactive approach adopted by the organisations they represented. This was closely followed by a mixture of proactive and reactive approachs, which again led to a positive experience. A purely reactive response was considered by those in FG3 as representative of a 'box ticking' culture:<br><br>(LOT 1, LOT 2, LOT 3) |

## Q6. Do you think that regular TRiM / trauma awareness sessions would benefit your colleagues / organisation and if so, how and why? Discuss

| Low Order Themes | High Order Themes |
|---|---|
| 6. Yes: to create a normalising cultural effect with a well-considered approach (not taking up too much time etc.):<br><br>(FG1: 25, 26), (FG2: 54, 55, 56, 57, 58, 59), (FG3: 63, 64, 65, 66), (FG4: 60, 61, 62, 65, 67, 68, 69 | 1. The contents of the TRiM programme can be used to encourage good practice within organisations that work in challenging environments to improve general awareness and understanding around psychological health and wellbeing (including trauma and resilience awareness): |

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| 7. Yes: as part of wellbeing programmes, such as during probationary periods of someone's career, Continuous Professional Development (CPD) or annually:<br><br>(FG1: 25, (FG2: 59, 62, 63), (FG4: 70, 71)<br><br>8. Yes: to include all staff, in particular senior leaders / managers:<br><br>(FG1: 26), (FG4: 60)<br><br>9. Yes: but be mindful not to be too overbearing with TRiM:<br><br>(FG1: 25), (FG2: 50, 51, 53), (FG4: 63, 64, 66 (not tick box),<br><br>10. Yes: to include significant others (families / partners etc.):<br><br>(FG2: 61, 62, 63, 64)<br><br>*Not using TRiM but just demonstrating good practice: (FG2: 63, 64) | (LOT 1, LOT 2, LOT3, LOT 4, LOT 5)<br><br>2. TRiM awareness sessions / training / practice can be conducted generally as well as at key times in someone's career, encompassing initial training, probationary periods or as part of continuous professional development (CPD) for example:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5)<br><br>3. Trauma / resilience informing awareness should be inclusive and participation should be encouraged across organisational workforces (including elements of leadership) and where suitable dependents or families:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5)<br><br>4. As with all elements of TRiM, careful consideration should be given to methodologies involved with the employment of TRiM awareness to ensure that the subject doesn't become overbearing or loses impact within organisations:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5) |

## Q7. Given technical and online advances, how do you feel a blended approach to delivering TRiM could be used more effectively in providing effective support to your colleagues and organisation, i.e., part online self-directed learning and part face to face? Discuss

| Low Order Themes | High Order Themes |
|---|---|
| 7. A blended approach can help relieve individual / organisational time pressures: | 1. A blended delivery approach to TRiM training allows greater flexibility in an organisations ability to deliver effective |

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| (FG1: 27, 30, 32), (FG2: 77, 78), (FG3: 67), (FG4: 74, 76, 77, 79, 83, 84)<br><br>8. A blended approach allows flexibility in training TRiM practitioners / managers as well as allowing trained personnel to 'dip in and out' at a time of their choosing to maintain currency:<br><br>(FG1: 27, 28, 29, 30), (FG2: 66, 70, 78), (FG3: 67), (FG4: 72, 73, 74, 76, 77, 78, 80, 81, 82, 83, 84, 85, 86, 87)<br><br>9. A blended approach to using TRiM allows a wider, more flexible provision of support to individuals and organisations:<br><br>(FG1: 32, 33), (FG2: 75, 77, 78), (FG3: 76), (FG4: 72, 73, 76, 77, 78, 79, 80, 81, 83, 84, 85)<br><br>10. A blended approach may hinder the purpose and / or ability to hold face to face meaningful conversations:<br><br>(FG1: 31), (FG2: 65, 67, 68, 69, 70, 71, 72, 73, 74, 76), (FG3: 69, 70, 71, 72, 74, 75, 76, 77)<br><br>11. TRiM sessions using virtual / online resources, as part of the blended approach, do not work / work less well:<br><br>(FG3: 70, 71, 72, 74, 75, 77), (FG4: 74 (you do not necessarily have the ability to hold people to account, you relinquish responsibility to the individual with risk of them not completing the TRiM training)<br><br>12. A blended approach may work, but face to face training / interventions / conversations with purpose are the <u>preferred</u> options (not ruling out virtual sessions in extremis): | potential trauma and resilience support to staff:<br><br>(LOT 1, LOT 2, LOT 3, LOT 6)<br><br>2. Careful consideration needs to be given to conducting TRiM assessments (individual or group) using virtual / online means:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6)<br><br>3. Face to face training and delivery (ie. assessments) are the preferred method delivering TRiM effectively.<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6) |

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| (FG1: 30, 31, 32, 33), (FG2: 65, 66, 67, 68, 69, 70, 72, 73, 74, 75, 76, 77, 78), (FG3: 68, 73, 77), (FG4: 86, 87) | |

## Q8. What advice would you give to other organisations that were thinking of implementing a TRiM programme to others that work in psychologically or physically challenging, potentially traumatic environments?

| Low Order Themes | High Order Themes |
|---|---|
| 11. Find the right person / people / department to lead the TRiM coordination within the organisation that can find sufficient time, can influence at all levels and has the credibility and skills to build a positive trauma informing culture:<br><br>(FG1: 35, 36), (FG2: 81, 84, 85, 86, 88, 89, 91, 94, 95), (FG3: 81, 87, 88), (FG4: 88, 91, 92, 93, 94, 96, 97, 98, 99, 100, 101, 102, 103, 107, 108, 109)<br><br>12. Put considerable thought into recruiting the right people to be TRiM practitioners in terms of time available, experience, position, role, motivations, etc. and brief them thoroughly beforehand on the realities of being a TRiM practitioner.<br><br>(FG1: 35), (FG2: 85, 86), (FG3: 78, 79, 80, 81, 82, 84, 86, 87, 88), (FG4: 89, 90, 91, 92, 93, 94, 99, 107, 108)<br><br>13. Where possible try to create a TRiM team to lead and coordinate the TRiM implementation rather than relying on a single person as the sole lead:<br><br>(FG1: 36), (FG2: 89), (FG3: 84), (FG4: 89, 96, 97, 98, 104, 105, 107, 109) | 1. Take time to plan and prepare for the implementation of TRiM; get the right structures in place, including the right people:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9)<br><br>2. Do not rush the process and train too many people / practitioners at the start as TRiM needs to be managed effectively in order to work and be accepted by all:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 8, LOT 9)<br><br>3. Ensure you have organisational buy in, especially from senior leadership / management / HR etc (which may include necessary budgeting):<br><br>(LOT 1, LOT 3, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9)<br><br>4. Connect and communicate with other organisations that successfully use TRiM, in order to share experiences and offer support. |

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| 14. Don't train too many TRiM practitioners too early (and beware of the ones that are only looking to enhance their CV):<br><br>(FG1: 37), (FG2: 82), (FG3: 79, 80, 81, 82, 83, 84, 86, 87, 88), (FG4: 89, 90, 91, 92, 107, 109)<br><br>15. Ensure you research and get the right service provider for you that can provide ongoing support during the TRiM setup / implementation phase:<br><br>(FG4: 95, 96, 104)<br><br>16. Ensure your organisation creates a robust and reliable TRiM structure from the outset to look after all interests including welfare of TRiM practitioners, TRiM management systems / IT programmes and databases etc:<br><br>(FG1: 38), (FG2: 81, 82, 83, 84, 87, 88, 89, 92, 93, 94), (FG3: 84, 85, 86, 88), (FG4: 90, 92, 96, 97, 98, 99, 101, 102, 105, 106, 109)<br><br>17. Ensure you have organisational buy in, including senior (very importantly) leadership / management and include them in the process wherever possible / suitable:<br><br>(FG1: 36), (FG2: 79, 81, 82, 83, 84, 88, 91, 92, 93, 94, 95), (FG3: 84, 85, 88), (FG4: 88, 92, 93, 94, 95, 98, 99, 100, 101, 102, 103, 105, 107, 109)<br><br>18. Identify other similar organisations that have implemented TRiM and where suitable, ask to learn from them (many Trusts in the NHS and police forces have done this successfully):<br><br>(FG1: 34), (FG2: 89, 90, 91, 92), (FG3: 84)<br><br>19. It takes time, effort and dedication to implement the TRiM process fully and effectively into an organisation: | (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9) |

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| (FG2: 82, 92, 95), (FG3: 79, 81, 83, 84, 85, 86, 87, 88), (FG4: 92, 96, 98, 99, 100, 101, 102, 104, 109)<br><br>20. Successful implementation of TRiM often requires long term investment in methods of support, often involving cultural change around education, dialogue and practices:<br><br>(FG1: 34, 35, 36, 38), (FG2: 79, 80, 81, 82, 84, 88, 92, 93, 95), (FG3: 81, 84, 85, 86, 87, 88), (FG4: 88, 92, 93, 94, 98, 99, 100, 101, 102, 103, 105, 107, 109) | |

## Q9. How else do you think the TRiM programme could be improved?

| Low Order Themes | High Order Themes |
|---|---|
| 1. TRiM training needs to be sector specific so that language used, for instance, is constant:<br><br>(FG1: 39, 42, 44), (FG4: 122)<br><br>2. TRiM should be regularly shared cross-sector, at training or annual events, for instance (sharing good practice):<br><br>(FG1: 41, 44), (FG2: 96), (FG4: 129)<br><br>3. Ideally the TRiM programme should fit around an organisation's needs rather than an organisation bending itself out of shape to fit around the TRiM process:<br><br>(FG1: 39, 40, 42, 43), (FG2: 97, 98, 100, 101, 102, 104), (FG3: 89, 91, 92, 93, 96), (FG4: 110, 111, 112, 114, 115, 116, 117, 118, 119, 120, 121, 124, 125, 126) | 1. To be effective within an organisation, TRiM ideally needs to be delivered in a tailored way, mindful of keeping the TRiM fundamentals (ie. 3 pillars: education – assessment – support and safety – 'do no harm'.), but in a way that improves or optimises operational output (through promoting health and wellbeing etc) whilst accommodating organisational / cultural philosophy, values and beliefs:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 7)<br><br>2. Many see TRiM's strength in that it provides structure (3 pillars: which should only be modified or deviated from with careful consideration and advice from a recognised TRiM provider:<br><br>(LOT 1, LOT 2, 3, LOT 4, LOT 5, LOT 6) |

4. There are cultural issues both within certain organisations and also internationally that often need addressing in order to find acceptance of both the philosophy and fundamental employment of TRiM:

   (FG1: 40, 41, 42, 43, 44), (FG2: 96, 97, 98, 99, 100, 101, 102, 103, 104), (FG3: 92, 93, 95, 96, 97), (FG4: 110, 111, 112, 113, 114, 115, 116, 118, 119, 120, 121, 122, 124, 126)

5. The way TRiM is delivered needs to be carefully considered. Some suggest TRiM model needs to be flexible in terms of delivery methods and usage and conversely, some suggest that the strength of TRiM is it provides structure, which is needed, and when not followed can lead to complications:

   (FG1: 41, 42, 43, 44), (FG2: 96, 97, 98, 99, 100, 102, 103, 104), (FG3: 89, 95, 97, 99, 100), (FG4: 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126)

6. TRiM could be rebranded in order to reduce the potential stigma often associated with trauma:

   (FG2: 96, 98, 100, 101, 102, 103), (FG4: 110, 111, 114, 116, 118, 119, 120, 121)

7. The TRiM programme philosophy / programme could be used to distribute trauma focused education to the wider community, following incidents for example:

   (FG1: 40, 43), (FG2: 96, 98, 99, 100, 101, 102, 103), (FG4: 110, 111, 114, 115, 116, 117, 118, 119, 120, 121, 122)

8. TRiM practitioners shouldn't be allowed to practice as TRiM Practitioners unti they've been peer assessed by their TRiM Lead:

3. The composite parts (3 pillars) of TRiM could be used in a broader context to reach, educate and upskill wider audiences (such as a council supporting the general public / community following a large building fire (Grenfell Towers scenario?)):

   (LOT 2, LOT 3, LOT 4, LOT 5, LOT 6)

4. Time needs to be taken over the careful management of all aspects of delivering the TRiM programme safely, both in terms of those aiming to support and those being supported:

(LOT 1, LOT 2, LOT 3, LOT 4, LOT 6, LOT 7)

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| (FG1: 39), (FG3: 90), (FG4: 124, 126) | |

## Q10. Is there anything else that you would like to add that you think is important and may aide this focus group and further research?

| Low Order Themes | High Order Themes |
|---|---|
| 1. Use TRiM 'experiences' as a useful way to influence others (leadership, managers, staff and wider community:<br><br>(FG1: 45), (FG2: 105, 108, 109, 110), (FG3: 101, 102, 103, 106, 107), (FG4: 127, 128, 129)<br><br>2. Volunteers or people chosen to have a TRiM role, should ideally come with some form of relevant 'life' experience:<br><br>(FG1: 45), (FG2: 105, 110), (FG3: 104, 105), (FG4: 133, 136)<br><br>3. Taking into account Point 1, confidentiality and codes of conduct also requires important organisational consideration and provision of psychological safety:<br><br>(FG1: 45), (FG4: 130, 132, 134, 135, 136, 137)<br><br>4. TRiM allows for trauma informing education to be delivered and shared, resulting in greater understanding and less stigma attached to the subject across the community through 'normalisation' and appropriate guidance / support:<br><br>(FG1: 45), (FG2: 105, 106,108, 109), (FG3: 101, 102, 103, 107), (FG4: 128, 129, 131, 133, 136) | 5. TRiM allows for effective trauma informing education to be delivered and shared, resulting in greater understanding and less stigma attached to the subject across the community through 'normalisation' and appropriate guidance / support:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5)<br><br>6. TRiM is not always the answer to all individual / organisational problems and must be used with care and attention (both in terms of those delivering and receiving psychological support) in terms of delivery and / or with other support interventions (such as coaching, mentoring or psychotherapy etc):<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5) |

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|---|---|
| 5. Care needs to be taken to ensure TRiM isn't misused; not being considered as the silver bullet to fixing all personnel issues but it can be used in conjunction with other interventions<br><br>(FG2: 107, 108, 110), (FG4: 127, 135, 136) | |

## High Order Themes summary

### Q1. What would you say are the biggest strengths or benefits of the TRiM programme? Discuss

1. The use of TRiM within an organisation can lead staff to feeling supported (by peers, leadership etc) whilst working within challenging environments:

   (LOT 1, LOT 2, LOT 4, LOT 5, LOT 6, LOT 7, LOT 10, LOT 11)

2. The TRiM programme provides trauma and resilience informing education to raise individual and organisational awareness and understanding, in terms of the effects of potential 'trauma' and knowing how to best look after themselves and support their colleagues, whilst working in challenging environments:

   (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9, LOT 10, LOT 11)

3. TRiM provides a credible, structured and pragmatic support programme for individuals and organisations that operate in physically and psychologically challenging environments that can also be used in conjunction with other interventions such as Mental Health First Aide:

   (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9, LOT 10, LOT 11)

4. With care, TRiM can be used flexibly to suit individual / organisational requirements as long as it remains safe and sits within the parameters of doing no-harm:

   (LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 9, LOT 10, LOT 11)

## Q2. What would you say are the biggest drawbacks or weaknesses of the TRiM programme? Discuss

5. As part of an effective TRiM programme, TRiM practitioners need to be managed effectively both in terms of what and how they deliver (professional conduct and standards, etc.) as well as looking after their general health and wellbeing (regular supervision / check ins etc):

   (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 9)

6. Time constraints: The TRiM programme takes time to set up, manage and run effectively, which can impact heavily on staff, especially if their TRiM role is voluntary and on top of their day job:

   (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 9)

7. In order for a TRiM programme to be accepted and effective, implementation and daily running requires organisational 'buy in' by leadership / management and workforce alike. If TRiM is considered as a 'box ticking exercise', it is unlikely to work effectively, if at all:

   (LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9)

8. There is a general lack of organisational and individual trauma and resilience awareness and understanding:

   (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 9)

9. TRiM has reduced credibility with some staff and organisations that may see it as unnecessary or simply as a 'box ticking 'exercise:

   (LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9)

## Q3. Would you say that TRiM is an accepted methodology within your organisation and if so or not, why is that so? Discuss

10. Yes, TRiM is accepted <u>because</u> an organisation has taken time and effort to carefully embed the TRiM programme providing effective support to it's workforce:

    (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT7, LOT 8)

11. Yes, because TRiM has proven efficacy:

    (LOT 1, LOT 2, LOT 3, LOT 4, LOT 6, LOT 7, LOT 8)

12. Yes, but it's potential is hindered by easier / cheaper methodologies such as mental heath first aide training etc:

    (LOT 4, LOT 5, LOT 6)

13. Yes, but it sometimes takes a major event to jolt an organisation into acting (*often influencing a workforce into associating TRiM with negative connotations ie. something's gone wrong):

    (LOT 6, LOT 7, LOT 8)

14. No, TRiM is not an accepted methodology at the moment:

    (LOT 9)

## Q4. Can you say how the implementation of TRiM has led to a positive or negative cultural change within your organisation? Discuss

15. In organisations that operate in challenging environments, TRiM can proactively reassure workforces by 'normalising' potential reactions to potentially traumatic experiences through ongoing education whilst providing ongoing supporting where necessary:

    (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6)

16. Positive: TRiM can create a positive cultural change if time is taken to firstly consider carefully all that's needed to ensure successful implementation and secondly to maintain all the necessary parts to make it work efficiently and confidently (TRiM lead / manger / team, IT database, regularly refresher training, etc):

    (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7)

17. Positive: TRiM needs to be seen and used as a proactive tool, not just as a reactive one and requires involvement of all relevant parties such as senior leadership, HR and Occupational Health etc):

    (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6)

18. The TRiM lead / team need to be carefully appointed:

    (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7)

Q5. In your opinion, how would you describe your experience of delivering TRiM in terms of whether you perceive it as a proactive or reactive tool or methodology? Discuss

19. The majority of people that participated in the Focus Groups considered their successful experience of TRiM down to a proactive approach adopted by the organisations they represented. This was closely followed by a mixture of proactive and reactive approachs, which again led to a positive experience. A purely reactive response was considered by those in FG3 as representative of a 'box ticking' culture:

    (LOT 1, LOT 2, LOT 3)

Q6. Do you think that regular TRiM / trauma awareness sessions would benefit your colleagues / organisation and if so, how and why? Discuss

20. The contents of the TRiM programme can be used to encourage good practice within organisations that work in challenging environments to improve general awareness and understanding around psychological health and wellbeing (including trauma and resilience awareness):

    (LOT 1, LOT 2, LOT3, LOT 4, LOT 5)

21. TRiM awareness sessions / training / practice can be conducted generally as well as at key times in someone's career, encompassing initial training, probationary periods or as part of continuous professional development (CPD) for example:

    (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5)

22. Trauma / resilience informing awareness should be inclusive and participation should be encouraged across organisational workforces (including elements of leadership) and where suitable dependents or families:

    (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5)

23. As with all elements of TRiM, careful consideration should be given to methodologies involved with the employment of TRiM awareness to ensure that the subject doesn't become overbearing or loses impact within organisations:

    (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5)

Q7. Given technical and online advances, how do you feel a blended approach to delivering TRiM could be used more effectively in providing effective support to your colleagues and organisation, i.e., part online self-directed learning and part face to face? Discuss

24. A blended delivery approach to TRiM training allows greater flexibility in an organisations ability to deliver effective potential trauma and resilience support to staff:

    (LOT 1, LOT 2, LOT 3, LOT 6)

25. Careful consideration needs to be given to conducting TRiM assessments (individual or group) using virtual / online means:

    (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6)

26. Face to face training and delivery (ie. assessments) are the preferred method delivering TRiM effectively.

    (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6)

Q8. What advice would you give to other organisations that were thinking of implementing a TRiM programme to others that work in psychologically or physically challenging, potentially traumatic environments?

27. Take time to plan and prepare for the implementation of TRiM; get the right structures in place, including the right people:

    (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9)

28. Do not rush the process and train too many people / practitioners at the start as TRiM needs to be managed effectively in order to work and be accepted by all:

    (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 8, LOT 9)

29. Ensure you have organisational buy in, especially from senior leadership / management / HR etc (which may include necessary budgeting):

    (LOT 1, LOT 3, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9)

30. Connect and communicate with other organisations that successfully use TRiM, in order to share experiences and offer support.

    (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9)

## Q9. How else do you think the TRiM programme could be improved?

31. To be effective within an organisation, TRiM ideally needs to be delivered in a tailored way, mindful of keeping the TRiM fundamentals (ie. 3 pillars: education – assessment – support and safety – 'do no harm'.), but in a way that improves or optimises operational output (through promoting health and wellbeing etc) whilst accommodating organisational / cultural philosophy, values and beliefs:

    (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 7)

32. Many see TRiM's strength in that it provides structure (3 pillars: which should only be modified or deviated from with careful consideration and advice from a recognised TRiM provider:

    (LOT 1, LOT 2, 3, LOT 4, LOT 5, LOT 6)

33. The composite parts (3 pillars) of TRiM could be used in a broader context to reach, educate and upskill wider audiences (such as a council supporting the general public / community following a large building fire (Grenfell Towers scenario?)):

(LOT 2, LOT 3, LOT 4, LOT 5, LOT 6)

34. Time needs to be taken over the careful management of all aspects of delivering the TRiM programme safely, both in terms of those aiming to support and those being supported:

(LOT 1, LOT 2, LOT 3, LOT 4, LOT 6, LOT 7)

Q10. Is there anything else that you would like to add that you think is important and may aide this focus group and further research?

35. TRiM allows for effective trauma informing education to be delivered and shared, resulting in greater understanding and less stigma attached to the subject across the community through 'normalisation' and appropriate guidance / support:

(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5)

36. TRiM is not always the answer to all individual / organisational problems and must be used with care and attention (both in terms of those delivering and receiving psychological support) in terms of delivery and / or with other support interventions (such as coaching, mentoring or psychotherapy etc):

(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5)

**Appendix 3.5** General Dimension Check Analysis Results

## Focus Groups: General Dimensions

Thematic analysis was conducted across all four Focus Groups to identify Lower Order Themes then High Order Themes to come to General Dimensions.

Questions asked during each Focus Group.

31. What would you say are the biggest strengths or benefits of the TRiM programme? Discuss
32. What would you say are the biggest weaknesses or drawbacks of the TRiM programme? Discuss
33. Would you say that TRiM is an accepted methodology within your organisation and if so or not, why is that so? Discuss
34. Can you say how the implementation of TRiM has led to a positive or negative cultural change within your organisation? Discuss
35. In your opinion, how would you describe your experience of delivering TRiM in terms of whether you perceive it as a proactive or reactive tool or methodology? Discuss
36. Do you think that regular TRiM / trauma awareness sessions would benefit your colleagues / organisation and if so, how and why? Discuss
37. Given technical and online advances, how do you feel a blended approach to delivering TRiM could be used more effectively in providing effective support to your colleagues and organisation, i.e., part online self-directed learning and part face to face? Discuss
38. What advice would you give to other organisations that were thinking of implementing a TRiM programme to others that work in psychologically or physically challenging, potentially traumatic environments?
39. How else do you think the TRiM programme could be improved?
40. Is there anything else that you would like to add that you think is important and may aide this focus group and further research?

| High Order Themes | General Dimensions |
|---|---|
| 37. The use of TRiM within an organisation can lead staff to feeling supported (by peers, leadership etc) whilst working within challenging environments:<br><br>(LOT 1, LOT 2, LOT 4, LOT 5, LOT 6, LOT 7, LOT 10, LOT 11)<br><br>38. The TRiM programme provides trauma and resilience informing education to raise individual and organisational awareness and understanding, in terms of the effects of potential 'trauma' and knowing how to best look after themselves and support their colleagues, whilst working in challenging environments:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9, LOT 10, LOT 11)<br><br>39. TRiM provides a credible, structured and pragmatic support programme for individuals and organisations that operate in physically and psychologically challenging environments that can also be used in conjunction with other interventions such as Mental Health First Aide:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9, LOT 10, LOT 11)<br><br>40. With care, TRiM can be used flexibly to suit individual / organisational requirements as long as it remains safe and sits within the parameters of doing no-harm:<br><br>(LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 9, LOT 10, LOT 11)<br><br>41. As part of an effective TRiM programme, TRiM practitioners need to be managed effectively both in terms of what and how they deliver (professional conduct and standards, etc.) as well as looking after their general health and wellbeing (regular supervision / check ins etc):<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 9)<br><br>42. Time constraints: The TRiM programme takes time to set up, manage and run effectively, which can impact heavily on staff, especially if their TRiM role is voluntary and on top of their day job:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 9) | **1. Perceived <u>benefits</u> associated with TRiM:**<br><br>(HOT 1, 2, 3, 4, 11, 15, 16, 17, 19, 20, 21, 22, 24, 31, 33, 35)<br><br>- Staff feel supported<br>- Provides suitable psychological resilience / trauma informing education<br>- Provides both a proactive and reactive structured peer / clinical support programme that can be adapted to organisational / individual needs<br>- Has proven efficacy<br>- Can lead to a positive cultural change through raising inclusive (all staff structures, leadership etc) organisational awareness and provision of necessary skills / training<br>- Can be provided through blended delivery methods (face to face, online etc)<br>- Can be used to support staff, staff families and the wider community<br>- TRiM can reduce stigma attached to mental / emotional health issues and promote 'normalisation' of responses associated with increased / overwhelming stress<br><br>**2. Perceived <u>drawbacks</u> associated with TRiM:** |

43. In order for a TRiM programme to be accepted and effective, implementation and daily running requires organisational 'buy in' by leadership / management and workforce alike. If TRiM is considered as a 'box ticking exercise', it is unlikely to work effectively, if at all:

    (LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9)

44. There is a general lack of organisational and individual trauma and resilience awareness and understanding:

    (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 9)

45. TRiM has reduced credibility with some staff and organisations that may see it as unnecessary or simply as a 'box ticking' exercise:

    (LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9)

46. Yes, TRiM is accepted <u>because</u> an organisation has taken time and effort to carefully embed the TRiM programme providing effective support to its workforce:

    (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT7, LOT 8)

47. Yes, <u>because</u> TRiM has proven efficacy:

    (LOT 1, LOT 2, LOT 3, LOT 4, LOT 6, LOT 7, LOT 8)

48. Yes, <u>but</u> it's potential is hindered by easier / cheaper methodologies such as mental health first aide training etc:

    (LOT 4, LOT 5, LOT 6)

49. Yes, <u>but</u> it sometimes takes a major event to jolt an organisation into acting (*often influencing a workforce into associating TRiM with negative connotations ie. something's gone wrong):

    (LOT 6, LOT 7, LOT 8)

50. No, TRiM is not an accepted methodology at the moment:

    (LOT 9)

51. In organisations that operate in challenging environments, TRiM can proactively reassure workforces by 'normalising' potential reactions to potentially traumatic experiences through ongoing education whilst providing ongoing supporting where necessary:

- Takes organisational time to initially set up, takes time to bed-in, takes time to run effectively and takes individuals time to support colleagues appropriately
- Requires organisational 'buy-in' and the initial / ongoing support of leadership, management and staff to succeed
- TRiM can be perceived negatively by organisations where it has not succeeded

(HOT 6, 7, 8, 9, 14, 36)

**3. Potential considerations for implementing TRiM effectively:**

(HOT 5, 6, 7, 8, 9, 10, 12, 13, 15, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 36)

- Careful consideration should be given to selecting those responsible for delivering TRiM (Leads, Managers, practitioners), ie. 'the right people'
- Organisational TRiM programmes need to encompass the wellbeing of those being supported as well as those providing support
- The TRiM programme should aim to proactively raise general resilience / trauma awareness / normalisation as well as providing peer assessments and ongoing psychosocial support
- TRiM needs to be inclusive to be successful, involving all departments, staff, leadership

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| (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6)<br><br>52. Positive: TRiM can create a positive cultural change if time is taken to firstly consider carefully all that's needed to ensure successful implementation and secondly to maintain all the necessary parts to make it work efficiently and confidently (TRiM lead / manger / team, IT database, regularly refresher training, etc):<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7)<br><br>53. Positive: TRiM needs to be seen and used as a proactive tool, not just as a reactive one and requires involvement of all relevant parties such as senior leadership, HR and Occupational Health etc):<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6)<br><br>54. The TRiM lead / team need to be carefully appointed:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7)<br><br>55. The majority of people that participated in the Focus Groups considered their successful experience of TRiM down to a proactive approach adopted by the organisations they represented. This was closely followed by a mixture of proactive and reactive approaches, which again led to a positive experience. A purely reactive response was considered by those in FG3 as representative of a 'box ticking' culture:<br><br>(LOT 1, LOT 2, LOT 3)<br><br>56. The contents of the TRiM programme can be used to encourage good practice within organisations that work in challenging environments to improve general awareness and understanding around psychological health and wellbeing (including trauma and resilience awareness):<br><br>(LOT 1, LOT 2, LOT3, LOT 4, LOT 5)<br><br>57. TRiM awareness sessions / training / practice can be conducted generally as well as at key times in someone's career, encompassing initial training, probationary periods or as part of continuous professional development (CPD) for example:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5)<br><br>58. Trauma / resilience informing awareness should be inclusive and participation should be encouraged across organisational workforces (including elements of leadership) and where suitable dependents or families: | and management, regardless of whether individuals require support or not<br>- TRiM effectiveness can be increased through regular and timely integration ie. during training or through CPD<br>- TRiM can be delivered flexibly and in a way that suits organisation requirements<br>- TRiM assessments are best delivered face to face, but other elements of TRiM can be delivered effectively using IT (blended approach)<br>- TRiM can encourage organisational communication / co-cooperation with other TRiM users<br>- TRiM may be useful in serving a wider audience (the public, families etc)<br>- TRiM on it's own may not be able to answer all organisational questions or concerns but when used proactively, it can be used as part of a wider approach to providing education and support for those that operate in challenging, potentially traumatic environments. |

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| (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5)<br><br>59. As with all elements of TRiM, careful consideration should be given to methodologies involved with the employment of TRiM awareness to ensure that the subject doesn't become overbearing or loses impact within organisations:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5)<br><br>60. A blended delivery approach to TRiM training allows greater flexibility in an organisations ability to deliver effective potential trauma and resilience support to staff:<br><br>(LOT 1, LOT 2, LOT 3, LOT 6)<br><br>61. Careful consideration needs to be given to conducting TRiM assessments (individual or group) using virtual / online means:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6)<br><br>62. Face to face training and delivery (ie. assessments) are the preferred method delivering TRiM effectively.<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6)<br><br>63. Take time to plan and prepare for the implementation of TRiM; get the right structures in place, including the right people:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9)<br><br>64. Do not rush the process and train too many people / practitioners at the start as TRiM needs to be managed effectively in order to work and be accepted by all:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 8, LOT 9)<br><br>65. Ensure you have organisational buy in, especially from senior leadership / management / HR etc (which may include necessary budgeting):<br><br>(LOT 1, LOT 3, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9)<br><br>66. Connect and communicate with other organisations that successfully use TRiM, in order to share experiences and offer support. | |

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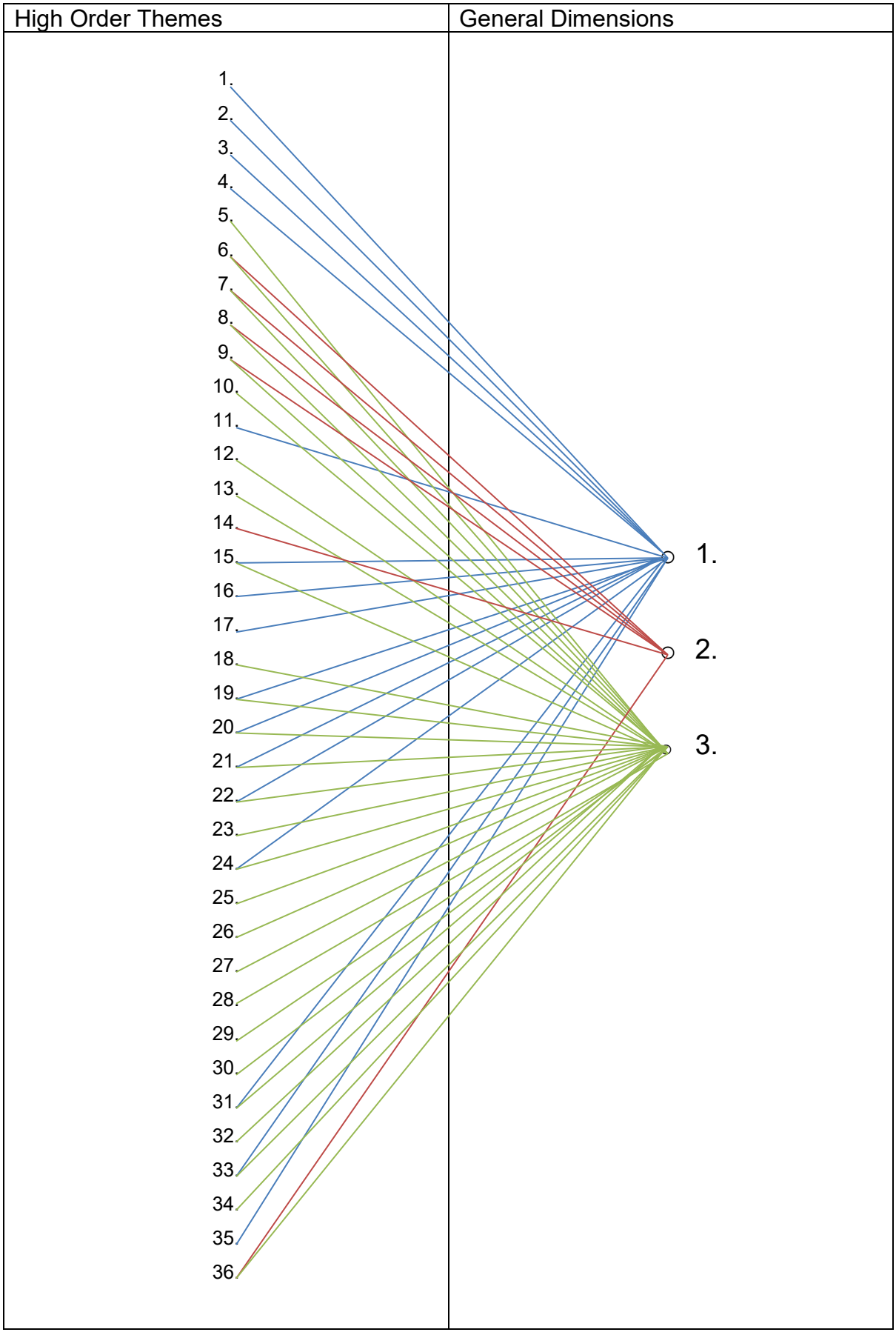
| (LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 6, LOT 7, LOT 8, LOT 9)<br><br>67. To be effective within an organisation, TRiM ideally needs to be delivered in a tailored way, mindful of keeping the TRiM fundamentals (ie. 3 pillars: education – assessment – support and safety – 'do no harm'.), but in a way that improves or optimises operational output (through promoting health and wellbeing etc) whilst accommodating organisational / cultural philosophy, values and beliefs:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5, LOT 7)<br><br>68. Many see TRiM's strength in that it provides structure (3 pillars: which should only be modified or deviated from with careful consideration and advice from a recognised TRiM provider:<br><br>(LOT 1, LOT 2, 3, LOT 4, LOT 5, LOT 6)<br><br>69. The composite parts (3 pillars) of TRiM could be used in a broader context to reach, educate and upskill wider audiences (such as a council supporting the general public / community following a large building fire (Grenfell Towers scenario?)):<br><br>(LOT 2, LOT 3, LOT 4, LOT 5, LOT 6)<br><br>70. Time needs to be taken over the careful management of all aspects of delivering the TRiM programme safely, both in terms of those aiming to support and those being supported:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 6, LOT 7)<br><br>71. TRiM allows for effective trauma informing education to be delivered and shared, resulting in greater understanding and less stigma attached to the subject across the community through 'normalisation' and appropriate guidance / support:<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5)<br><br>72. TRiM is not always the answer to all individual / organisational problems and must be used with care and attention (both in terms of those delivering and receiving psychological support) in terms of delivery and / or with other support interventions (such as coaching, mentoring or psychotherapy etc):<br><br>(LOT 1, LOT 2, LOT 3, LOT 4, LOT 5) | |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