Complex trauma in adult mental health services: Prevalence and the role of therapeutic support workers.

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Thesis Abstract

Background Childhood abuse and neglect are strongly associated with adverse mental health outcomes across the lifespan. Adults accessing specialist mental health services are likely to have elevated rates of childhood trauma exposure; however, variability in assessment practices and workforce preparation may limit services' ability to respond consistently in trauma-informed ways. This thesis portfolio aimed to examine the prevalence of interpersonal childhood trauma within adult mental health services and to explore the experiences of support workers working with these individuals in these services.

Method The portfolio comprises of a systematic review and an empirical qualitative study. The systematic review synthesises and appraises the findings from 38 studies reporting the prevalence of childhood abuse and neglect among adults accessing specialist mental health services using a random effects meta-analysis. The empirical study utilises a qualitative approach to explore therapeutic support workers' experiences of delivering care to individuals with a history of complex trauma within adult mental health services. Thirteen support workers were interviewed from various services and thematic analysis was utilised to analyse the data.

Results The systematic review identified high rates of childhood abuse and neglect among adults in specialist mental health services, with a pooled prevalence estimate of 66% of individuals accessing these services having experienced some form of childhood abuse or neglect. However, prevalence estimates varied substantially across studies due to methodological differences, including sampling approaches and trauma assessment measures. Overall study quality was mixed, with high heterogeneity limiting direct comparison across findings. The empirical study identified five themes relating to the relational and emotional demands of support work in this context, challenges in role clarity and boundaries, and variability in the availability of training, supervision, and support. Support workers described frequently encountering trauma-related material without consistently receiving structured training or protected clinical supervision.

Conclusion This portfolio highlights the pervasive presence of childhood abuse and neglect within adult mental health services and the implications of high levels of complex trauma for clinical practice and service design. Findings support the need for routine and sensitive trauma assessment, clearer role definition for support workers, structured supervision

standards, and workforce training in trauma-informed principles. Taken together, the studies contribute to the broader field of clinical psychology by linking prevalence-level evidence with workforce experience and by emphasising the importance of organisational approaches to trauma-informed care.

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Chapter One: Introduction to the Thesis Portfolio

Overview of the portfolio

Complex trauma is defined as exposure to multiple, chronic, or repeated traumatic events often involving interpersonal threats and occurring during childhood (Cook et al., 2003; UK Trauma Council, 2025). This includes the exposure to all forms of childhood abuse or neglect which are widely recognised as significant risk factors for the development of a range of mental health difficulties across the lifespan (McKay et al., 2021). Experiences of interpersonal trauma during childhood, including physical, sexual, and emotional abuse and physical or emotional neglect, are associated with an increased risk of depression, anxiety, post-traumatic stress disorder, psychosis, and difficulties with emotional regulation and interpersonal functioning in adulthood (Freeman & Fowler, 2009; Jansen et al., 2016; Johnson et al., 1999; Kuzminskaite et al., 2022; Lewis et al., 2019; Morrison et al., 2003). Given this context, it is understandable that for many individuals, the impacts of these early experiences are cumulative and enduring, contributing to complex clinical presentations that require specialist mental health input. As a result, adult mental health services, particularly specialist secondary and tertiary services, frequently support individuals with extensive trauma histories, often alongside comorbid difficulties and significant psychosocial adversity (Balmer et al., 2022; Costa et al., 2022).

The overarching focus of this thesis portfolio is complex trauma, specifically childhood abuse and neglect, and its relevance to adults accessing specialist mental health services. The portfolio comprises two papers. The first paper is a systematic review and meta-analysis examining the prevalence of exposure to interpersonal childhood trauma among adults accessing specialist mental health services. By synthesising prevalence estimates across international studies, this review addresses a fundamental question: how common are childhood abuse and neglect experiences in this population? Establishing the scale of trauma exposure is a crucial step in informing service planning, routine assessment practices, and workforce training. The second paper is an empirical study exploring the experiences of therapeutic support workers working with individuals within NHS adult mental health services who have experienced complex trauma. Given the high prevalence of childhood trauma identified in the review, it is likely that a substantial proportion of frontline mental health work involves supporting individuals with trauma related needs. Within these services, much of this relational, stabilisation-focused work is undertaken by non-registered staff such

as therapeutic support workers, who are commonly employed at Agenda for Change Bands 2–4. Whilst role titles vary between services, therapeutic support workers typically provide practical, emotional, and psychologically informed support under the supervision of registered professionals. Their work often centres on developing therapeutic relationships, supporting engagement with services, facilitating recovery-focused activities, and helping individuals apply therapeutic strategies in everyday life. Unlike peer support workers, whose roles draw on lived experience, or assistant psychologists, who support psychological assessment and formulation, therapeutic support workers are generally not employed to undertake formal psychological assessment or intervention planning, instead providing much of the day-to-day relational support within mental health services. Despite their central role, there remains limited research examining how these staff understand and experience their work, particularly in the context of complex trauma. The empirical paper therefore seeks to explore what supporting this population looks like in practice, from the perspective of those delivering care on the frontline of these services.

Together, these two pieces of work form a coherent programme of research. The systematic review establishes the scale and significance of childhood trauma exposure within adult mental health services, whilst the empirical paper examines how this reality is experienced and managed within services. The connecting chapters within this portfolio aim to articulate this coherence, situating the two papers within a broader clinical and theoretical context and critically reflecting on their combined contribution.

Clinical and theoretical context

Exposure to interpersonal trauma during childhood has been shown to have a profound and long-lasting effect on psychological development (Danese & McCrory, 2015). From a developmental perspective, early trauma can disrupt the formation of secure attachment relationships and interfere with the development of effective emotion regulation systems (Schore, 2002). Neurobiological models suggest that chronic exposure to threat during sensitive developmental periods can alter stress response systems, increasing vulnerability to later mental health difficulties (Perry, 2009; Perry & Pollard, 1998). Psychologically, individuals who experience childhood abuse or neglect may develop negative beliefs about themselves, others, and the world, alongside heightened threat sensitivity and difficulties trusting or relying on others (Karatzias et al., 2016; Thompson et al., 2014). These

developmental experiences help to explain why adults with histories of childhood trauma often present to mental health services with complex and comorbid difficulties.

Although there is a substantial body of research examining the relationship between childhood trauma and later mental health outcomes, several important gaps remain. Firstly, while epidemiological studies have documented the prevalence of adverse childhood experiences in the general population (Madigan et al., 2023), there has been limited synthesis of prevalence estimates specifically among adults accessing specialist mental health services. Individual studies vary widely in their reported rates of abuse and neglect, making it difficult to draw firm conclusions about the scale of trauma exposure in this population. Without robust, synthesised prevalence estimates, services may over or underestimate the extent to which trauma histories are the norm rather than the exception amongst service users. Secondly, the existing literature highlights considerable variability in the ways in which childhood trauma is assessed within both research and clinical contexts. Studies differ in their use of self-report questionnaires, structured interviews, or clinician-led assessments, and in whether they distinguish between different types of abuse and neglect. This variability has implications not only for prevalence estimates but also for routine clinical practice, where trauma histories may be inconsistently identified or documented. Understanding the extent of this variability and the impact of assessment methods is crucial for informing recommendations around assessment practices within services. The first paper in this portfolio will therefore systematically review and analyse data from studies that have reported prevalence estimates of exposure to various types of childhood abuse and neglect within adults accessing specialist mental health services and assess the impact that assessment methods may have on this prevalence estimate.

However, prevalence data alone is not sufficient to inform service development. Knowing that childhood trauma is highly prevalent among service users does not, in and of itself, explain how services respond to this reality or how staff experience and manage this work. Within the specialist mental health services that these individuals are likely to access, rather than discrete, single diagnosis presentations, clinicians frequently encounter overlapping symptoms of mood disorders, anxiety, post-traumatic stress, dissociation, substance misuse, and interpersonal difficulties (Balmer et al., 2022; Costa et al., 2022). Such complexity can pose significant challenges for these teams as existing service structures and care pathways are often insufficiently flexible or integrated to meet complex needs, leading to staff and

service users facing struggles within systems shaped by diagnostic categorisation, fragmented pathways, and limited access to longer term support (Foye et al., 2022; Priester et al., 2016). Service users with complex trauma histories, who are more likely to present with complexity and comorbidities (Gekker et al., 2018; Singh et al., 2021), may therefore struggle to engage with traditional models of care, experience repeated service contact, or be felt to require prolonged periods of stabilisation before trauma-focused interventions are considered.

In response to these challenges, trauma-informed care has emerged as a guiding framework within mental health services (NHS England, 2025). Trauma-informed approaches emphasise an understanding of the widespread impact of trauma, the importance of safety, trust, collaboration, and empowerment, and the need to avoid practices that may inadvertently increase distress or trigger trauma memories for these individuals (Reeves, 2015). Rather than viewing difficulties solely through a diagnostic lens, trauma-informed care encourages clinicians and services to consider how past trauma may shape current presentations and interactions within care systems (Sweeney et al., 2018). Within adult mental health services, this often involves prioritising relational safety, emotion regulation, and practical support alongside, or prior to, formal psychological therapy.

However, the implementation of trauma-informed care occurs within the context of significant systemic pressures. Adult mental health services in the UK face increasingly high demand, workforce shortages, and increasingly complex presentations (British Medical Association, 2026; House of Commons Committee of Public Accounts, 2023). Within this context, there has been a growing reliance on non-registered professionals, including support workers, to provide day-to-day therapeutic and practical support. These roles are often characterised by their flexibility, frequent contact with service users, and a strong relational focus. This positions support workers as key figures in delivering trauma-informed principles in practice.

Despite their value and importance in this work, support work roles are often poorly defined, with variability in training, supervision, and expectations across services. This lack of clarity may be particularly problematic when working with individuals with complex trauma histories given the emotional demands of the work and the potential risks associated with complexity, vicarious trauma, or role drift. Understanding how support workers experience

and conceptualise their role in this context is therefore essential for ensuring that trauma-informed care is delivered safely and effectively.

Whilst there is a growing body of literature on support roles within mental health services, including assistant psychologists and peer support workers (Klingemann et al., 2025; Wood et al., 2019), there remains limited research focusing specifically on therapeutic support workers and their experiences of working with individuals with complex trauma. Existing studies in other settings often highlight issues of role ambiguity, undervaluation, and limited access to training and supervision (Kelly et al., 2024; Wilberforce et al., 2017), but few have examined these issues explicitly in the context of trauma-informed care. As a result, there is a lack of detailed understanding around how support workers navigate the emotional and professional demands of trauma-focused work, and what support structures are necessary to enable them to work effectively. The second paper in this portfolio therefore utilises a qualitative approach to explore the views and experiences of support workers within adult mental health teams working directly with service users who have complex trauma histories.

Aims and structure of the portfolio

The overall aim of this portfolio is to contribute to a more comprehensive understanding of childhood abuse and neglect within adult mental health services, and to explore the implications of this for trauma-informed care and the mental health workforce. Following this introductory chapter, chapter two presents the systematic review and meta-analysis examining the prevalence of childhood abuse and neglect in adults accessing specialist mental health services. This is then followed by a bridging chapter (chapter three) which synthesises the key findings of the review and outlines how these inform and relate to the empirical paper which is presented in chapter four. This paper explores therapeutic support workers' experiences of working with complex trauma in NHS adult mental health services. Finally, chapter five provides an overall discussion and critical reflection on the portfolio as a whole, integrating findings across both studies, considering clinical, theoretical, and methodological implications, and reflecting on the contribution of this work to clinical psychology more broadly.

I have chosen to present the papers in this order to reflect the conceptual progression of the research. The systematic review establishes the scale and significance of childhood trauma exposure, providing the rationale for exploring how services and staff respond to this reality.

The empirical study then builds on this foundation, offering an in-depth exploration of trauma-informed care as it is enacted in practice by support workers within adult mental health services, highlighting their experiences of working with this specific population.

Chapter Two: Systematic Review

The prevalence of exposure to interpersonal childhood trauma amongst adults accessing specialist mental health services: A systematic review and meta-analysis.

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Abstract

Exposure to interpersonal childhood trauma, including abuse and neglect, is a well-established risk factor for the development of mental health difficulties. However, its prevalence among adults accessing specialist mental health services has not previously been synthesised. This systematic review and meta-analysis sought to estimate the prevalence of childhood abuse and neglect in this population, and to examine whether method of assessment moderates prevalence estimates. Studies were identified through searches of CINAHL, PsycInfo, PubMed, and PTSDpubs, yielding 38 studies that met inclusion criteria (N = 10,605). Random-effects meta-analyses estimated the pooled prevalence of exposure to any childhood abuse or neglect as 66.3% (95% CI 56.2-75.8). Pooled prevalence estimates for specific trauma types were also substantial, ranging from 32.5% (95% CI 21.5-44.5) for physical neglect to 47.5% (95% CI 37.5-57.6) for emotional abuse. All analyses were characterised by high levels of heterogeneity ($I^2 \geq 94\%$), with wide prediction intervals indicating marked variability between studies and service contexts. Sensitivity analyses restricted to high quality studies produced comparable prevalence estimates, suggesting robustness of findings. Moderator analyses indicated that method of assessment did not significantly influence prevalence estimates for most trauma types, with the exception of emotional neglect, which was more frequently identified in studies using self-report questionnaires compared to interview-based assessments. These findings indicate that exposure to childhood abuse and neglect is highly prevalent among adults accessing specialist mental health services. The implications for routine assessment, trauma-informed care, and service provision are discussed.

Keywords: Childhood Abuse; Childhood Neglect; Mental Health Services; Meta-Analysis; Prevalence; Systematic Review

Introduction

Exposure to interpersonal childhood trauma, including physical, sexual, or emotional abuse and physical or emotional neglect prior to the age of 18, is widely recognised as a significant risk factor for the development of mental health difficulties (McKay et al., 2021). This association has been consistently demonstrated in research with links made to mood disorders, anxiety disorders, psychosis, and personality disorders amongst others (Freeman & Fowler, 2009; Jansen et al., 2016; Johnson et al., 1999; Kuzminskaite et al., 2022). These difficulties in mental and psychological wellbeing are thought to occur, in part, as a result of the attachment disruption and altered stress response observed as the result of exposure to this type of trauma (Perry & Pollard, 1998; Schore, 2002). As a result, the long term impacts of these experiences are often complex, severe, and enduring, requiring specialist support (Dye, 2018) and making substantial contributions to the global mental health burden (Chandan et al., 2019; Grummitt et al., 2024).

Epidemiological studies suggest that exposure to Adverse Childhood Experiences (ACEs), broadly defined as potentially traumatic experiences occurring during childhood such as abuse, neglect, and household dysfunction (Felitti et al., 1998), is highly prevalent within the general population with approximately 60% of people having experienced at least one category of ACE (Madigan et al., 2023). There is also evidence to suggest that individuals with a history of mental health difficulties have higher levels of exposure to these ACEs and are more likely to have experienced multiple types of adverse experiences (Madigan et al., 2023; Tognin et al., 2025). This includes exposure to various forms of childhood abuse or neglect and several experiences categorised as 'household dysfunction' such as parental divorce or parental substance use (Felitti et al., 1998). However, the estimated number of children exposed specifically to abuse or neglect is estimated to be lower at anywhere between 7-36% for abuse and between 16-19% for neglect (Stoltenborgh et al., 2015; Stoltenborgh et al., 2013). Whilst these studies highlight the general prevalence of these experiences and establish a relationship between exposure to adverse childhood experiences and later mental health difficulties, they do not tell us how common childhood trauma is amongst adults currently accessing specialist mental health services.

A thorough understanding of the trauma histories and needs of this population is essential for the efficient and effective delivery of services. Adults accessing secondary and tertiary mental health services often present with complex, difficult-to-treat, and comorbid conditions

(Balmer et al., 2022; Costa et al., 2022). A history of childhood trauma may influence patterns of help-seeking, treatment engagement, and clinical outcomes (Copeland et al., 2018; Curran et al., 2021), and therefore has important implications for service planning and workforce training. Despite this, trauma histories are not always routinely or reliably assessed within clinical practice with evidence suggesting that the level of trauma exposure documented in clinical records is significantly lower than the patient reported prevalence when assessed with routine measures (Read et al., 2018).

Previous systematic reviews have examined the prevalence of child abuse and neglect in specific populations including forensic males (Webb et al., 2025), eating disorders (Pignatelli et al., 2017), and homeless individuals (Sundin & Baguley, 2015). There have also been reviews examining the association between ACEs and various psychiatric outcomes (Sahle et al., 2022). However, to the best of our knowledge, no review has synthesised the prevalence estimates of childhood maltreatment amongst adults accessing specialist mental health services. Establishing prevalence rates in this population is therefore an essential step in understanding the childhood histories of this population and informing routine clinical assessment, staff training, and service design.

The aim of this systematic review and meta-analysis is to estimate the prevalence of exposure to various types of childhood abuse and neglect amongst adults accessing specialist mental health services. Where possible, the review will also explore the impact of service type, and method of assessment on this prevalence estimate in order to build a more nuanced understanding of trauma exposure within this population.

Method

The protocol for this review was pre-registered on PROSPERO (reference: CRD 420251011514) prior to any formal review of searches. A completed Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) checklist for the review can be found in Appendix B.

Search strategy

A comprehensive search strategy was designed to identify all relevant studies. Searches were conducted across CINAHL, PsycInfo, PubMed, and PTSDpubs from inception to 17th June

2025 when searches were conducted. Searches were updated in November 2025 prior to analysis.

The following search terms were used for each database, processing study titles or abstracts only: ("childhood trauma" OR "adverse childhood experiences" OR "childhood maltreatment" OR "child abuse" OR "early life adversity" OR "child neglect") AND (Adult*) AND ("mental health services" OR "psychiatr* services" OR "community mental health" OR "outpatient psychiatr*" OR "psychiatr* care" OR "specialist mental health" OR "psychiatr* patient" OR "mental health care") AND (prevalence OR epidemiology OR frequency OR rate OR proportion). Medical Subject Headings (MeSH) terms, and other equivalent key words for other databases were used for each search term where applicable.

Inclusion and exclusion criteria

Studies were included in the review if they presented data on the prevalence of adults aged 18 and over who were currently accessing mental health services that had been exposed to interpersonal trauma, such as abuse or neglect, during childhood (prior to the age of 18) and if this was assessed using a validated measure of trauma exposure or clinical interview. Mental health services were considered as any secondary or tertiary services providing specialist mental health care for adults including community mental health teams, specialised services such as those for psychosis or obsessive-compulsive disorder, inpatient mental health units, or psychiatric outpatient clinics. Studies were required to be published in English and available in their full-text format in peer-reviewed journals.

Studies were excluded if they utilised a non-clinical sample of people not accessing mental health services, included children or adolescents under the age of 18, reported the prevalence of exposure to traumatic events occurring only in adulthood, or if the prevalence of exposure was taken from the review of clinical notes and records without being formally assessed. Studies recruiting participants from primary care services were excluded. Qualitative methodology, single case studies, reviews, and meta-analyses were also excluded.

Screening, data extraction, coding, and synthesis

Any duplicate studies were removed prior to screening. All studies were screened, and the data extracted by the first author with a subset of papers screened at each stage (20% of all title and abstract screening, and 20% of full text screening) checked by an independent

researcher. Any queries were discussed and an agreement reached between the researchers. Data was extracted using a data extraction form containing the information summarised in Table 1. Where data had been aggregated in an unclear way, for example the prevalence for emotional abuse and emotional neglect had been combined, authors were contacted directly in an attempt to obtain the raw data.

During data extraction, several rules were followed to ensure consistency between studies. Some articles (Lu et al., 2008; Rosenberg et al., 2007; Wu et al., 2010) reported a total prevalence estimate which included exposure to household dysfunction items in addition to abuse and neglect. In these cases, the decision was made not to include the study in the total prevalence analysis, however, they were included in the analyses for any specific included trauma types that were reported. Additionally, some studies (Anderson et al., 2016; Barnes et al., 2023; Bruni et al., 2018; Waikamp et al., 2021; Wu et al., 2010) reported a combined figure for certain trauma types such as physical and emotional neglect or emotional neglect and emotional abuse. In these instances, the decision was made not to include these papers in these analyses, however they were included in other analyses based on reported data. Where papers reported prevalence of more specific trauma exposures these were matched, where possible, to the identified trauma subtypes. For example in the paper by Gloger et al. (2021) exposure to 'harsh physical punishment' was counted as physical abuse and 'forced sexual contact from a relative' was counted under sexual abuse. Additionally, in the paper by (Schalinski et al., 2015) exposure to 'parental physical abuse' was captured within physical abuse and 'parental verbal abuse' was included under emotional abuse. Where items could not be clearly defined under one of the five named categories of abuse or neglect, they were not included. These decisions were made through discussion and agreement with the research team and care was taken to ensure that no dataset contributed more than one data point in any one meta-analysis. One study used multiple measures for the assessment of exposure to trauma in childhood (Nagar et al., 2020). In this case, the prevalence data reported from clinician interviews was prioritised as it was deemed to be the most reliable data source. When absolute frequencies were not reported, these were calculated from the reported percentage prevalence.

Quality assessment and risk of bias

The first author assessed the risk of bias using a researcher developed tool based on the Checklist for Prevalence Studies (Munn et al., 2015) operationalised to meet the needs of this

review which can be found in Appendix C. The second author assessed the risk of bias for 20% of the papers to ensure reliability in scoring. The quality assessment checklist consisted of nine items assessing the sample, recruitment, assessment of trauma exposure, reporting of prevalence data, and rate of participation. Each item was scored as either zero or one and the following categorical system was used to rate the total risk of bias score: 0-5 high risk/low quality, 6-7 moderate risk/quality, 8-9 low risk/high quality. A table containing the full quality ratings for each study can be found in Appendix D. An inter-rater reliability assessment was conducted for all ratings between the two raters which indicated excellent correlation on overall scores (ICC = 0.95, 95% CI = 0.83-0.98).

Meta-analytic method

The meta-analyses were conducted using the metafor package (version 4.8-0; (Viechtbauer, 2010)) in R (version 5.4.2). The extracted prevalence of trauma exposure, as a proportion of all service users, was pooled to provide a weighted estimate of the prevalence of exposure to childhood abuse and neglect in adults accessing mental health services overall (with 95% CI). Secondary meta-analyses were also completed using prevalence estimates of exposure to the following specific types of interpersonal childhood trauma: physical abuse, sexual abuse, emotional abuse, physical neglect, and emotional neglect.

A random-effects model was used given the high degree of variability expected in effect size between samples as it provides a broader and more conservative 95% CI around the estimate of the prevalence. The estimates of the prevalence underwent an arcsin transformation to ensure that the CIs did not fall below zero for samples where the prevalence estimate was low (Barendregt et al., 2013); results were then back transformed for ease of interpretation.

Cochran's Q test (Cochran, 1954) was used to ascertain if heterogeneity within samples was significant. The I^2 statistic (Higgins & Thompson, 2002) was used to determine the percentage of total variation in sample estimates that is due to between-study heterogeneity. A funnel plot and regression test was used to assess for publication bias (Egger et al., 1997; Higgins & Altman, 2008).

Sub-group and moderator analyses of prevalence estimates were conducted to ascertain if method of assessment impacted the prevalence estimate. Other sample characteristics, such as service setting or primary mental health diagnosis, were not explored as there were not

enough samples to allow for these comparisons to be made due to the wide variety between studies. A sensitivity analysis was used to assess the impact of risk of bias on the estimated pooled prevalence. This was achieved by repeating the meta-analyses, excluding those samples that constituted a high risk of bias. Any difference in the moderator and sensitivity analyses were tested for clinical significance by meta-analytic regression.

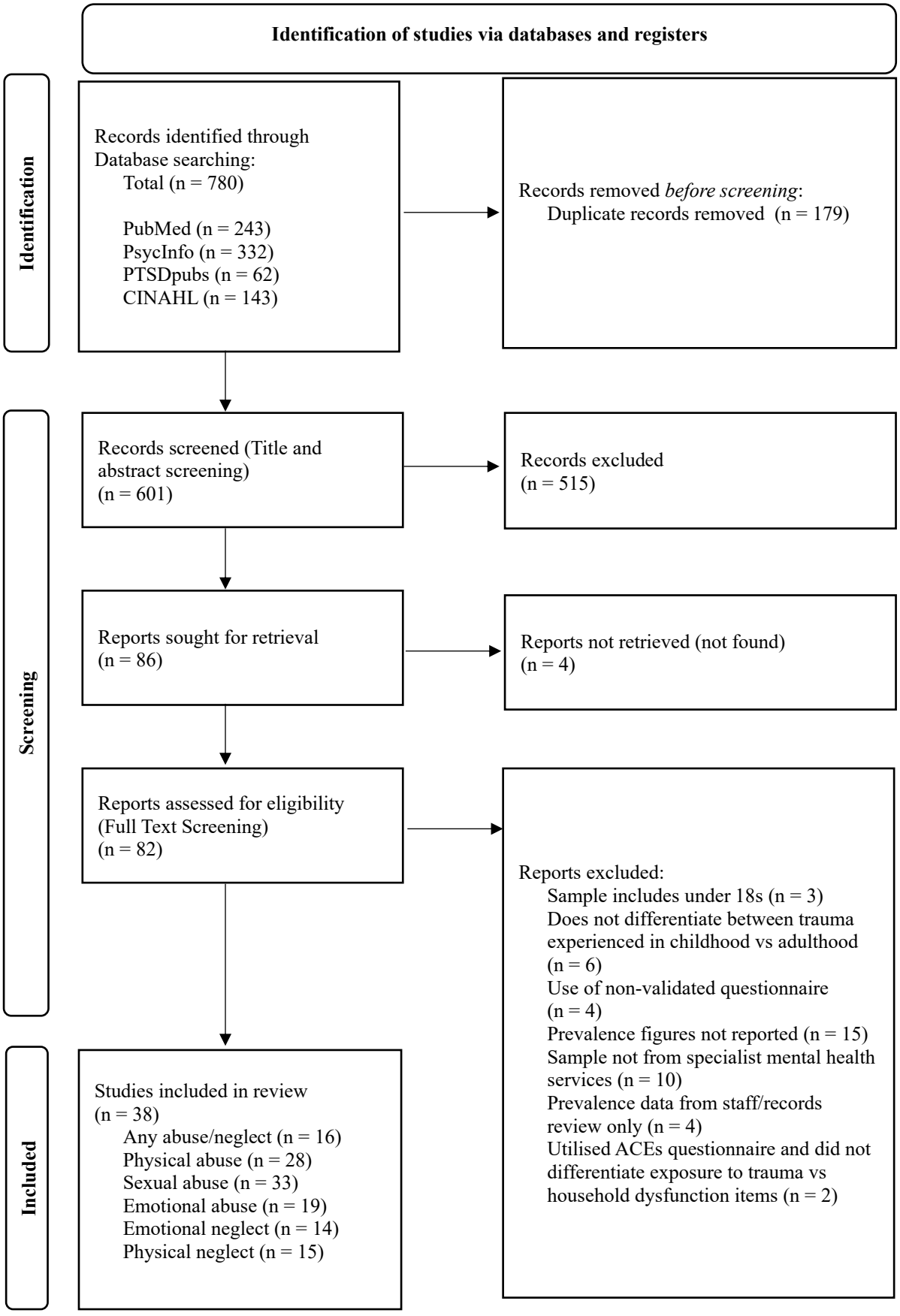
Results

A Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) flowchart (Figure 1) is provided as a summary of the search and selection process.

Search outcomes

The search identified 780 papers. Following the removal of 179 duplicates, there remained 601 studies which were screened based on the title and abstract. Full text screening was carried out for the 82 papers which were screened as relevant and available in their full-text format.

Figure 1 *PRISMA diagram showing the process of study identification, screening, and inclusion*



Study characteristics

Thirty-eight studies met inclusion criteria for the meta-analyses, comprising 10,605 participants. Of these, 16 reported an overall prevalence of any form of childhood abuse or neglect, 28 reported data on physical abuse, 33 reported data on sexual abuse, 19 reported data on emotional abuse, 14 reported data on emotional neglect, and 15 reported data on physical neglect. The studies were published between 1998 and 2025 and spanned across 18 countries. Thirty-four out of the 38 studies were from high income countries. Twenty-four studies examined outpatient services, six studies examined inpatient services, and eight studies reported data from a combination or inpatient and outpatient services. Assessment tools used were varied with a total of 24 different assessment tools utilised across studies. Eighteen studies utilised self-report questionnaires for gathering prevalence data whilst the other 20 studies used an interview-based approach in which participants were directly asked questions by a clinician or member of the research team. Study characteristics, including assessment methods and quality ratings, are presented in Table 1.

Risk of bias assessment

The 38 included studies were assessed using the risk-of-bias tool described above. Eleven studies were rated as high quality or low risk-of-bias (10 scoring eight out of nine and one scoring nine out of nine). Eighteen studies were rated as moderate quality or medium risk-of-bias (seven scoring six out of nine and 11 scoring seven out of nine). The remaining nine studies were rated as low quality or high risk-of-bias (one scoring three out of nine and eight scoring five out of nine).

Table 1 *Included sample characteristics*

		Sample Demographics			Assessment of Trauma Exposure			N						
Study	**Country (SES Status)**	**Service Type**	**Primary Mental Health Presentation**	**Age and Gender**	**Assessment tool**	**Method of Assessment**	**Quality**	**Tot**	**Any**	**PA**	**SA**	**EA**	**EN**	**PN**
Anderson et al. 2016	England (HI)	Outpatient	SMI	M: 41.76 SD: 10.74 43% Female	CTQ-SF	Questionnaire	High	318	92	85	109			
Barnes et al. 2021	England (HI)	Outpatient	Psychotic disorders	Age 18-65	THQ; CECA-Q	Interview	Moderate	146		93*	64*	105		
Bru et al. 2009	Spain (HI)	Outpatient	Dissociative Disorder	M: 48.7 SD: 10.14 94% Female	QTE	Questionnaire	Low	36	21		10			
Bruni et al. 2018	Italy (HI)	Inpatient	Psychotic or mood disorders	Age 18-65 55% Female	CECA-Q	Interview	Moderate	248		68		47		
Cusack et al. 2007	USA (HI)	Outpatient	Mixed SMI	M: 46.2 SD: 11.6 44% Female	TAA	Interview	High	142			42*			
Foote et al. 2006	USA (HI)	Outpatient	Mixed diagnoses	M: 37.4 SD: 11.4 64% Female	TEQ; DDIS	Questionnaire	Moderate	231		103*	58*			
Ford & Fournier, 2007	USA (HI)	Outpatient	Psychotic or mood disorders	Age 29-68 (median = 41) 100% Female	TESI	Interview	Low	35		17	8			
Fung et al. 2019	Hong Kong (HI)	Outpatient	Mixed diagnoses	M: 46 SD: 13.4 61% Female	ACE-Q	Questionnaire	Moderate	202		67	32	87	42	78
Gearon et al. 2003	USA (HI)	Outpatient	Psychotic disorders and comorbid substance use	M: 40.6 SD: 6.8 100% Female	TLEQ	Interview	Low	54		26	33			
Gloger et al. 2021	Chile (HI)	Outpatient	Depression	M: 40.53 SD: 12.71 67% Female	BPSAQ	Interview	Moderate	1001		258	109			
Kealy & Lee, 2018	Canada (HI)	Outpatient	Mixed diagnoses	M: 35.4 SD: 11.78 66% Female	CTQ	Questionnaire	Moderate	136	117	62	48	92	76	94
Lu et al. 2008	USA (HI)	Mixed	Mood disorders	M: 42.87 SD: 11 44% Female	SAEQ; CTS	Interview	High	254		142	105			
Lysacker et al. 2001	USA (HI)	Outpatient	Psychotic disorders	M: 44 SD: 9.32 4% Female	CSTQ	Questionnaire	Low	54			19			
Marshall et al. 2018	Ireland (HI)	Outpatient	Mood disorders	M: 48.74 SD: 12.56 63% Female	CTQ	Questionnaire	Moderate	49	38	18	15	24	20	29

Study	Country (SES Status)	Sample Demographics			Assessment of Trauma Exposure		Quality	N						
		Service Type	Primary Mental Health Presentation	Age and Gender	Assessment tool	Method of Assessment		Tot	Any	PA	SA	EA	EN	PN
Meade et al. 2009	USA (HI)	Outpatient	Psychotic or mood disorders	M: 38.61 SD: 9.28 46% Female	THQ	Interview	Moderate	152	106	84	71			
Michal et al. 2016	Germany (HI)	Outpatient	Depersonalisation - derealisation syndrome	M: 30.7 SD: 10.0 44% Female	CTQ	Questionnaire	Low	223	129	27	14	100	34	80
Moodley et al. 2023	South Africa (UMI)	Outpatient	SMI	M: 42.7 SD: 14 100% Female	ACE-IQ	Questionnaire	Moderate	154		33	67	43	32	72
Mowlds et al. 2010	Northern Ireland (HI)	Outpatient	Bipolar disorder	M: 50.94 SD: 12.76 60% Female	CTQ	Interview	Moderate	52	25	14	12	13	11	11
Mueser et al. 1998	USA (HI)	Mixed	SMI	M: 40 SD: 11.57 56% Female	THQ	Interview	Moderate	275			122			
Mulligan et al. 2025	USA (HI)	Outpatient	Bipolar disorder	M: 39.4 SD: 11.3 69% Female	CTQ-SF	Questionnaire	Low	201			133			
Nagar et al. 2020	Israel (HI)	Mixed	N/A	M: 37.5 SD: 13.7 59% Female	FEI	Interview	Moderate	170		79	53	133		
Øhre et al. 2015	Norway (HI)	Outpatient	Mixed diagnoses	Age 18-62 71% Female	TEC	Questionnaire	Low	62	44			24		29
Rienecke et al. 2022	USA (HI)	Inpatient	Eating Disorders	M: 26.86 SD: 9.82 88% Female	ACE-Q	Questionnaire	High	1819		309	364	637	146	691
Rosenberg et al. 2007	USA (HI)	Outpatient	Psychotic disorders	M: 42 SD: 9 32% Female	SAEQ; CTS	Interview	Moderate	569		321	191			
Rossiter et al. 2015	Ireland (HI)	Mixed	Mixed diagnoses	M: 44 SD: 15 48% Female	CTQ	Questionnaire	High	129	99	36	32	52	52	80
Schalinski et al. 2015	Germany (HI)	Inpatient	Psychosis	M: 32.2 SD: 10.3 31% Female	MACE	Interview	Low	62	45	13	13	17	4	15
Schutz et al. 2013	Canada (HI)	Inpatient	N/A	M: 40.2 SD: 10.3 35% Female	CTQ-SF	Questionnaire	High	92		49*	42*	51*	43*	43*
Schwartz et al. 2005	USA (HI)	Outpatient	N/A	M: 45.1 SD: 11.4 64% Female	TEI	Interview	High	184		64	71			
Shah et al. 2014	Australia (HI)	Mixed	Psychosis	M: 38.4 SD: 11.2 40% Female	Clinical Interview	Interview	High	1825	558					

Study	Country (SES Status)	Sample Demographics			Assessment of Trauma Exposure		Quality	N						
		Service Type	Primary Mental Health Presentation	Age and Gender	Assessment tool	Method of Assessment		Tot	Any	PA	SA	EA	EN	PN
Sideli et al. 2018	England (HI)	Inpatient	Psychosis	M: 28.1 SD: 9.1 37% Female	CECA-Q	Questionnaire	Moderate	231	65					
Spidel et al. 2010	Canada (HI)	Outpatient	Psychotic or mood disorders	M: 25.14 SD: 6.8 36% Female	CTQ	Questionnaire	Moderate	118		72	47	107		
Steel et al. 2004	USA (HI)	Mixed	N/A	Age 18-60 (M: 26.9) 66% Female	SHQ	Questionnaire	Moderate	105			62			
Taycan et al. 2014	Turkey (UMI)	Outpatient	Somatization Disorder	M: 32.5 SD: 9.3 100% Female	CAN-Q	Interview	High	40	20	8	2	10	10	12
Vivalya et al. 2023	Uganda (LI)	Mixed	Mixed diagnoses	Median: 28 IQR: 23.4 43% Female	ACE-IQ	Interview	Moderate	249		163	136	174	202	77
Vrijsen et al. 2017	The Netherlands (HI)	Inpatient	Mixed (excluding psychosis and bipolar disorders)	M: 38.2 SD: 11.6 71% Female	NEMESIS-CTQ	Interview	Low	252	201					
Waikamp et al. 2021	Brazil (UMI)	Outpatient	N/A	M: 32 SD: 12.21 69% Female	CTQ	Questionnaire	High	197	187	136	57		105	
Wota et al. 2014	Ireland (HI)	Mixed	Mixed diagnoses	M: 45 SD: 15 49% Female	CTQ	Interview	High	136	103	38	33	55	64	83
Wu et al. 2010	USA (HI)	Outpatient	Psychotic or mood disorder and comorbid substance use	M: 36.4 SD: 8.4 47% Female	LSC-R	Interview	Moderate	402		198	193		66	

Notes: HI = High Income; UMI = Upper Middle Income; LI = Low Income

SMI = Severe Mental Illness

CTQ-SF = Childhood Trauma Questionnaire – Short Form; THQ = Trauma History Questionnaire; CECA-Q = Childhood Experiences of Care and Abuse Questionnaire; QTE = Questionnaire for Traumatic Experiences; TAA = Trauma Assessment for Adults; TEQ = Traumatic Experiences Questionnaire; DDIS = Dissociative Disorders Interview Schedule; TESI = Traumatic Events Screening Inventory; ACE-Q = Adverse Childhood Experiences Questionnaire; TLEQ = Traumatic Life Events Questionnaire; BPSAQ = Brief Physical and Sexual Abuse Questionnaire; CTQ = Childhood Trauma Questionnaire; SAEQ = Sexual Abuse Exposure Questionnaire; CTS = Conflict Tactics Scale; CSTQ = Childhood Sexual Trauma Questionnaire; ACE-IQ = Adverse Childhood Experiences International Questionnaire; FEI = Familial Experiences Interview; TEC = Traumatic Experiences Checklist; MACE = Maltreatment and Abuse Chronology of Exposure; TEI = Traumatic Events Inventory; SHQ = Sexual History Questionnaire; CAN-Q = Childhood Abuse and Neglect Questionnaire; NEMESIS-CTQ = Netherlands Mental Health Survey and Incidence Study Childhood Trauma Questionnaire; LSC-R = Life Stressor Checklist Revised

Tot = Total sample size; Any = Number of people exposed to any type of childhood abuse or neglect; PA = Number or people exposed to childhood physical abuse; SA = Number of people exposed to childhood sexual abuse; EA = Number of people exposed to childhood emotional abuse; EN = Number of people exposed to childhood emotional neglect; PN = Number of people exposed to childhood physical neglect

*Indicates that sample size was different to total study sample

Meta-analytic prevalence estimates

Random-effects meta analyses indicated high rates of childhood trauma exposure across adults accessing specialist mental health services. The pooled prevalence of any childhood abuse or neglect was 66.3% (95% CI 56.2-75.8), based on 3900 participants across 16 studies (see Table 2). High heterogeneity was observed (I^2 = 97.1%), and the 95% prediction interval (PI) ranged from 25.9-96.0%, indicating substantial between-study variability.

Across trauma subtypes, pooled prevalence ranged from 32.5% (95% CI 21.5-44.5) for physical neglect to 47.5% (95% CI 37.5-57.6) for emotional abuse. All analyses demonstrated significant heterogeneity ($I^2 \geq 94\%$). Complete pooled estimates, CIs, PIs, and heterogeneity statistics for each trauma type are presented in Table 2. Forest plots for each of the six main analyses can be found in Appendix E.

Sensitivity analyses

Sensitivity analyses, restricted to the inclusion of high-quality low risk-of-bias studies only, yielded broadly comparable prevalence estimates across all trauma types (Table 2). For the prevalence of any type of childhood abuse or neglect, the pooled prevalence based on high-quality studies alone was 67.6% (95% CI 46.9-85.2) (k = 6). High-quality estimates for trauma subtypes ranged from 28.9% for sexual abuse to 50% for emotional neglect, with wide prediction intervals and persistently high heterogeneity. This suggests that whilst results were robust to study quality, between study variation remained substantial.

Table 2 *Pooled prevalence estimates of childhood abuse and neglect among adults accessing specialist mental health services, with subgroup, moderator, and sensitivity analyses*

	k	*n*	Pooled Prevalence (%)	95% CI	95% PI	I^2	*Q* test
Any Abuse/Neglect	16	3900	66.3	56.2 – 75.8	25.9 – 96.0	97.1	959.9*
High Quality Only	6	2645	67.6	46.9 – 85.2	16.2 – 99.7	98.6	625.6*
Assessment type							
Questionnaire	9	1381	70.0	55.7 – 82.5	25.7 – 98.5	96.7	311.1*
Interview	7	2519	61.5	47.0 – 75.0	23.1 – 92.9	96.5	406.3*
Moderation analysis:			Non-Significant (QM(df = 1) = 0.68, p = 0.41				
Physical Abuse	28	7344	40.6	34.0 – 47.4	10.8 – 75.0	96.9	1050.9*
High Quality Only	9	3152	37.9	25.5 – 51.3	6.0 – 77.8	97.6	400.2*
Assessment type							
Questionnaire	12	3595	38.8	27.5 – 50.7	6.0 – 79.2	97.6	498.3*
Interview	16	3749	42.2	34.3 – 50.2	14.4 – 73.0	95.6	365.4*
Moderation analysis:			Non-Significant (QM(df = 1) = 0.23, p = 0.63				
Sexual Abuse	33	7895	33.5	28.0 – 39.1	8.0 – 65.9	96.1	887.5*
High Quality Only	10	3287	28.9	21.0 – 37.6	7.4 – 57.5	95.1	122.8*
Assessment type							
Questionnaire	16	3984	33.4	25.4 – 41.9	6.8 – 67.8	96.1	383.2*
Interview	17	3911	33.6	26.2 – 41.4	8.1 – 66.0	95.8	484.5*
Moderation analysis:			Non-Significant (QM(df = 1) = 0.001, p = 0.97				
Emotional Abuse	19	4388	47.5	37.5 – 57.6	9.8 – 87.0	97.4	580.3*
High Quality Only	6	2517	40.4	29.7 – 51.5	15.7 – 68.0	94.1	37.4*
Assessment type							
Questionnaire	11	3285	49.5	37.4 – 61.5	12.9 – 86.4	97.3	261.9*
Interview	8	1103	44.7	27.4 – 62.6	3.9 – 90.9	97.2	288.1*
Moderation analysis:			Non-Significant (QM(df = 1) = 0.20, p = 0.66)				
Emotional Neglect	14	3388	44.3	36.3 – 52.5	17.2 – 73.4	94.0	148.4*
High Quality Only	5	2199	50.0	37.5 – 62.5	22.3 – 77.7	92.5	62.3*
Assessment type							
Questionnaire	9	2849	49.9	41.8 – 58.1	26.6 – 73.2	91.7	94.2*
Interview	5	539	33.4	20.2 – 48.2	7.0 – 67.7	90.7	48.2*
Moderation analysis:			Significant (QM(df = 1) = 4.39, p < .05				
Physical Neglect	15	3925	32.5	21.5 – 44.5	1.4 – 79.0	98.0	982.0*
High Quality Only	6	2396	37.0	21.1 – 54.5	3.8 – 80. 3	97.3	407.8*
Assessment type							
Questionnaire	9	2984	33.0	20.7 – 46.7	3.2 – 74.9	97.5	465.0*
Interview	6	941	31.4	11.6 – 55.7	0.0 – 90.0	98.0	361.6*
Moderation analysis:			Non-Significant (QM(df = 1) = 0.02, p = 0.90				

*Indicates significant heterogeneity $p < 0.0001$

Subgroup and moderator analyses

For each trauma outcome, separate pooled estimates were generated for studies using interview-based versus self-report questionnaire methods (Table 2). Across outcomes, studies

using self-report questionnaires generally reported slightly higher prevalence estimates than interview-based studies, although confidence intervals overlapped in most cases.

Moderator analyses examined the influence of assessment method on pooled prevalence. Assessment method did not significantly moderate prevalence estimates for most trauma types, including overall exposure to any type of abuse or neglect, physical abuse, sexual abuse, emotional abuse, or physical neglect.

A significant moderation effect of assessment method was observed only for emotional neglect ($QM(1) – 4.39$, $p < .05$), with self-report questionnaire assessments yielding higher pooled prevalence estimates than interview-based assessments.

Publication bias

Publication bias was assessed via visual inspection of funnel plots and Egger's regression test for each of the main meta-analyses (Egger et al., 1997). Egger's test for funnel plot asymmetry suggested no significant publication bias in any of the six main analyses. Funnel plots for each of the six analyses can be found in Appendix F.

Discussion

This systematic review and meta-analysis synthesised evidence from 38 studies reporting data on the prevalence of various forms of interpersonal childhood trauma among adults currently accessing specialist mental health services. Exposure to childhood abuse or neglect was highly prevalent within this population, with a pooled prevalence of 66.3% for exposure to any type of abuse or neglect. Prevalence estimates for individual trauma subtypes were also substantial, ranging from approximately one-third for physical neglect to nearly half for emotional abuse. These findings suggest that childhood trauma is not only a correlate of later mental health difficulties, but a common lived experience within secondary and tertiary care mental health services. However, these pooled estimates should be interpreted in the context of substantial between-study heterogeneity, indicating marked variability in observed prevalence across individual studies and service settings.

Prevalence estimates in this review appear to be markedly higher than previous population based estimates for childhood maltreatment, with estimates in previous studies ranging from around 7-36% for abuse and 16-19% for neglect (Stoltenborgh et al., 2015; Stoltenborgh et

al., 2013). Despite wide prediction intervals and substantial heterogeneity, the lower bounds of the observed confidence intervals exceed these population estimates for several types of maltreatment. This suggests that elevated exposure to childhood adversity is characteristic of individuals with severe or complex mental health difficulties requiring support from such services. The present findings support the idea that exposure to childhood maltreatment may be an important part of the clinical presentation of many service users and warrants routine assessment.

Heterogeneity was high across all analyses indicating substantial between-study variability beyond that expected by sampling error alone. High prediction intervals suggest that prevalence of trauma exposure in individual clinical settings may vary widely depending on sample, service context, assessment practice, or broader sociocultural factors. These wide intervals underscore the clinical importance of context when interpreting prevalence data and highlight that childhood trauma may be highly prevalent in some services, while less common in others. This again highlights the need for accurate assessment of individual trauma histories within such services.

Several potential contributors to heterogeneity were identified within the characteristics of the included studies. These include differences in the diagnostic composition of samples, variation in eligibility criteria and recruitment, and heterogeneity in assessment measures used. Prior reviews demonstrate that trauma prevalence can vary substantially based on the presence of comorbidities, clinical severity, or gender and treatment setting (Madigan et al., 2023; Sundin & Baguley, 2015). Future meta-analyses with larger numbers of studies per trauma type may permit further moderation analyses on the impact of these variables. Nevertheless, the moderator analyses conducted in the present review indicated that assessment method had a non-significant influence on prevalence estimates for most trauma types. This suggests that utilising self-report questionnaire assessments leads to a similar level of disclosure to interview-based methods.

Overall, the results of this review align with previous meta-analyses conducted with psychiatric and socially marginalised populations which have similarly reported high levels of childhood adversity. Although the levels of neglect were not found to be as high as those specifically accessing eating disorder services (Pignatelli et al., 2017), the rates of physical and sexual abuse were observed to be comparable but slightly higher than in homeless

individuals (Sundin & Baguley, 2015). In addition to this, the prevalence of all five subtypes of abuse were higher than the rates reported specifically in male forensic psychiatric patients (Webb et al., 2025). The present review extends this literature by synthesising the prevalence and highlighting the significance of the presentation specifically among adults in specialist mental health services where clinical pathways and service level responses remain variable and trauma histories are not always assessed or identified (Read et al., 2018; Sampson & Read, 2017). The high level of observed prevalence suggests an urgent need for consistent trauma-informed approaches and assessments across mental health services.

Implications for clinical practice and service delivery

The present findings have significant implications for specialist psychiatric and community mental health services. First, the extent of childhood trauma exposure among service users supports the necessity of routine enquiry using validated assessment measures. The lack of significant impact of assessment method in most cases suggests that both self-report questionnaires and clinical interviews invite similar levels of abuse disclosure which is in line with previous research (Gayer-Anderson et al., 2020) and supports the use of either method of assessment. However, additional research into the experiences of childhood abuse survivors suggests that interview methodologies may provide a much desired space to openly share and give voice to their experiences whilst also affording clinicians the opportunity to understand the specific details and dynamics of their experiences (Bifulco & Schimmenti, 2019). However, within resource-constrained services where clinicians may feel uncertain about asking detailed questions regarding childhood abuse and neglect (Nixon & Quinlan, 2022), structured self-report questionnaires could offer a feasible and resource-efficient mechanism for embedding routine assessment. Nevertheless, reliance on self-report questionnaires should not replace the need for training clinicians to ask about and respond to childhood trauma with confidence and sensitivity, given evidence that the quality of professional responses plays a significant role in how disclosures are experienced (McLaren & Read, 2025).

Clinical guidance increasingly advocates for trauma-informed care within mental health systems (Harper et al., 2008; NHS England, 2025), but operationalisation remains inconsistent. The prevalence estimates reported here are significant given that failure to identify trauma histories during assessment may result in missed opportunities for trauma-specific intervention, contribute to misunderstood presentations and less-developed

psychological formulations, and impede engagement or response to treatment. Trauma informed approaches that prioritise the recognition of trauma and childhood maltreatment can improve engagement and reduce barriers to care by fostering safety and trust (Roberts et al., 2025). Services that do not recognise trauma may inadvertently cause additional distress or disengage individuals (Edelman, 2023). The burden of unrecognised trauma exposure may also contribute to workforce stress and therapeutic ruptures, particularly in settings with limited staff training in trauma-informed approaches, whilst organisational change towards trauma-informed practice has been associated with improved staff well-being and readiness for change (Barnhill et al., 2019; Marvin & Volino Robinson, 2018).

The high prevalence across multiple trauma subtypes highlights the need for service offerings capable of addressing cumulative and complex trauma. Emotional abuse and neglect, which are often under detected in clinical settings relative to other forms of abuse (Sampson & Read, 2017; Stoltenborgh et al., 2013), were found to be prevalent in a high proportion of service users. These forms of maltreatment are associated with long-term relational, attachment, and affect regulation difficulties (Kumari, 2020), suggesting that psychologically informed multidisciplinary approaches may be required.

Critical appraisal and recommendations

This review was pre-registered, involved comprehensive database searches, and included rigorous screening and quality assessment procedures. The synthesis of prevalence data across multiple trauma subtypes represents an advance in the understanding of the level of childhood maltreatment experienced by adults in mental health services.

However, findings should be interpreted in light of several limitations. First, included studies varied widely in assessment methods and operationalisation of trauma exposure. Although validated tools were utilised, multiple versions, thresholds, and definitions of abuse were represented within the data. Retrospective self-report is vulnerable to both under- and over-reporting, and can be influenced by memory biases or current memory state. Prospective cohort data were not represented within this review.

Secondly, multiple trauma types frequently co-occurred, yet few studies reported data on the number of people who experienced multiple types of trauma, or the frequency of trauma

episodes or experiences. Future reviews might examine dose-response associations or clustering of trauma types among mental health service users.

An additional limitation concerns the geographical distribution of the evidence base. Most included studies were conducted in high-income countries, with only a small number originating from low- and middle-income settings. As a result, the pooled prevalence estimates may be most applicable to specialist mental health services within higher-income healthcare systems and may not fully reflect patterns of childhood trauma exposure among service users in other global contexts. Differences between countries in the prevalence and reporting of childhood maltreatment, cultural understandings of adversity, access to mental health services, and pathways into specialist care may all influence observed prevalence estimates. Although the limited number of studies from low- and middle-income countries precluded meaningful moderator analyses, future research should prioritise prevalence studies in underrepresented regions to determine the extent to which these findings generalise internationally.

High heterogeneity limited the interpretability of pooled estimates, particularly where only a small number of studies were included. Prediction intervals may be more informative than confidence intervals in such contexts, however, wide prediction intervals leave a high level of uncertainty. In addition to this, only one study-level moderator could be meaningfully analysed due to insufficient numbers.

Finally, risk-of-bias assessment indicated that nearly a quarter of studies were of low quality, although sensitivity analyses suggested that pooled prevalence estimates were robust to study quality.

Conclusion

This systematic review demonstrates that exposure to interpersonal childhood trauma is common among adults accessing specialist mental health services. Estimated prevalence greatly exceeds population-level estimates, highlighting the importance of routinely assessing for childhood trauma exposure in mental health services working with serious and complex mental health presentations. Findings underscore a need for routine and systematic assessment of childhood trauma assessment in specialist services, workforce training in

trauma-informed care, and ongoing research to identify service and individual level moderators of prevalence and outcomes.

The substantial heterogeneity observed suggests that prevalence likely varies across settings, reinforcing the value of local assessment and monitoring. Future research should prioritise standardisation of trauma assessment, longitudinal designs to understand causal pathways, and evaluation of trauma-informed interventions in routine care. Recognising and responding to trauma histories in mental health services may be essential for improving engagement, treatment effectiveness, and long term-recovery.

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Chapter Three: Bridging Chapter

The previous chapter provided a systematic review of the available research and meta-analyses of the pooled prevalence of exposure to various types of childhood abuse and neglect in adults accessing specialist mental health services. The findings of this review demonstrate that exposure to childhood abuse and neglect is highly prevalent in these populations but there is likely to be substantial variability across services, settings, and trauma types. These findings highlight that interpersonal childhood trauma is a significant and widespread feature of adult mental health service populations, whilst also pointing to inconsistencies in how trauma is identified and assessed across services.

Whilst establishing the scale of childhood trauma exposure is an essential foundation, prevalence data alone offers limited insight into how services respond to this reality in practice. The review could not address how trauma histories are recognised or viewed within routine clinical work, how they inform day-to-day support, or how trauma-informed principles are enacted within complex and pressured service environments. Nor could it capture the experiences of staff who provide much of the ongoing relational and practical support to individuals with complex trauma histories. As such, the systematic review raised important questions about service readiness, workforce roles, and the lived experience of delivering care within trauma-saturated services. The following chapter will aim to address some of these questions.

Within adult mental health services in the UK, a significant proportion of frontline support is provided by non-registered staff such as therapeutic support workers. These roles often involve higher levels of contact with service users and focus on emotion regulation, engagement, and support with daily functioning. Given the high prevalence of childhood trauma identified in the systematic review, it is likely that therapeutic support workers routinely work with individuals whose current difficulties are shaped by complex trauma histories. However, there is limited research exploring how therapeutic support workers experience this work, how they understand their role within trauma-informed care, or the challenges they face and the support they have access to.

The empirical paper presented in chapter four aims to fill some of these gaps. Building on the prevalence-level evidence provided by the systematic review, the empirical study seeks to

explore the experiences of therapeutic support workers working with adults within NHS mental health services who have experienced complex trauma. This has the aim of contributing to a better understanding of the role of therapeutic support workers within these teams and how best they can be utilised to support individuals who have experienced complex trauma, ensuring they have the appropriate support and training to do so.

Chapter Four: Empirical Paper

Relational care without recognition: The experience of therapeutic support workers working with individuals with a history of complex trauma in adult mental health services.

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(Appendix G)

Abstract

Background: Therapeutic support workers are increasingly relied upon within adult community mental health services to support individuals with histories of complex trauma, yet their role remains poorly defined and under-researched. **Objectives:** This study explored how therapeutic support workers conceptualise and experience their role when working with adults who have experienced complex trauma, the value they perceive themselves as bringing to multidisciplinary teams, and the training, supervision, and support available to them. **Methods:** Thirteen non-registered support workers from six NHS mental health trusts in England participated in semi-structured interviews, which were analysed using reflexive thematic analysis from a critical realist perspective. **Results:** Five themes were identified: developing competence, confidence, and professional identity; flexibility without clarity; bridging gaps between people, professionals, and systems; and relational safety as the foundation of engagement and recovery. Findings highlight the central relational and stabilisation work undertaken by therapeutic support workers, alongside significant challenges related to role ambiguity, inconsistent supervision and training, and emotional burden. **Conclusions:** This underscores the need for clearer role definition, consistent trauma-informed training and supervision, and greater recognition and understanding of the role and contribution that therapeutic support workers make within adult mental health services. Limitations and recommendations for future research are also discussed.

Keywords: Support workers, complex trauma, adult mental health services, thematic analysis

Introduction

Complex trauma refers to traumatic experiences involving multiple or prolonged events with interpersonal threats, often experienced during childhood or adolescence (Cook et al., 2003; UK Trauma Council, 2025). Experiencing complex trauma has been shown to have long lasting effects on a person's development at both the biological and psychological level. These effects can impact a person's brain structure and cortisol levels over their lifetime (Jeong et al., 2021; Steudte-Schmiedgen et al., 2016), negatively affect psychological and emotional functioning (Danese & McCrory, 2015), and leave individuals twice as likely to experience mental health difficulties (Lewis et al., 2019). More specifically, Lewis et al. (2019) found that individuals who experience trauma during childhood are at an increased risk of developing a number of mental health difficulties including anxiety, depression, and post-traumatic stress disorder. Traumatic experiences have also been linked to the development of severe mental illness such as psychosis (Morrison et al., 2003). They are also more likely to experience difficulties with emotional regulation, interpersonal relationships, and heightened vulnerability to dissociation (Dorahy et al., 2013; Ehring & Quack, 2010; Van Nieuwenhove & Meganck, 2019).

Repeated or prolonged exposure to trauma during childhood can disrupt socio-emotional development, attachment processes, and affect regulation, often resulting in later difficulties with self-concept, relationships, and managing distress (Ford et al., 2005; Herman, 1998). Therefore, effective support for survivors of complex trauma requires a multicomponent approach including an emphasis on emotional regulation, safety, and stabilisation in addition to the processing of trauma memories (Coventry et al., 2020). Various models of trauma therapy often refer to an initial phase of stabilisation prior to commencing the processing of traumatic experiences (Ford et al., 2005; Herman, 1998). This initially involves a focus on psychoeducation, establishing a sense of safety and promoting trusted relationships, and developing emotion regulation skills to address practical and psychological barriers to engaging in therapy (National Institute for Health and Care Excellence, 2018). Although not all approaches to trauma therapy utilise this phased approach, the nature of complex trauma and the resulting impact on an individual's development mean that it is often common for these individuals to require support in meeting these needs before they are able to engage in psychological therapy and trauma reprocessing. These ideas are consistent with the Maslow (1943) hierarchy of needs, which posits that basic physiological and safety needs must be met before higher-order psychological needs can be addressed.

Within the UK, most adults seeking psychological support for the consequences and impacts of complex trauma are seen within the NHS in secondary care mental health teams or specialist services operating at the interface between primary and secondary care. However, NHS mental health services face persistent pressures due to high demand and staff shortages, with the rise in demand for services outstripping the increase in workforce over recent years (House of Commons Committee of Public Accounts, 2023). As a result, service users with a history of complex trauma are often faced with lengthy waiting lists before accessing psychological therapy. This is exacerbated by a range of reported barriers to offering trauma-focused interventions to people with complex mental health presentations including a lack of training, clinicians' confidence in delivering such interventions, and a fear of re-traumatisation or increasing distress (Chadwick & Billings, 2022; Finch et al., 2020; Salyers et al., 2004). Evidenced-based psychological therapies, such as trauma-focused cognitive behavioural therapy (TF-CBT), eye movement desensitisation and reprocessing (EMDR), and compassion-focused therapy (CFT) are increasingly used to support individuals with histories of complex trauma. However, early stabilisation work emphasising regulation, engagement, and trust in addition to physical safety can be time-intensive and may fall outside of the scope of what qualified psychologists and therapists can feasibly provide within resource-limited systems due to the higher levels of input and flexibility which may be required. Additionally, many people who experience complex trauma may present to services requiring interventions for other difficulties such as anxiety or depression (Hovens et al., 2010) which may not meet the service requirements for one-to-one therapy with a Psychologist. This creates a critical gap in the early stages of trauma-informed care. Addressing such gaps is likely to become increasingly important given the NHS 10-Year Health Plan's emphasis on expanding community-based, preventative, and person-centred models of care, which will require a workforce capable of providing flexible support to individuals with complex and enduring mental health needs (NHS, 2025).

Most mental health services employ non-registered clinical support staff who regularly work with service users and deliver components of psychological interventions or practical support in a flexible, informal manner (Palmer et al., 2021). Due to the flexibility of their role, these individuals, referred to here as Therapeutic Support Workers (TSWs), may be ideally placed to engage service users in a range of stabilisation and trauma informed interventions focusing on emotional regulation, practical and psychological safety, and relational engagement. This

preparatory work has the potential to support trauma-focused interventions which, although effective, often have high drop-out rates (Ehring et al., 2014), by ensuring that service users feel safe and supported by the service before engaging in extensive trauma-focused therapeutic work which can be experienced as extremely challenging and emotionally overwhelming (Gjerstad et al., 2024).

Although TSWs may be well placed to deliver these interventions, their role within adult mental health services remains poorly defined and under-researched. This can result in inconsistent expectations, lack of training and supervision, and vulnerability to role drift. Previous research into the role of support workers in older adult community mental health services highlighted that boundaries around the role were often breached and there were limited opportunities for training and development (Wilberforce et al., 2017). An additional study exploring the views of support workers in Child and Adolescent Mental Health Services found that staff felt undervalued and under supported as they were viewed as 'just' a support worker (Kelly et al., 2024). Such undervaluation can contribute to reduced job satisfaction and staff retention difficulties (Scanlan et al., 2021). Yet, there is also evidence that when appropriately supported, non-registered staff can make meaningful therapeutic contributions within mental health services (Hall et al., 2024; Pace, 2009) particularly when aligned with trauma informed principles.

Working with individuals who have experienced complex trauma is emotionally demanding and can evoke strong affective responses in professionals (Coleman et al., 2021). Given the relational nature of support work, TSWs are likely to be exposed to these challenges but may lack the formal supervision structures and professional development pathways available to registered professionals. Although there is a growing body of literature on support roles in mental health services more broadly, including peer support workers and assistant psychologists (Klingemann et al., 2025; Wood et al., 2019) there remains limited research specifically addressing the role of support workers in services for individuals with a history of complex trauma. Understanding how TSWs perceive their role, their contributions within multidisciplinary teams, and the supports that enable them to work safely and effectively with this population is therefore essential. Such understanding can inform workforce planning, training, and supervision practices, ensuring that trauma-informed care principles are implemented consistently across services.

Aims

The present study aims to address this gap by exploring how therapeutic support workers in community-based adult mental health services conceptualise their role in supporting individuals with a history of complex trauma. Specifically, it examines (1) how therapeutic support workers understand and experience their role in working with this population; (2) the value they perceive themselves as bringing to multidisciplinary teams; and (3) the support, supervision, and training available to them when delivering trauma-informed care to individuals who have experienced complex trauma. By capturing the perspectives of those providing frontline therapeutic support, this study aims to illustrate both the opportunities and challenges inherent in utilising this workforce effectively, and to highlight implications for service design, training, and supervision within trauma-informed systems of care.

Materials and Method

Design

This study utilised a qualitative semi-structured interview design using reflexive thematic analysis (Braun & Clarke, 2021) to explore the roles and experiences of support workers providing therapeutic support to adults with a history of complex trauma in NHS mental health services. Due to the exploratory nature of the research and lack of existing research in this area, a qualitative approach was deemed to be the most suitable for this research.

Several different qualitative approaches could be used to explore the views and experiences of support workers in this setting. Another option could have been to use Interpretive Phenomenological Analysis (IPA) (Smith, 2004). IPA has a more idiographic focus and allows the researcher to understand how individuals make sense of their own experiences. Using IPA could elicit similar findings as approaching the data from a critical realist standpoint using thematic analysis, however, due to the exploratory nature of the research and the aim of understanding experiences across the sample as a collective group, rather than on an individual level, thematic analysis was felt to be more appropriate on this occasion (Braun & Clarke, 2021).

Participants

Thirteen non-registered mental health support workers working across various mental health teams in six NHS trusts in England were recruited to the study. Inclusion criteria for the study required participants to be currently employed as a support worker or equivalent role

(typically Agenda for Change bands 2-4, excluding peer support workers), working in an NHS community-based or outpatient adult mental health team, and have direct experience of supporting at least one individual with a history of complex trauma whilst working within that role. Peer support workers were excluded due to the distinct differences in the role including their primary use of lived experience and more explicit training and supervision structures.

For the purpose of this study, the definition of complex trauma was taken as that described by the UK Trauma Council (2020):

"…traumatic experiences involving multiple events with interpersonal threats during childhood or adolescence. Such events may include abuse, neglect, interpersonal violence, community violence, racism, discrimination, and war. These experiences have several key features. First, they typically arise within the context of a child's relationships. Second, they occur during child development, with important implications for their potential impact. Finally, they are chronic or repeated."

Procedure

Recruitment materials (Appendix H) were shared with potential participants either directly via their NHS Trust and service managers or via social media sites and groups which targeted non-registered support staff working within adult community and specialist mental health services. Interested individuals contacted the lead researcher directly via email to express their interest and confirm eligibility. Eligible individuals were provided with the participant information sheet (Appendix I) and consent form (Appendix J). Following informed consent, a mutually convenient time for the interview to take place was arranged.

A semi-structured interview guide was developed by the lead researcher in collaboration with other members of the research team (Appendix K). The interview guide covered four main areas of interest which are outlined, along with example questions, in Table 1.

Table 1 Interview guide topics and example questions

Area of interest	*Example questions*
Support workers view of their role when working with complex trauma	In your opinion, how does your role differ from that of other professionals (e.g., therapists, psychologists, social workers) in the treatment of complex trauma? What are some of the most challenging aspects of your role when working with survivors of complex trauma?
Perceived value of support workers within teams	Do you feel that your work and insights are valued by other team members (e.g., therapists, doctors, etc.)? Why or why not? Do you feel that there are any misconceptions or undervaluation of the work that support workers do in trauma-informed care?
Support, training, and supervision	What kind of training or support did you receive when you first began working with individuals who have experienced complex trauma? Has there been a time when you have been asked to deliver an intervention that you did not feel was part of your role or that you did not feel confident in?
Additional reflections	Looking back at your time working with individuals who have experienced complex trauma, what stands out as the most rewarding or fulfilling aspect of your role? Is there anything else you would like to add or something you feel you have not had the opportunity to say?

Interviews took place between February and August 2025. All of the interviews were conducted online via Microsoft Teams by the lead researcher. Prior to the interview taking place, participants were asked to complete a brief demographic questionnaire (Appendix L) which also asked them to provide information about any relevant training or experience they had outside of their role. They were also asked to rate their knowledge and understanding of

complex trauma, and their confidence working with individuals who had experienced complex trauma on a scale from zero to 10.

Interviews typically lasted one hour (ranging between 38 and 80 minutes) and were recorded via the Microsoft Teams platform. Microsoft Teams live transcription service was used to produce an initial transcription of the interviews which were checked for accuracy and amended accordingly by the lead researcher.

At the end of the interview, participants were asked if they would like to be contacted about the results of the study. They were also given the opportunity to review their transcript prior to analysis although no participants requested this. All participants were provided with a £10 gift voucher as reimbursement for their time and a token of gratitude for their participation.

Ethical considerations

Ethical approval for the study was provided by a university research ethics committee (Appendix M). As the study involved interviewing current NHS staff members, approval was also sought and granted by the Health Research Authority (Appendix N).

Participants involvement in the study was anonymised and remained confidential to everyone apart from the lead researcher and all data was treated and stored in accordance with the General Data Protection Regulations (GDPR). Participants were allocated a participant identification number which was used to identify participants during the analysis in order to preserve anonymity. Informed consent was obtained from all participants prior to any data being collected using a consent form which can be found in Appendix J. Participants were reminded that they had the right to stop and withdraw from the interview at any time should they wish to do so and that there would be no consequences to this. They were also informed that should they wish to withdraw their data from the study they could do so up until the point at which data analysis had occurred, at which point it would not be feasible to do so. Participants were offered a debrief following completion of the interview, which was not recorded, where they were given the opportunity to ask any questions or discuss any issues raised by the interview and be directed to further support if needed.

Data analysis

The study was conducted from a critical realist standpoint, acknowledging that findings are co-constructed through interactions between the researcher and participant. The lead researcher has prior professional experience working in mental health services, including in support worker roles, and later within a community mental health team. This background facilitated rapport with, and understanding of participants' contexts but also required ongoing reflexivity to ensure that existing assumptions about the support worker role did not constrain interpretations. Reflexive journaling, supervisory discussions, and analytic memos were used throughout to document assumptions and analytic decisions.

Analysis of the interviews was conducted using Braun and Clarke (2006) six phase process for Thematic Analysis, informed by the principles of Reflexive Thematic Analysis described by Braun and Clarke (2021). All six stages of the analysis (data familiarisation, coding, generating, reviewing, and defining themes) were completed by the lead researcher. An audit trail of coding, reflexive notes, and thematic maps was also maintained throughout the analysis process. Themes were refined through discussion within the research team to enhance analytic rigour and reflexivity. NVivo software version 14 for mac (Lumivero, 2023) was used to support data organisation.

Results

Participant information

Participants were three males and 10 females aged between 23 and 53 (M = 35.5, SD = 10.6) working across community mental health, early intervention in psychosis, rehabilitation, and psychological therapy services. The length of experience ranged from three months to 20 years and there was a range of previous experience or training. Demographic details for participants can be found in Table 2. Additional relevant training included undergraduate psychology degrees, training in low intensity CBT or family interventions, PhD studies, and brief training courses such as Dialectical Behaviour Therapy (DBT) essential skills.

Participants own self-rating of their knowledge and understanding of complex trauma ranged between five and eight out of 10 (M = 6.9, SD = 0.9). Confidence in working with complex trauma presentations varied between four and 10 (M = 6.9, SD = 1.7).

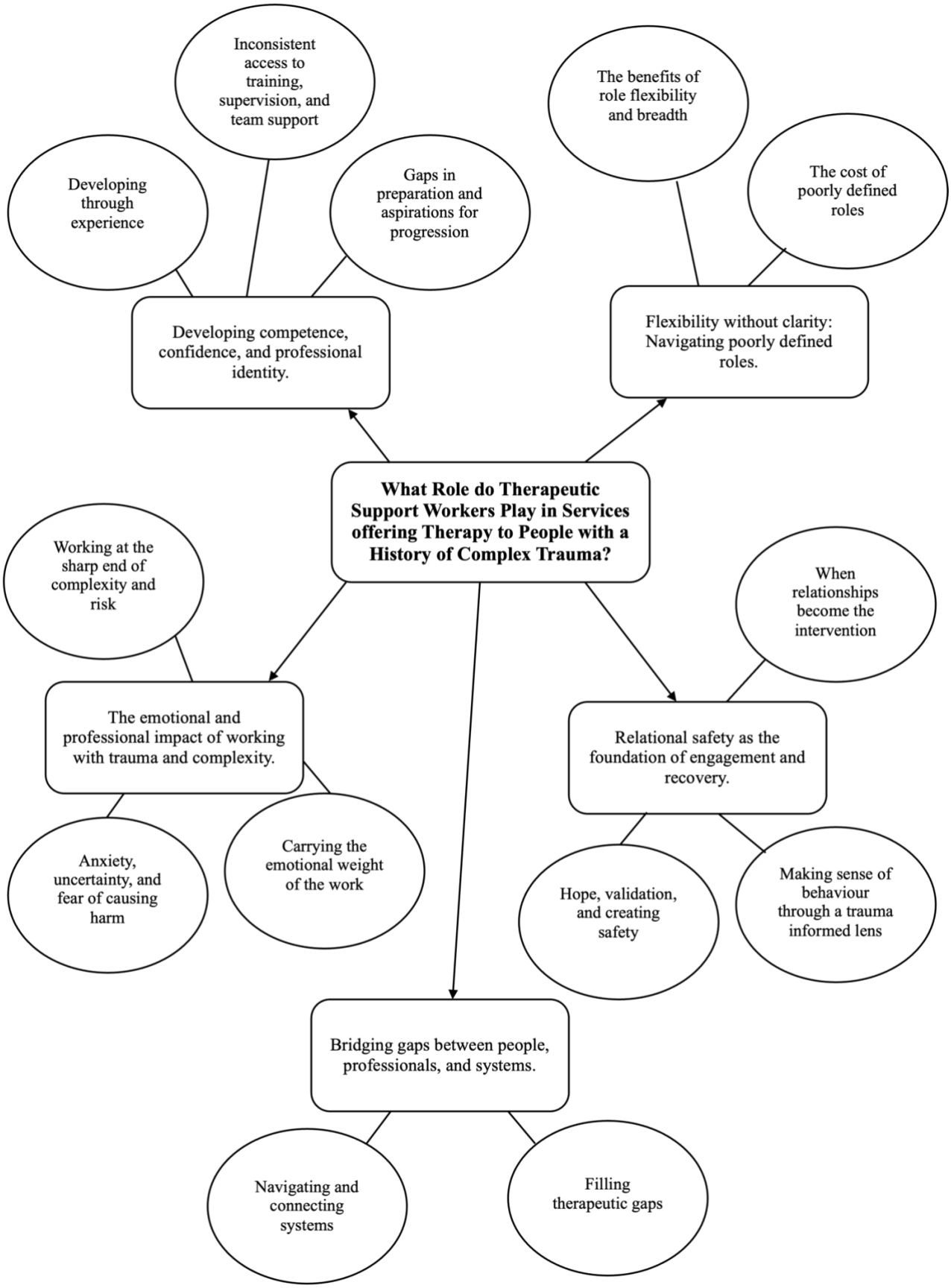
Table 2 Participant demographics

Participant ID	*Age*	*Gender*	*Service Type*	*Relevant experience or training*
1	28	Male	Community Mental Health Team	No
2	32	Male	Community Mental Health Team	No
3	27	Female	Early Intervention Psychosis	Yes
4	38	Female	Community Mental Health Team	No
5	47	Female	Community Mental Health Team	No
6	25	Female	Psychological Therapy Service	Yes
7	23	Female	Psychological Therapy Service	No
8	53	Female	Psychological Therapy Service	No
9	23	Female	Community Rehabilitation Service	Yes
10	32	Female	Psychological Therapy Service	Yes
11	34	Female	Early Intervention Psychosis	Yes
12	47	Female	Early Intervention Psychosis	No
13	53	Male	Community Mental Health Team	Yes

Themes

Five themes were identified: (1) Developing competence, confidence, and professional identity; (2) Flexibility without clarity: Navigating poorly defined roles; (3) The emotional and professional impact of working with trauma and complexity; (4) Bridging gaps between people, professionals, and systems; (5) Relational safety as the foundation of engagement and recovery. Each theme comprised a number of subthemes, reflecting distinct but interrelated aspects of participants' accounts. The themes and subthemes are presented visually in Figure 1. The frequency of codes in each theme and subtheme are shown in Appendix O. Additional illustrative quotes for each subtheme can be found in Appendix P.

Figure 1 Thematic map of themes and subthemes



Theme 1: Developing competence, confidence, and professional identity.

Participants described developing competence and confidence within their roles through a combination of formal support structures and experiential learning although the availability and suitability of these supports were widely inconsistent. Alongside role development, there were recognised gaps in preparation and learning, and aspirations of progression into other mental health professions were frequently reported.

1.1 Inconsistent access to training, supervision, and team support

Participants described variable access to training, supervision, and shared resources. Where available, these supports were described as providing helpful practical learning and containment:

> *"So during my supervisions if I'm not sure which route to go, I will ask what would, what's your advice? What do you think I should do? Because it's better to ask than do the wrong thing for sure." P10*

Regular team contact and opportunities to reflect collectively were described as being particularly important, suggesting that learning was not only individual but relational and embedded within team cultures:

> *"We're quite, in this team especially we are quite close knit, so we have two handovers a week. We have an MDT each week and we can talk to each other constantly." P12*

However, participants' accounts highlighted marked inconsistency in access to these supports. Supervision was sometimes absent or irregular, with participants describing this as going unnoticed until explicitly raised:

> *"With supervision, I did say like I'm not getting any supervision, it would be nice if I could have some supervision and that was, they were kind of shocked. I think they just didn't realise I wasn't getting it." P11*

This variability positioned support workers as unevenly resourced, with some left to manage the demands of the role without formal containment or oversight. In these contexts, participants described compensating through self-directed learning:

> *"I remember just like watching all of these training videos and just having pages and pages and pages of notes, trying to make sense of it." P6*

1.2 Developing through experience

Across accounts, participants consistently described experience as the primary mechanism through which competence and confidence developed. Learning was framed as iterative and ongoing, shaped by exposure to complexity and repeated practice:

> *"Yeah, I think it's, it's just experience. You learn, unfortunately, can't teach it from a book" P2*

Importantly, increased experience was linked both to confidence and clearer recognition of limits and boundaries. Participants described becoming more comfortable saying no, seeking support, or acknowledging uncertainty:

> *"I mean, I suppose I've been around for a bit now, so I feel more okay these days to sort of say no. I don't know. I don't feel comfortable. I don't know enough about that. I can't do that or this is why I can't do that." P13*

This awareness of role boundaries and ability was presented as a sign of professional growth and understanding of limitations with participants emphasising this understanding as being essential for working effectively:

> *"I feel like everybody has different abilities. And it's about understanding your own ability and having your boundaries, knowing when to say yes and no and when to say no." P4*

1.3 Gaps in preparation and aspirations for progression

Despite developing confidence through experience, several participants identified gaps in preparation and learning, particularly in relation to role-specific training and awareness of trauma informed care:

> *"I think probably when you come into a service having more of an opportunity to access more structured training on what complex trauma is and the impact of it and sort of being trauma informed and things like that" P7*

These gaps appeared to shape how participants understood and viewed the support worker role within broader professional hierarchies. For some, the role was positioned as transitional, providing experience rather than a long-term professional identity:

> *"That it's kind of for me, it's a stepping stone job, which means that people don't necessarily stay in that role very long. That's personally, that's going to be my experience, hopefully." P9*

Theme 2: Flexibility without clarity: Navigating poorly defined roles.

The variability and flexibility of the support worker role was highlighted as being both its greatest strength and a source of significant challenge. Participants described the ability to fill multiple roles such as facilitating responsiveness to diverse service user needs and increased adaptability within teams. However, this flexibility also contributed to confusion and role ambiguity with some participants feeling they were viewed as 'less than' due to a lack of formal accreditation.

2.1 The benefits of role flexibility and breadth

Participants positioned flexibility as central to their ability to meet diverse and complex needs. The breadth of the role allowed support workers to respond holistically, integrating practical, emotional, and relational support:

> *"I think what we were talking about earlier is you almost being that go between of, of supporting in lots of different areas. You know, whether it's the finance, the housing, the emotional support, the kind of psychological interventions." P2*

This flexibility was described as being unique to the support worker role and of particular importance for individuals with complex trauma histories, where rigid interventions and service structure may be anxiety inducing or inaccessible:

> *"I think a lot of our clients really appreciate that with support work, that it is more flexible. Because I think a lot of clients can struggle with the real structured nature of therapy. And so I think having a support worker who can be a little bit more flexible, a lot of clients really appreciate that." P7*

Support workers also described this flexibility as enabling them to complement and support other professionals' roles, easing workloads and system pressures:

> *"That helps my colleagues because obviously they're, they're perhaps doing. You know, you know the initial assessments and, and formulations, which are really complex and I, I feel if I can help in that, some small way you know. Often I'll, I'll find out information for them ad hoc, you know, to, to help them if they're working with somebody." P8*

2.2 The cost of poorly defined roles

Alongside these benefits, participants described persistent ambiguity about role expectations. Variability across services and teams meant that the role was often misunderstood:

> *"What is a support worker, the, you know, what does a support worker look like? You know, what a support worker looks like to a nurse. What does a support look like to a patient? What does the support, you know, because for every single person sees a support worker very differently." P5*

This confusion around the role of support workers was also reported from the service user perspective with participants finding that often they may be allocated to work with someone who did not understand what a support worker could offer them:

> *"They're just unaware of what a support worker can do these days. Compared to, most people just think support worker's just like a caregiver that just comes over, cooks their food or what have you or enables them to take their medication" P2*

This lack of clarity contributed to, at times, feelings of being undervalued within teams, particularly in relation to professional status. Participants reported feeling as though other professionals looked down on their role:

> *"At times. It's just like, oh, it's just a support worker, it's beneath me." P10*

Participants reported how these experiences shaped their own view of themselves and their position within teams. They described having less influence, or a lower view of their role, suggesting that flexibility without clarity may reduce professional authority:

> *"Because I feel like what I'm going to say is not going to be as good as what like the clinical psychologist or like the CAPs* [Clinical Associate Psychologists] *are going to have to say." P6*

Theme 3: The emotional and professional impact of working with trauma and complexity.
This theme focuses on the emotional weight and responsibility that support workers often carry when working with trauma, complexity, and risk. Participants described being positioned at the forefront of distress, often holding significant responsibility for highly complex presentations. This work, without the training, qualifications, or theoretical frameworks held by other professionals, contributed to feelings of fear, uncertainty, and concerns about getting things wrong.

3.1 Working at the sharp end of complexity and risk
Participants consistently described working with individuals experiencing high levels of distress, complex histories, and ongoing risk as a routine part of their role rather than an exception. This was reflected in reports of frequently being allocated individuals with multiple complex needs, sometimes without consideration of whether this was suitable:

> *"But I do feel like people will, like managers, will allocate people to you without really thinking about the risk and the level of the patient, if they need a nurse or a support worker, I do feel like support workers do get lumbered, sometimes with some patients that are not appropriate for them." P4*

In some cases, participants described holding responsibility for individuals without the presence of other professionals typically associated with care co-ordination or risk management:

> *"Because yeah, not, not everyone on my caseload has a care coordinator or a nurse." P2*

This positioning placed support workers at the sharp end of services where distress, risk, and crisis are often most visible. Participants reflected on the intensity of this work and the expectation that they manage complexity despite occupying a role that was not formally designed to hold such responsibility:

> *"Making judgments out in the community, you know, you're left with your own devices with someone who's got this long history, someone's risky, demanding, trying to managing your own responses." P13*

3.2 Anxiety, uncertainty, and fear of causing harm

A prominent feature of participants' accounts was anxiety about making mistakes or inadvertently causing harm. This fear was particularly evident in relation to trauma focused work, where participants spoke about a fear of causing "retraumatisation":

> *"So it's not very uniformed I think and that's part of the nervousness is that sometimes I worry if I have the skills to be able to do it and there's a risk of, oh my goodness, I could retraumatise this person if, if I'm not mindful of it. So that's part of it, yeah." P3*

Participants also described ongoing uncertainty about whether they were responding in the "right" way, particularly when navigating emotionally charged situations:

> *"Cause I don't want to get things wrong or like, you know, I don't want to sort of make anything worse for them." P1*

These concerns were closely linked to participants' awareness of their own training and qualifications. Several participants described questioning their competence, particularly in comparison to more highly trained professionals within teams:

"That makes, you know, makes them question as well, makes me question am I competent? Do I have the confidence to be able to handle or manage this?" P3

This uncertainty did not reflect a lack of willingness to engage in trauma related work, but a heightened sense of responsibility and caution. Participants appeared to hold a strong awareness of the potential consequences of their actions and concern for service user safety rather than avoidance of complexity.

3.3 Carrying the emotional weight of the work

Participants described the emotional impact of sustained exposure to distress and trauma as cumulative and demanding. Building relationships with highly distressed individuals was experienced as emotionally draining, particularly where participants held responsibility for ongoing support:

"And just building that rapport, sometimes you see them for 5 minutes and in that 5 minutes there, they can completely drain you. There is nothing left of you just because you've sat there in silence because they can't even talk to you." P12

The emotional labour involved in this work required participants to actively monitor and manage their own wellbeing. Several participants described needing to consciously attend to their own mental health in order to remain effective in their role:

"I think it's because you, you have to have like that empathy and compassion and stuff like that. I think once you start losing it for people, it's very difficult to do your job because you need that, you need to, you know, have that element of compassion and stuff. And you know, if you haven't got anything left to give these people then it's not the right job for you to be doing." P5

Despite the emotional strain, participants also described the work as meaningful and rewarding. However, these positive aspects were often described alongside frustration and emotional exhaustion, reflecting the complex and demanding nature of the role:

"Is, it's a tricky job at times I must say, it's very rewarding though, but it can be very tricky and very frustrating." P10

Theme 4: Bridging gaps between people, professionals, and systems.

This theme recognises how support workers fill gaps within services by connecting service users with professionals, systems, and resources whilst also contributing directly to gaps in therapy provisions by supporting, enabling, and preparing people for structured psychological therapy. Across accounts, support workers were positioned as relational and practical connectors, often maintaining continuity where services felt disjointed or inaccessible by facilitating relational connections with other clinicians and supporting access to other services.

4.1 Navigating and connecting systems

Participants consistently described acting as intermediaries between service users, other professionals, and wider systems of care. This included supporting the development of the service user's relationship with the service and aiding communication between professionals:

"For example, if they have a support worker before they start an intervention is to get that connection within the service, is to get that reassurance that they are safe, that we're here to help them, you see." P10

Participants described this role as particularly important for individuals who may struggle to engage with multiple services or professionals simultaneously. Support workers positioned themselves as a consistent point of contact, helping service users to navigate various systems:

"They'd have to go via lots of different agencies to get various different types of support. Maybe it'd become too overwhelming or confusing for them. They don't know who's actually helping them, whether they haven't got their, the person to go through to talk to these agencies for them." P2

Participants also described their role in helping other professionals gain a fuller understanding of service users' needs and experiences. This extended beyond practical co-ordination to include patient advocacy where support workers used their knowledge of service users to inform multidisciplinary decision making:

"I've had cases before where I've referred someone on to do another therapy and a psychologist suggested, why don't you do a different kind of therapy? But I think that was like one of the few times where I felt confident enough to say no. I know this patient very well that he would not get on with this other type of therapy. It would have to be this like one to one therapy." P6

4.2 Filling therapeutic gaps

In addition to navigating systems, participants described contributing directly to therapeutic work, particularly in contexts where access to formal psychological therapy may be limited or delayed. Support workers described supporting service users to engage in psychologically informed activities, often alongside or in preparation for structured therapy:

"I'm giving them that foundation to be able to, you know. Sometimes move forward, you know in their life without another intervention, or sometimes prepare them and get them ready for obviously to be able to process the trauma, whether that's, you know, through EMDR or psychology. You know, it's given them that, that foundation and the skills and everything." P5

This work was described as practical and relational, helping service users apply therapeutic concepts to real-world contexts. Participants emphasised the importance of supporting individuals to practise these skills outside of sessions:

"I think I've had it a few times now where I've, a client's been, you know, doing therapy with another clinician and the clinician's suggested some support work to run alongside the therapy because as a support worker we can go out, witness the client's difficulties in the moment and find about, and find out ways to kind of embed the skills that they're learning in therapy into their lives." P7

Participants also described supporting engagement during periods of waiting for therapy, helping to maintain motivation and stability, often in the form of developing emotion regulation and grounding strategies that could be used day to day. In this way, they occupied a space between formal intervention and everyday support, contributing to continuity of care:

"I think because eventually, a lot of the time our service users go on to needing one to one trauma therapy or the group therapy for coping with trauma because the waiting time is so long that they can have an assessment one year and not be, be part of a group or therapy for another year. So a lot of the time recently is that support workers are being allocated kind of in the meantime to give them even, like a starting point of some skills to utilise." P6

Theme 5: Relational safety as the foundation of engagement and recovery.
This theme focuses on the relational core of support work, illustrating how trust, safety, and healthy connection are actively created through a trauma-informed understanding of behaviour which enables engagement and recovery despite the complexity and challenges of the work.

5.1 When relationships become the intervention
Participants consistently described the relational aspects of their role as central to their work, often spending more time with service users than other professionals. This time and continuity were described as enabling deeper understanding and trust to develop:

"I kind of feel like the work that I do, and other support workers do, we get to know patients more, better, like we sort of spend more time chatting to them." P1

Relationships were described as developing gradually, through repeated contact and small interactions rather than formal therapeutic techniques:

"So it is literally just slowly chipping away to encourage them that they can. They can trust us. We're not going anywhere and just building that relationship with them." P12

Participants framed this relational presence as meaningful in and of itself, particularly for individuals who had experienced repeated relational ruptures. In this context, the relationship not only facilitated further intervention, sometimes it was the intervention:

"You know, if that's the only take home. If they don't go on with any more of the skills, but if they've actually received that compassion, then that's something, yeah." P8

5.2 Hope, validation, and creating safety

Participants described creating emotional safety through validation, listening, and attunement to service users' experiences. Being heard and understood was described as a central need for many individuals:

> *"She just wanted someone to listen, to really understand that, that, you know, she had a very difficult life and I didn't have to say much, but just give, give kind of like a, just listen to what she had to say and express that it was difficult and validate." P3*

Participants linked feelings of safety to being understood, suggesting validation helped reduce distress and support engagement:

> *"And then when that person understands that you understand them, they feel safe in your presence." P4*

Support workers also described holding hope on behalf of service users who struggled to envisage their recovery. This involved maintaining a supportive presence and offering reassurance through consistent engagement. Participants described positive feedback from service users as reinforcing the importance of this work:

> *"And them recognising it, because sometimes you, we may see it and they may not be able to recognise the progress. I think he's, when they recognise it and tell you that." P10*

5.3 Making sense of behaviour through a trauma informed lens

Participants described interpreting service users' behaviour through a trauma-informed lens, which shaped how they responded to distress, avoidance, or challenging interactions. This perspective reduced reactivity and supported compassionate responses:

> *"I mean they might be frustrated or angry, I don't take anything to heart that, they're unwell, they're with us for a reason" P2*

Rather than viewing behaviour as problematic or oppositional, participants described focusing on understanding experiences and histories:

"Kind of, I like the strengths-based approaches, that you focused on, I suppose less on what's kind of, less on what's wrong with them, but focusing on what's actually happened to them" P3

This trauma informed understanding supported relational safety by helping participants remain calm and attuned in the face of complexity whilst adapting a consistent approach to their work:

"I hold in mind that they've experienced complex trauma, but I, I would treat a person, any individual with empathy, and listen to, to, to what they have to say and, and learn from what they're saying." P8

Discussion

This study explored how Therapeutic Support Workers (TSWs) in adult community mental health services understand and experience their role when working with individuals who have experienced complex trauma. It also examined the value they perceive themselves as bringing to multidisciplinary teams, alongside the training, supervision, and support available to them in delivering trauma-informed care. The findings highlight the central contributions of TSWs within frontline trauma-informed practice, whilst also identifying significant challenges related to role clarity, professional identity, and emotional burden. Overall, the themes depict a workforce that is highly relational and flexible, yet inconsistently supported and often under-recognised and undervalued within service structures.

Understanding and experience of the role

Participants described their roles as flexible, relational, and largely shaped through experience rather than clearly defined professional frameworks, depicting a role that evolves as individuals encounter new situations, clinical presentations, and complexity. Importantly, participants' understanding of their role was closely tied to relational work which was described as central to engagement, suggesting that the capacity to establish and maintain safe therapeutic relationships is a core component of support work roles.

The reliance on experiential learning reported by participants is consistent with research suggesting that non-registered mental health staff often develop competence through practice

rather than structured professionals pathways (Wilberforce et al., 2017). Experience was associated not only with increased confidence but with clearer awareness of limitations, including greater comfort in seeking support or declining tasks beyond one's role. This boundary awareness appeared integral to working safely within the intensive relational contexts that were described.

Despite this ongoing learning and development, participants identified gaps in the preparation and training they received when first starting their role in relation to their understanding of complex trauma. Many participants described routinely working with trauma-related distress and complex presentations without access to structured training in trauma theory or formulation. This led to feelings of fear or uncertainty about causing additional distress or retraumatisation which has been shown to prevent clinicians from asking service users about their trauma histories or offering trauma-focused interventions (Coyle et al., 2019; Finch et al., 2020). These gaps appeared to shape how participants viewed the sustainability of the role, with several positioning support work as a stepping stone rather than a long-term professional identity. This aligns with findings that limited accreditation, training, or progression opportunities can undermine role legitimacy and retention (Scanlan et al., 2021).

Perceived value within multidisciplinary teams

Participants articulated a strong sense of contribution through flexibility, relational engagement, and responsiveness to complexity. The breadth of the role enabled integration of practical, emotional, and psychological support, often in less formal settings, facilitating engagement for individuals who might struggle to access structured or clinic-based interventions. However, although this adaptability allowed creative responses to service user needs, poorly defined boundaries contributed to strain and uncertainty within the role.

Participants also described supporting the wider team functioning by complementing the work of registered professionals, maintaining continuity of care, and holding contextual knowledge about service users that could inform assessments, care planning and psychological formulations. These findings support literature which highlights the role of non-registered professionals in providing relief to qualified staff and increasing authentic engagement with service users (Kessler et al., 2010).

However, this perceived value coexisted with experiences of role ambiguity. Poorly defined roles contributed to confusion among professionals and service users, with participants reporting that their role was often misunderstood or undervalued. This echoes findings that support workers feel undervalued within teams and view themselves as sitting at the bottom of the staff hierarchy (Kelly et al., 2024). This reflects broader findings that flexibility without clarity can increase vulnerability to devaluation despite central involvement in care (Scanlan et al., 2021), supporting recommendations for greater professionalisation, standardisation, and recognition of the role (Tudor et al., 2018).

Training, supervision, and support

Participants' described significant variability in access to supervision, training, and reflective spaces. Where available, supervision and team reflection provided containment, guidance, and reassurance, particularly when navigating complexity. However, supervision was frequently irregular, absent, or insufficient for the work being undertaken, raising concerns about the level of professional oversight afforded to support workers in some teams.

When combined with the emotional demands of working with trauma and complexity, and the level of risk and responsibility held by some participants, the absence of consistent clinical supervision and training may go some way towards explaining the increased emotional burden and uncertainty reported by participants. These findings align with literature on the emotional impact of trauma work and the need for reflective, clinical, supervisee-led supervision (Coleman et al., 2021), and suggests that trauma-informed practice must be supported structurally through these spaces (Berger & Quiros, 2014).

Clinical implications

The current findings have several implications for trauma-informed service design and workforce development. The central role of therapeutic support workers in engagement, stabilisation, and creating relational safety suggests that support work should be explicitly recognised as a core component of trauma-informed care pathways, rather than positioned as an adjunct to formal psychological therapy. Participants highlighted the clinical significance of stabilisation and preparatory work, including emotional regulation, psychoeducation, and relational groundwork, particularly when service users are awaiting therapy or are not yet ready to engage in trauma processing. This aligns with phase-based models of trauma treatment (Ford et al., 2005; Herman, 1998) and literature on the importance of considering

readiness for therapy (Norcross et al., 2011), supporting the view that this work constitutes a legitimate therapeutic intervention. Participants also described how support workers contribute to a fuller understanding of service users' presentations through their ongoing relational contact, suggesting they should be actively involved in team formulations and in advocating for readiness and appropriate timing of therapy. Importantly, support workers often play a key role in repairing relational ruptures and rebuilding trust in services following previous negative or invalidating experiences, creating a foundation for further therapeutic engagement. Many evidenced-based trauma therapies, including cognitive therapy for post-traumatic stress disorder (CT-PTSD; (Ehlers & Clark, 2000)), emphasise elements of behavioural activation or reclaiming life assignments, such as reducing avoidance, re-engaging with valued activities, and rebuilding a sense of agency and identity. Support workers can provide practical and motivational assistance to facilitate this reengagement which is vital for restoring a sense of agency and identity often eroded by prolonged trauma (Bell et al., 2019; Berman et al., 2020).

Second, the variability in training and supervision highlights the need for consistent access to trauma-informed training, reflective supervision, and team-based containment. Research suggests that investment in these areas may reduce anxiety, support safer practice, and protect staff wellbeing (Rose & Gallivan, 2019; Stacey et al., 2020). Given the level of responsibility described, governance structures should ensure that therapeutic support workers are adequately supported when working with considerable levels of risk and complexity. In addition to this, clarifying the scope and boundaries of the support worker role could help reduce role ambiguity and professional undervaluation, whilst preserving the flexibility that participants identified as essential. This aligns with previous findings suggesting that whilst support workers allow community teams to meet the varied needs of service users, there is a need for managers to ensure that there is clarity around the role and professional boundaries (McCrae et al., 2008). Explicit recognition of the contribution support workers make to multidisciplinary teams could go some way to enhancing collaboration between professionals as well as improving staff retention and service user outcomes.

These findings can be aligned with the broader context of the NHS Long Term Plan (NHS, 2025) and its emphasis on integrated, place-based models of care. Support workers are well positioned to contribute to place-based approaches by working across organisational and systemic boundaries, maintaining continuity, and supporting engagement with local

resources. Their ability to bridge gaps between services and communities suggests that they may be key enablers in achieving more joined-up, person-centred care. However, for this potential to be realised, investment in training, supervision, and role development is essential.

Critical appraisal and recommendations for future research

This study offers a novel and in-depth exploration of the experiences of therapeutic support workers working with individuals with a history of complex trauma, addressing a notable gap in the literature. A key strength lies in its focus on an under-researched yet increasingly relied upon workforce, whose contributions to trauma-informed care are often overlooked. The use of reflexive thematic analysis allowed for rich, nuanced accounts of relational work, emotional labour, and role ambiguity to be captured across participants from multiple NHS trusts and teams, enhancing the credibility and depth of the findings. The analytic process was strengthened by reflexive practices and supervisory discussion, supporting transparency and rigour in interpretation.

However, several limitations should be considered when interpreting the findings. The study focused exclusively on the perspectives of support workers, providing valuable insight into their lived experience but offering only a partial view of the wider system. As such, the findings do not capture how the support work role is experienced by service users, carers, or other professionals within multidisciplinary teams. Future research would benefit from incorporating these perspectives to develop a more comprehensive understanding of how support worker roles are perceived, valued, and integrated within trauma-informed services. In particular, exploring service users' experiences of relational safety, continuity, and stabilisation work delivered by support workers would help to clarify the clinical impact of this role from those receiving care.

The sample size was relatively small, and participation was voluntary, which may have introduced self-selection bias, with participants potentially holding particularly strong views about their role. Additionally, whilst participants were recruited from a range of NHS community services, the findings may not be transferable to other contexts such as inpatient, crisis, or non-NHS settings. The wide variability and heterogeneity of the support worker roles may further complicate interpretations. Although this variability was a central finding of the study, it also limits the extent to which conclusions can be drawn about a clearly defined or standardised role. Additionally, participants varied considerably in their length of

experience, with several having been in post for less than one year. This may have limited some participants' exposure to the full range of role demands. Future research might use comparative or case study designs to examine how differences in role definition, supervision structures, and service models shape both staff experiences and service user outcomes.

As with all qualitative research, the findings are co-constructed through the interaction between researcher and data. The lead researcher's professional background within mental health services, including experience in support roles, likely enhanced rapport and contextual understanding, but may also have influenced analytic focus and interpretation. Reflexive strategies were utilised to mitigate this although alternative interpretations are still possible.

Building on these findings, future research could examine specific areas of the support worker experience in more depth such as workforce role satisfaction, burnout, and the development of professional identity. Longitudinal studies may be particularly useful in understanding how confidence, boundaries, and emotional impact evolve over time. Further research is also needed to explore how support work roles function within emerging place-based and integrated models of care. Such research would support clearer articulation of the role within trauma-informed systems and inform workforce planning, training, and supervision structures that protect both staff wellbeing and quality of care.

Conclusion

This study examined how therapeutic support workers working with individuals who have a history of complex trauma understand and experience their role, the value they perceive themselves as bringing to multidisciplinary teams, and the support available to them in delivering trauma-informed care. In doing so, it highlights both the indispensable contribution of support workers and the structural vulnerabilities within which their work is undertaken. Therapeutic support workers occupy a central, relational position within adult mental health services, supporting engagement, relational safety, and continuity of care. However, inconsistent training, supervision, and role ambiguity risk undermining both staff wellbeing and service quality. Recognising and investing in the support work role is essential if trauma-informed principles are to be meaningfully embedded within adult mental health services in order to support those with a history of complex trauma.

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Chapter Five: Discussion and Critical Evaluation

This thesis systematically reviewed and analysed the available data on the prevalence of exposure to childhood abuse and neglect in adults accessing specialist mental health services and explored the role and experiences of therapeutic support workers within these services who work with individuals who have experienced complex trauma. This chapter provides a critical and integrative discussion of the findings presented within this portfolio. Drawing on both the systematic review and the empirical study, it considers what this body of work contributes to existing knowledge on complex trauma in adult mental health services, evaluates the strengths and limitations of the research, and reflects on the clinical, theoretical, and practical implications for trauma-informed care. In doing so, this chapter situates the findings within the broader clinical psychology literature.

Overview of Results

Whilst each study addressed a distinct research question, when considered together, the findings highlight both the scale of childhood trauma exposure among adults accessing specialist mental health services and the implications of this reality for the workforce tasked with delivering care within these trauma saturated systems.

At a broad level, the systematic review demonstrated that experiences of childhood abuse and neglect are highly prevalent among adults accessing specialist mental health services. Although prevalence estimates varied considerably across studies, the overarching conclusion was that interpersonal childhood trauma is common within this population rather than the exception, with around 66% of individuals accessing these services having potentially experienced some form of childhood abuse or neglect. This finding provides an important case for the implementation of trauma-informed approaches, reinforcing the need for services to assume a high likelihood of trauma exposure when working with adults presenting with complex mental health difficulties. However, the review also highlighted substantial heterogeneity, suggesting that the prevalence estimates may be shaped not only by true differences between populations, but also by variability in assessment practices, service context, and conceptualisations of trauma.

The empirical study extends this prevalence-level understanding by exploring how complex trauma is encountered and managed within everyday service provision. By foregrounding the

experiences of therapeutic support workers, the study offers insight into what high levels of childhood trauma exposure mean in practice for those delivering frontline care. Support workers described working routinely with individuals whose current difficulties were shaped by complex trauma histories, often in the context role ambiguity and emotionally demanding situations. These accounts provide a critical perspective on how trauma-informed care is enacted within adult mental health services, highlighting both the centrality of relational work and the challenges inherent in sustaining this work within existing organisational structures.

A key insight arising from these findings concerns the relationship between prevalence and preparedness. Whilst the review demonstrates that exposure to childhood trauma is widespread, the empirical findings raise questions about the extent to which services and staff are adequately supported to respond to this reality. Support workers often occupy a pivotal position in delivering trauma-informed principles through sustained relational contact, and may hold detailed, contextually grounded knowledge of service users' experiences. However, their accounts highlight variability in training, supervision, recognition, and inclusion within psychological formulation processes. This apparent mismatch between the scale of trauma exposure and the consistency of workforce support suggests that high prevalence does not necessarily equate to systemic readiness for trauma-informed care. Strengthening preparedness may therefore require more consistent integration of support workers within multidisciplinary formulations, enabling the development of shared understandings and more supportive networks around service users and the staff involved in their care.

Additionally, the heterogeneity observed in prevalence estimates mirrors the diversity of experiences described by support workers across service contexts. Together, these findings suggest that responses to complex childhood trauma within adult mental health services are shaped by organisational factors as much as by individual need. Differences in assessment practices, service models, and workforce structures may influence not only how trauma is identified, but also how it is understood and responded to in practice. This reinforces the importance of viewing trauma-informed care as an organisational and systemic priority, rather than solely as a set of individual clinical skills.

When considered together, the findings of the systematic review and empirical study demonstrate how complex childhood trauma functions as a systemic feature of adult mental health services, rather than solely as an individual characteristic. The studies highlight a clear

disconnect between the extent of trauma exposure within service populations and the degree to which services are equipped to support trauma-informed practice at a workforce level. This underscores that responding to complex trauma requires not only awareness of its prevalence, but organisational structures that adequately support assessment practices, role clarity, supervision, and the sustainability of relational work within adult mental health services.

Critical Evaluation

The findings of the systematic review are broadly consistent with existing literature demonstrating elevated rates of childhood abuse and neglect among individuals with mental health difficulties compared to the general population (Madigan et al., 2023). Previous epidemiological and clinical studies have repeatedly identified strong associations between adverse childhood experiences and a wide range of mental health outcomes including mood disorders, psychosis, personality difficulties, and complex post-traumatic stress presentations (Felitti et al., 1998; Freeman & Fowler, 2009; Jansen et al., 2016; Johnson et al., 1999; Kuzminskaite et al., 2022). By synthesising prevalence estimates specifically within specialist mental health services, the review extends this literature by situating interpersonal childhood trauma as a key feature of secondary and tertiary care populations, rather than a historic risk factor relevant only to particular diagnostic groups.

The high degree of heterogeneity identified in the review aligns with existing critiques of the literature, which highlight substantial variability in assessment methods (Newson et al., 2020), as well as variation in the categorisation and identification of various forms of childhood maltreatment (Massullo et al., 2023). Prior research has noted that retrospective self-report measures, clinical interviews, and record-based assessments often yield markedly different prevalence estimates (Read et al., 2018), raising questions about comparability across studies. The present review reinforces these concerns, suggesting that variability in reported prevalence reflects not only differences in underlying populations but also inconsistencies in how trauma is conceptualised and measured across research and clinical contexts. Greater methodological consistency may therefore be warranted, including routine use of validated and standardised measures of childhood adversity, such as the Childhood Trauma Questionnaire (Bernstein et al., 1998) or the Adverse Childhood Experiences Questionnaire (Felitti et al., 1998), to enhance comparability, transparency, and interpretability across research contexts.

The empirical findings resonate with existing research examining trauma-informed care and the experiences of frontline mental health staff. Previous studies have emphasised the central role of relational safety, emotional containment, and consistency in supporting individuals with a history of complex trauma (Chouliara et al., 2024), as well as the emotional demands placed on staff delivering this work (Coleman et al., 2021). The accounts of therapeutic support workers in the present study echo themes relating to fears of retraumatisation seen in other professional groups (Finch et al., 2020), while extending the literature by focusing on a workforce group that has received comparatively limited attention. In particular, the findings contribute to emerging discussions regarding role ambiguity, emotional labour, and the sustainability of trauma-informed practice within under-resourced services.

Taken together, the portfolio adds to the existing literature by addressing both the prevalence of childhood trauma within specialist mental health settings and the experiences of staff working within these contexts. Although these questions are often examined separately, the findings highlight how widespread trauma exposure shapes everyday service delivery. This reinforces arguments within the literature that trauma-informed care should be conceptualised as an organisational and systemic priority (Bargeman et al., 2022).

Strengths and limitations

A key strength of this portfolio lies in its use of complementary methodologies to address complex clinical questions. The systematic review provides a robust synthesis of existing prevalence data from 38 separate studies, obtained from an in-depth search of four databases which has been shown to minimise the risk of publication bias (Song et al., 2002). The qualitative empirical study adds depth and contextual understanding by exploring how this prevalence is experienced by staff delivering frontline care. Together, these approaches allow for a more comprehensive understanding of childhood trauma at both the population and practice levels.

An additional strength is the applied focus of the empirical study, which foregrounds the perspectives of therapeutic support workers operating within real-world service contexts. By exploring the experiences of a workforce group that that is central to trauma-informed care, yet often under-represented in research, the study contributes novel insights with direct relevance to service design, supervision, and workforce development. The portfolio as a

whole is therefore well placed to inform clinically meaningful discussions about trauma-informed practice within adult mental health services.

However, several limitations should be considered when interpreting the findings. The studies included in the systematic review used a wide variety of assessment tools and definitions when considering what constituted abuse or neglect. This contributed to the substantial heterogeneity within the review which limits the precision with which the pooled prevalence estimates can be interpreted. Heterogeneity would usually be explored with further subgroup analysis and although this was completed to compare self-report and interview assessment methods, there were a range of other factors which it was not possible to explore due to the small number of studies within each group which would have rendered the analysis inconclusive (Sterne et al., 2011). Had this been possible, further post-hoc subgroup analysis comparing additional groups of study characteristics including specific assessment tools or questionnaires used, primary mental health presentation, service type, and participant characteristics such as gender, would have been conducted to assess whether prevalence estimates differed as a function of these factors. This would have potentially enabled the source of the heterogeneity to be identified and would have informed any nuance in the prevalence estimates.

The empirical study is also subject to limitations relating to sampling and service contexts. These findings are based on the experiences of therapeutic support workers within specific service contexts, which may limit their generalisability to other services or workforce groups. Although the recruitment from a range of NHS trusts and services can be seen as a strength, participants' accounts were variable and shaped by their organisational contexts, levels of training, and supervision structures, and may not reflect the experiences of support workers operating in differently resourced environments. Several participants had been in their current role for less than one year, which may have limited their exposure to the full range of challenges associated with supporting individuals who have experienced complex trauma. Consequently, some accounts may reflect the perspectives of staff who were still developing confidence and understanding within their role. However, the inclusion of participants at different stages of their careers may also be viewed as a strength. One of the key findings of the study was that knowledge and confidence were often developed through experience, supervision, and ongoing exposure to trauma-related work. Including participants with varying levels of experience therefore enabled exploration of how understandings of the role

developed over time and captured perspectives that may have been overlooked had the sample been restricted to more experienced staff. Furthermore, the aim of the study was not to establish expert consensus regarding support worker practice, but rather to understand how support workers experienced their role when working with individuals who had experienced complex trauma. In this respect, the perspectives of both newer and more experienced staff were considered valuable. Additionally, as with all qualitative research, the findings represent an interpretive account shaped by the analytic framework and the researcher's positioning and experience of working within these settings. However, wide generalisability is often not the aim of thematic analysis or qualitative research more broadly (Braun & Clarke, 2021). Instead, the focus tends to be on examining similarities and differences across participant accounts whilst also generating potentially unanticipated insights (Braun & Clarke, 2006).

The decision to exclude peer support workers from the empirical study also warrants consideration. Whilst peer support workers often work alongside support workers within mental health services and may provide similar forms of emotional and practical support, their roles are typically underpinned by the intentional use of lived experience as a core component of their practice (Repper, 2013). Peer support roles may therefore involve distinct role expectations, training pathways, supervision arrangements, and professional identities. Furthermore, there is a growing body of research exploring the experiences and contributions of peer support workers within mental health services (Kemp & Henderson, 2012; Walker & Bryant, 2013; Wall et al., 2022), whereas comparatively little attention has been paid to the experiences of non-peer support staff providing therapeutic support to individuals who have experienced complex trauma. The decision to focus specifically on non-peer support workers was therefore intended to address a gap within the existing literature and facilitate a more focused exploration of this under-researched workforce. Future research may benefit from exploring similarities and differences between peer and non-peer support roles in the delivery of trauma-informed care.

The methodological approaches adopted across the portfolio reflect deliberate choices aligned with the research questions under investigation. Alternative approaches could have generated different forms of knowledge. For example, quantitative survey methods might have enabled the collection of data from a larger sample of support workers, potentially increasing generalisability and allowing for statistical analysis of associations between training, supervision, and perceived preparedness for working with individuals who have experienced

complex trauma. Additionally, mixed-methods designs could have integrated such data with qualitative interviews to triangulate findings. Within the empirical study, alternative qualitative methodologies were also considered. A Grounded Theory approach may have been appropriate had the primary aim been to develop a novel theoretical model of support workers' experiences, whilst Framework Analysis may have offered a more structured approach to data management and analysis. However, these approaches were considered less consistent with the exploratory aims of the study and the critical realist position underpinning the research than Reflexive Thematic Analysis. Whilst these alternatives may offer distinct advantages, such as the potential for larger sample sizes or different forms of analytic output, they would have addressed different research questions and posed additional challenges. For example, given the variety in experiences reported by support workers, quantitative surveys would likely have lacked the rich contextual information needed to understand the experiences of this workforce. The methodological choices made in this portfolio therefore represent a considered balance between feasibility and the need to generate clinically meaningful insights. Nevertheless, recognising the limits of these choices is essential when considering the scope and generalisability of these findings.

Overall, the findings of this portfolio should be interpreted with an appropriate degree of caution, recognising both the strengths of the evidence and the limitations imposed by methodological and contextual factors.

Clinical and Theoretical Implications

These findings support formulation based models that conceptualise adult mental health difficulties as meaningfully shaped by early relational experiences (Johnstone & Dallos, 2013). The high prevalence of childhood abuse and neglect within specialist mental health services reinforces the value of formulations that prioritise developmental histories, attachment disruptions, and cumulative adversity when understanding complex and enduring difficulties. Participants' accounts suggest that support workers could play a key role in supporting systems to understand and support service users more effectively by drawing on sustained relational contact to contextualise service users' distress within their life histories and current circumstances. In doing so, they may help teams move beyond symptom-focused or diagnostically driven interpretations towards more developmentally and relationally informed perspectives. This position is consistent with the Power Threat Meaning Framework (Johnstone et al., 2018), which shifts the focus from "what is wrong with you?" to "what has

happened to you?" and emphasises the power, threat, and meaning in the development of psychological distress. In this context, the findings add weight to critiques of narrow, symptom-focused or diagnostically driven approaches, suggesting that without formulation-informed contributions, services may struggle to fully account for the relational and contextual origins of distress for a substantial proportion of service users.

The findings from the empirical paper further underscore the importance of relational and contextual theories of trauma (Pearlman & Courtois, 2005). Support workers' accounts highlight how trauma-related difficulties are often expressed and managed within ongoing relationships rather than discrete therapeutic episodes. This aligns with theoretical perspectives that view trauma recovery as embedded within sustained interpersonal processes, rather than solely within time-limited, protocol-driven interventions (Herman, 1998). Taken together, the findings support theoretical models that emphasise formulation-based, relationally informed approaches as central to effective work with individuals who have experienced complex trauma (Herman, 1998; Johnstone et al., 2018).

The findings of this portfolio have several implications for clinical psychology practice and multidisciplinary working within adult mental health services. In particular, they highlight the importance of routine trauma assessment, workforce training and supervision, and service designs that meaningfully support trauma-informed care. The high prevalence of childhood abuse and neglect identified in the systematic review suggests that routine and sensitive enquiry about trauma histories should be a core component of assessment within specialist mental health services, however previous findings suggest this may not currently be standard practice (Read et al., 2007). Importantly, the present findings suggest that self-report measures yield comparable levels of disclosure to clinical interviews, indicating that structured questionnaires may offer a feasible and effective mechanism for identifying trauma histories in contexts where services are stretched or clinicians are concerned about retraumatisation.

Additionally, the empirical findings indicate that support workers often receive little or no training in how to ask about trauma, particularly in relation to less overt forms of adversity such as emotional abuse or neglect. This raises concerns about the extent to which trauma histories are consistently identified and integrated into formulations and care planning. Failure to acknowledge or explore past trauma may have implications for the effectiveness of

treatment, particularly where interventions focus narrowly on presenting difficulties without attending to their developmental origins. From a clinical psychology perspective, this underscores the importance of ensuring that trauma enquiry is embedded within assessment processes and supported by appropriate training, supervision, and clear guidance regarding the recognition and support for those with complex trauma histories.

The empirical findings highlight therapeutic support workers as a key workforce group in delivering relationally focused, trauma-informed care, often through sustained contact with service users. Despite this, participants described variability in access to training, supervision, and role clarity. These findings suggest a need for greater standardisation and investment in workforce development and point to the potential value of establishing clearer standards regarding the frequency and quality of supervision for support workers. Regular, structured, clinical supervision may be particularly important given the emotional demands of trauma-informed work and the risks of burnout, boundary difficulties, and uncontained emotional labour. Clinical psychologists are well placed to contribute to the development and delivery of such supervision models, drawing on their expertise in formulation, reflective practice, and trauma-informed approaches.

There are also implications for the content of core training for support workers. The findings suggest a need for training that explicitly addresses difficult conversations, boundaries and endings, and how to structure work within less formal or unstructured roles. In addition, training in psychologically informed skills such as grounding and behavioural activation may enhance support workers' capacity to work effectively with individuals experiencing chronic and complex difficulties. Ensuring that training includes guidance on recognising and sensitively enquiring about different forms of trauma, including emotional abuse and neglect, is particularly important to support their understanding of the individuals they are working with. Evidence from evaluations of trauma-informed care training programs in mental health services indicates that structured training can improve clinicians confidence, attitudes, and capacity to apply trauma-informed principles in practice (Palfrey et al., 2019), and enhance practitioners knowledge and ability to integrate trauma-informed approaches into care planning (Stewart et al., 2024). At a service level, the findings highlight the importance of clearly defining and contracting the role of therapeutic support workers within trauma-informed systems. Ambiguity regarding role expectations and responsibilities may increase emotional burden and reduce the consistency of care delivered to service users (Scanlan et al.,

2021; Tubre & Collins, 2000). Greater clarity and standardisation regarding the remit, limits, and aims of support work may help to protect both staff wellbeing and service quality.

The implications of this portfolio align closely with current NHS policy emphasising trauma-informed, person-centred, and psychologically informed care (NHS England, 2025). National guidance increasingly recognises the impact of adverse childhood experiences on mental health (Public Health England, 2020) and the importance of workforce wellbeing and supervision (NHS England, 2021). The findings of this portfolio provide empirical support for these priorities, particularly in relation to the role of support workers within multidisciplinary teams. Clinical psychologists play a key role in supporting the translation of policy into practice, including contributing to service design, workforce training, and supervision structures (British Psychological Society, 2017). By supporting clearer role definitions, standardised supervision expectations, and psychologically informed training pathways for support workers, clinical psychologists can help to embed trauma-informed care more sustainably within adult mental health services. In this way, the findings of this portfolio contribute not only to academic knowledge but also to ongoing discussions about how NHS services can respond more effectively to the pervasive impact of childhood trauma.

Recommendations and Future Research

Whilst this portfolio contributes to the understanding of childhood trauma within adult mental health services, several avenues for future research would strengthen and extend this work. Firstly, future studies should prioritise the inclusion of service user perspectives. The current programme of research foregrounded prevalence data and workforce experiences, however, a fuller account of trauma-informed care requires direct exploration of how service users experience trauma enquiry and relational support. In particular, research exploring how service users experience support work intervention, including the nature of relational contact, boundaries, consistency, endings, and practical or psychologically focused work, would provide valuable insight into the distinct contribution of this role within multidisciplinary teams. Understanding whether service users feel heard, validated, and safely contained when discussing childhood adversity, and how they experience ongoing support work input, would offer important information about the effectiveness, acceptability, and perceived value of current practices.

Secondly, longitudinally focused research would offer greater clarity regarding how trauma-informed approaches influence outcomes over time. Cross-sectional and retrospective designs can identify prevalence and capture staff experience, but they cannot determine how routine trauma enquiry, supervision structures, or training initiatives shape service user trajectories or workforce wellbeing in the longer term. Prospective or repeated measures designs could examine whether improvements in trauma-informed service delivery are associated with changes in clinical outcomes, engagement, or staff retention.

Finally, broader system-level evaluations are needed. Future research could examine whole-service or multi-site implementations of trauma-informed models. Evaluations that integrate service-level outcomes such as training uptake, supervision frequency, and staff wellbeing with service user outcomes could help to determine how trauma-informed principles translate into measurable change. Mixed-methods designs may be particularly valuable in capturing both experimental and outcome-level data.

Personal Reflections

The critical realist stance within which this research was conducted emphasises the active role of the researcher across the research process (Maxwell, 2012) and the importance of researcher reflexivity (Watt, 2007). Reflexivity involves critically examining how one's experiences, assumptions, and values shape the research process, and is particularly important for novice researchers (Gough, 2017). Throughout the research process I have been mindful of the ways in which my personal and clinical experiences, professional identity, and developing theoretical commitments may have influenced the questions I asked, the interpretations I made, and the aspects of the data that felt most salient.

I was drawn to this topic following professional experience within a community mental health psychology team where I observed the central role of therapeutic support workers in engaging individuals with complex trauma histories. Witnessing both the relational depth of this work and the pressures experienced by staff shaped my interest in exploring how childhood trauma is encountered within adult services. This positioning offered advantages, including familiarity with service structures and an understanding of the contextual demands facing participants. However, it also carried the risk of pre-existing assumptions about workforce challenges and trauma-informed practice. To mitigate this, I maintained a reflexive diary throughout the research process (Gabriel, 2015), documenting moments where I noticed

strong emotional reactions, assumptions about likely themes, or tensions between my expectations and the data. Regular research supervision provided an additional space to examine how my positioning might be shaping analysis and ensured that themes remained grounded in participants' accounts rather than privileging interpretations that aligned with my prior expectations. I achieved this by repeatedly returning to the coded transcripts and verbatim extracts to check that each theme was directly supported by participants' words, and by refining or reshaping themes where we noticed that my interpretations were extending beyond what had been expressed.

A further consideration relates to the shift in my professional identity over time. Prior to beginning clinical psychology training, I worked in support worker roles similar to those held by many participants. Whilst this provided a degree of shared understanding, I was also conscious that, at the time of conducting the research, I occupied a different position within professional hierarchies. Although trainee clinical psychologists do not hold managerial authority, the role is often afforded greater status, influence, and access to decision-making within mental health services. I was therefore mindful that participants may have viewed me not only as someone who had previously undertaken similar work, but also as a representative of a profession that can hold greater power within multidisciplinary teams. This awareness encouraged me to remain curious about participants' experiences rather than assuming shared perspectives and to pay particular attention to accounts describing feeling overlooked, undervalued, or excluded from clinical decision-making. Reflecting on these dynamics helped me to recognise how power operates within both research relationships and mental health services more broadly.

Being immersed in trauma research and literature at this level presented both intellectual and emotional challenges. Engaging with literature detailing high rates of childhood abuse and neglect, alongside hearing staff accounts of working with distressing material, required careful attention to my own emotional boundaries. At times, I noticed a pull towards responding from a clinical stance rather than a research one, particularly when participants described feeling unsupported or uncertain within their roles. Remaining within the researcher role, whilst acknowledging empathy and respect for participants' experiences, required conscious reflection. I was mindful that providing space for participants to articulate their experiences may in itself have been experienced as validating, but I also remained aware

of the ethical responsibility to avoid slipping into informal supervision or therapeutic conversations.

The ethical dimensions of researching trauma extended beyond participant wellbeing to considerations of how the findings might impact services. Presenting themes relating to workforce strain, gaps in training, or systemic limitations required balancing transparency with fairness. I was conscious of holding responsibility both to participants, whose accounts deserved accurate representation, and to services operating within broader structural constraints. This tension reinforced the importance of grounding interpretations carefully in the data and situating critiques within systemic rather than individual frames.

Conducting this research alongside clinical placements introduced additional complexity. The parallel demands of doctoral training required sustained organisation and emotional resilience, particularly when engaging in qualitative analysis whilst managing clinical responsibilities. However, the integration of research and practice was also a significant strength. The process deepened my appreciation for the centrality of trauma-informed thinking in everyday clinical work and increased my confidence in raising questions about trauma enquiry, supervision structures, and workforce wellbeing within teams. I became more attentive to how and when trauma histories are explored, and more reflective about the support needs of colleagues engaged in relationally demanding work. As a direct result of this work, I have also been able to contribute to the trauma-informed care training delivered within my current placement to wider clinical staff groups.

Overall, this research has shaped my developing professional identity. It has strengthened my commitment to formulation-based, contextually informed practice and reinforced the importance of considering both service user experience and workforce sustainability when advocating for trauma-informed care. Engaging in reflexive practices throughout the research process has highlighted the inseparability of researcher and clinician roles within professional training and the value of critical self-awareness in both domains. I wholeheartedly believe that the work on this research portfolio will influence my clinical practice as I move into qualified roles and progress through my career.

Conclusion

This portfolio has examined childhood abuse and neglect within adult mental health services from both an epidemiological and applied perspective. The systematic review highlighted the high prevalence of childhood trauma among individuals accessing specialist mental health services, reinforcing the position that trauma exposure is not peripheral but central to understanding adult mental health presentations. The empirical study extended this understanding by exploring how trauma is encountered within everyday service delivery, foregrounding the experiences of therapeutic support workers who operate at the relational frontline of care.

Taken together, the work contributes to the literature by linking population-level evidence with service-level realities. It underscores the importance of viewing trauma-informed care not only as a clinical aspiration but as an organisational responsibility requiring appropriate assessment practices, workforce training, supervision structures, and role clarity. By drawing attention to the distinct contribution of support work within multidisciplinary teams, the portfolio also highlights an area of practice that is central to service delivery yet often under-theorised and under-researched.

For the wider profession of clinical psychology, this work has particular relevance. Clinical psychologists are uniquely positioned at the intersection of formulation, service development, supervision, and systems leadership. These findings reinforce the importance of developmentally informed, formulation-based approaches that attend to what has happened to individuals rather than solely to symptom presentations. They also point to the profession's role in shaping trauma-informed systems through providing reflective clinical supervision, training, and advocating for psychologically informed service structures.

Ultimately, this portfolio argues that acknowledging the pervasive impact of complex childhood trauma is not only a matter of individual clinical competence but of systemic responsibility. By integrating prevalence data, workforce experiences, and reflexive consideration of practice, this work contributes to ongoing efforts to embed trauma-informed principles within adult mental health services in a way that is sustainable, ethical, and clinically meaningful. In doing so, it reflects the broader commitment of clinical psychology to understanding distress within its relational, developmental, and social context, and to

translating that understanding into practice that supports both service users and the professionals who work alongside them.

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Appendices

Appendix A – Author Guidelines for Psychological Medicine

Preparing your materials

Important notice: We have become aware that there are websites such as University Press Journals, Association of British University Presses and International Agency for Development of Culture, Education and Science (IADCES) which are claiming to offer publication in certain Cambridge University Press journals for a fee. We do not work with such companies. Submissions to Cambridge University Press journals can only be made via the online peer review systems linked to from this Cambridge Core website, or else directly to the editorial offices of those journals that do not operate online peer review systems. To submit a paper, go to the 'Submission of manuscripts' section below and follow the instructions. For more information on predatory publishing, please visit the Think Check Submit website

Please see the below table for the types of papers accepted:

Article Type	Usual Max Word count*	Abstract	References	Tables/figures**	Supplementary material online only	Eligible for Transformative Agreement(opens in a new tab)Coverage
Original article	4500	250 words, structured, using subheadings Background, Methods, Results, Conclusions	APA style – see elsewhere in this document for full details	Usually up to 5 total	Yes	Yes
Review article	4500	250 words, not structured	APA style	Usually up to 5 total	Yes	Yes
Editorial	3500	No	APA style	Usually up to 5 total	Yes	No
Correspondence* **	1500	No	max 20	Max 1	No	No

			APA sty le			
Commentary	2000 By invitati on of editor	No	max 20 APA style	Not usually	Yes	No

*** Editors may request shortening or permit additional length at their discretion in individual cases**

**** May be adjusted in individual cases at Editors' discretion**

***** Please note, Correspondence papers must be in response to content published in *PSM***

Generally papers should not have text more than 4500 words in length (excluding abstract, tables/figures and references) and should not have more than a combined total of 5 tables and/or figures. Papers shorter than these limits are encouraged. For papers of unusual importance the editors may waive these requirements. Articles require a structured abstract of no more than 250 words including the headings: Background; Methods; Results; Conclusions. Review Articles require an unstructured abstract of no more than 250 words. The name of an author to whom correspondence should be sent must be indicated and a full postal address given in the footnote. Any acknowledgements should be placed at the end of the text (before the References section).

Contributors should also note the following:

1. 1. S.I. units should be used throughout in text, figures and tables.
2. 2. Authors should spell out in full any abbreviations used in their manuscripts.
3. 3. Foreign quotations and phrases should be followed by a translation.
4. 4. If necessary, guidelines for statistical presentation may be found in: **Altman DG., Gore SM, Gardner, MJ. Pocock S** <="" strong="" style="box-sizing: border-box;">(1983). Statistical guidelines for contributors to medical journals. *British Medical Journal* **286**, 1489-1493.

Neuroscience-based Nomenclature

For papers concerning neuropsychopharmacological treatments, *Psychological Medicine* encourages authors to utilize the 'Neuroscience-based Nomenclature' developed by the ECNP Taskforce on Nomenclature. The need for such a change arose to address a longstanding concern within the neuropsychopharmacological community that the nomenclature of psychotropic drugs did not properly reflect the underlying neuroscience of these compounds, as well as being unhelpful to clinicians and confusing to patients (e.g. the prescription of 'antipsychotics' for depression).

More information about the nomenclature can be found on the ECNP website here, website here, and in the paper here. The Neuroscience-based Nomenclature (NbN) itself is available free of charge as a mobile app (for both Android and iOS devices).

References

The guidelines set forth in the *Publication Manual of the American Psychological Association* (6th ed.) should be used in the text and a complete list of References cited given at the end of the article.

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Type of citation	First citation in text	Subsequent citation int text	Parenthetical format, in first citation	Parenthetical format, Subsequent citation int text
One work by one author	Walker (2007)	Walker (2007)	(Walker, 2007)	(Walker, 2007)
One work by two authors	Walker and Allen (2004)	Walker and Alien (2004)	(Walker & Allen, 2004)	(Walker & Alien, 2004)
One work by three authors	Bradley, Ramjrez, and Soo (1999)	Bradley et al. (1999)	(Bradley, Ramirez, & Soo, 1999)	(Bradley et al., 1999)
One work by four authors	Bradley, Ramirez, Soo, and Walsh (2006)	Bradley et al. (2006)	(Bradley, Ramirez, Soo, & Walsh, 2006)	(Bradley et al., 2006)
One work by five authors	Walker, Alien, Bradley, Ramirez, and Soo (2008)	Walker et al. (2008)	(Walker, Allen, Bradley, Ramirez, & Soo, 2008)	(Walker et al., 2008)
One work by six authors or more	Wasserstein et al. (2005)	Wasserstein et al. (2005)	(Wasserstejn et al., 2005)	(Wasserstejn et al., 2005)

The References section should be in alphabetical order. Examples follow:

Journal article Author's Last name, F. M. (Year published). Article title. *Journal Title, Volume*(Issue), pp.-pp.

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Light, M. A., & Light, I. H. (2008). The geographic expansion of Mexican immigration in the United States and its implications for local law enforcement. *Law Enforcement Executive Forum Journal*, *8*, 73–82. doi:XXX

Journal article without DOl (when DOl is not available) Good, C. D., Johnsrude, I. S., Ashburner, J., Henson, R. N. A., Firston, K. J., & Frackowiak, R. S. J. (2001). A voxel-based morphometric study of ageing in 465 normal adult human brains. *NeuroImage, 14,* 21–36. Retrieved from http://xxxx

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Journal article with DOl, more than seven authors Gilbert, D. G., McClernon, F. J., Rabinovich, N. E., Sugai, C., Plath, L. C., Asgaard, G., ... Botros, N. (2004). Effects of quitting smoking on EEG activation and attention last for more than 31 days and are more severe with stress, dependence, DRD2 A1 allele, and depressive traits. *Nicotine and Tobacco Research*, *6*, 249–267. doi:XXX

Journal article without DOl, title translated into English, print version Guimard, P., & Florin, A. (2007). Las evaluations des enseignants en grande section de maternelle sont-elles predictives des difficultes de lecture au cours préparatoire? [Are teacher ratings in kindergarten predictive of reading difficulties in first grade?]. *Approche Neuropsychologique des Apprentissages chez l'Enfant*, *19*, 5–17.

Journal article with DOI, advance online publication Von Ledebur, S. C. (2007). Optimizing knowledge transfer by new employees in companies. *Knowledge Management Research & Practice*. Advance online publication. doi: 10.1 057/palgrave.kmrp.8500141

In-press article Briscoe, R. (in press). Egocentric spatial representation in action and perception. *Philosophy and Phenornenological Research*. Retrieved from http://cogprints.org/5780/l/EC...

Citations for Websites

Author's Last name, F. M. (Year, Month Day published). Title of article or page. Retrieved from URL

Simmons, B. (2015, January 9). The tale of two Flaccos. Retrieved from http://grantland.com/the-trian...

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Appendix B – Systematic Review Supplementary Table 1 (PRISMA Checklist)

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	P16
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	P17
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	P18-19
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	P19
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	P20
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	P19
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	P20
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	P20-21
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	P21
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	P21
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	P26-28
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	P21-22
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	P22
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	P21
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary	P20-21

Section and Topic	Item #	Checklist item	Location where item is reported
		statistics, or data conversions.	
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	P20-21
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	P22
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	P22-23
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	P22-23
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	P22
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	N/A
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	P24
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	P21
Study characteristics	17	Cite each included study and present its characteristics.	P26-28
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	P26-28 Supplementary material
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	Supplementary material
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	P29-30
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	P30
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	P30-31
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	P29-30
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	P31 Supplementary material

Section and Topic	Item #	Checklist item	Location where item is reported
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	N/A
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	P31-33
	23b	Discuss any limitations of the evidence included in the review.	P34-35
	23c	Discuss any limitations of the review processes used.	P34-35
	23d	Discuss implications of the results for practice, policy, and future research.	P33-35
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	P19
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	N/A
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	N/A
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	N/A
Competing interests	26	Declare any competing interests of review authors.	N/A
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	N/A

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71. This work is licensed under CC BY 4.0. To view a copy of this license, visit https://creativecommons.org/licenses/by/4.0/

Appendix C – Systematic Review Supplementary Table 2 (Quality Appraisal Criteria)

JBI Item	What It Means	How to Operationalise/Score
1. Was the sample frame appropriate to address the target population?	Does the sampling frame represent the full population of interest?	*Yes if:* The study recruited from the full caseload or registry of adults accessing the identified service (e.g. community mental health team, specialist clinic). *No if:* The sample frame is restricted (e.g. single ward, private practice patients, convenience sample, or a sub-group not representative of the wider service users).
2. Were study participants sampled in an appropriate way?	Was a representative and unbiased sampling method used?	*Yes if:* Participants were randomly or consecutively recruited from eligible service users, or if all eligible service users in a defined period were included. *No if:* Recruitment was based on convenience, clinician referral only, self-selection, or unclear method that may introduce bias.
3. Was the sample size adequate?	Was the study large enough to give precise estimates?	*Yes if:* Sample size calculation reported, or ≥100 participants in a single setting, or a large service-based or national sample. For smaller studies (N = 50-100), assess whether the 95% confidence interval around the trauma prevalence is narrow (±10%) or whether the sample size is adequately justified and aligned with the aims of the study. *No if:* No rationale for sample size and N<50 without justification or sample size is N = 50-100 and CI's are wide or not reported or sample size is not adequately justified and aligned with the aims of the study.
4. Were the study subjects and the setting described in detail?	Can readers judge if the findings apply to other contexts?	*Yes if:* Age, gender, diagnosis, service type (e.g., CMHT, psychosis team), and country/region are clearly described. *No if:* minimal demographic or service information provided, or setting not defined (e.g., just says "mental health service" without details).
5. Was data analysis conducted with sufficient coverage of the identified sample?	Were all relevant subgroups adequately represented?	*Yes if:* The authors report how many eligible participants were approached, how many participated, and if there were no large differences between responders/non-responders.

		No if: Response rates are unclear or show selective participation (e.g., only those willing to discuss trauma).
6. Were valid methods used for the identification of the condition?	Was trauma exposure assessed using a valid measure?	*Yes if:* Childhood trauma was measured using a validated instrument specifically assessing childhood trauma exposure in either self-report or interview format (e.g., CTQ, CECA, ACE-Q) OR trauma assessed using a generic measure of trauma exposure (e.g. THQ, Trauma Assessment for Adults, Life Stressor Checklist) in interview format only, OR assessed using a specified clinical interview (e.g., SCID, CAPS, NEMESIS). *No if:* Trauma assessed using a generic measure of trauma exposure in a self-report format only (e.g. THQ, Trauma Assessment for Adults, Life Stressor Checklist), OR unspecified clinician interview.
7. Was the condition measured in a standard, reliable way for all participants?	Was the same tool used consistently and reliably?	*Yes if:* Same assessment tool used for all participants; assessors trained; clear instructions provided; standardized administration. *No if:* Measure varied across participants or settings, or administration procedures differed.
8. Was there appropriate statistical analysis?	Was the analysis suitable and clearly reported?	*Yes if:* Prevalence estimates presented as clear frequencies for the whole sample; subgroup analyses justified and clear. *No if:* Prevalence reported in percentages or inappropriate/unclear aggregation of trauma types.
9. Was the response rate adequate, and if not, was the low response rate managed appropriately?	Did enough people participate, and were non-responders handled?	*Yes if:* No missing data or ≥70% response rate within sample with missing data acknowledged and addressed and authors compared responders vs. non-responders and found no major bias. *No if:* Response rate <70% with no discussion of bias or missing data handling.

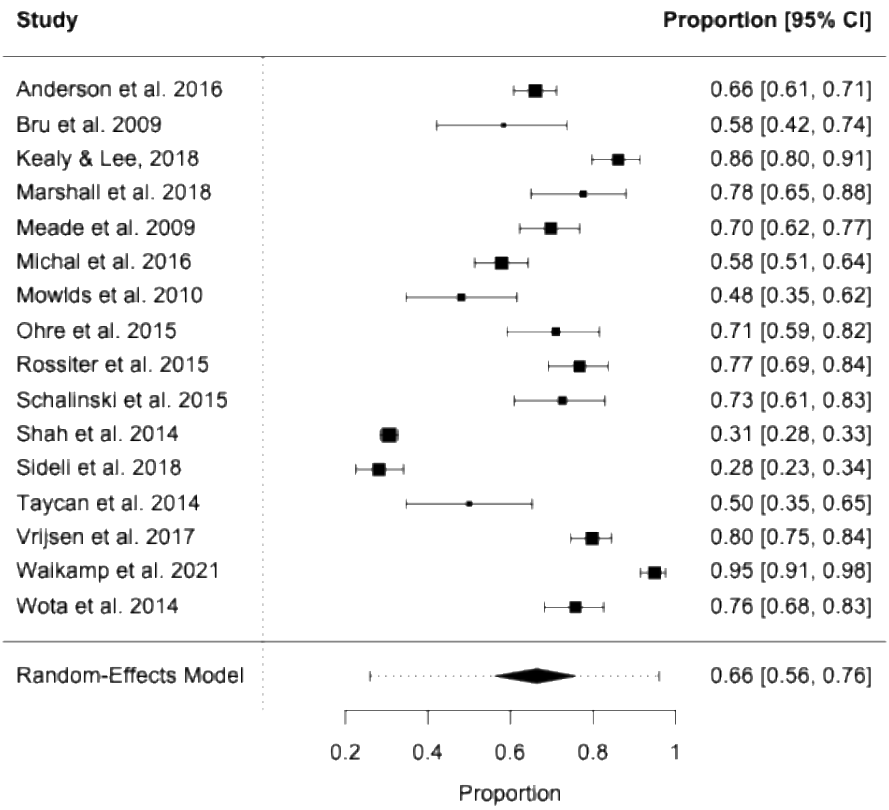
Appendix D – Systematic Review Supplementary Table 3 (Full Quality Ratings)

	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7	Item 8	Item 9	Total score	Quality rating
Anderson et al. 2016	1	1	1	1	1	1	1	0	1	8	High
Barnes et al. 2021	0	1	1	0	0	1	1	1	1	6	Moderate
Bru et al. 2009	0	1	0	1	0	0	1	1	1	5	Low
Bruni et al. 2018	0	1	1	1	0	1	1	1	1	7	Moderate
Cusack et al. 2007	1	1	1	1	1	1	1	0	1	8	High
Foote et al. 2006	1	1	1	1	1	0	0	1	0	6	Moderate
Ford & Fournier, 2007	0	0	0	1	0	1	1	1	1	5	Low
Fung et al. 2019	0	1	1	1	0	1	1	0	1	6	Moderate
Gearon et al. 2003	0	0	0	1	0	1	1	1	1	5	Low
Gloger et al. 2021	1	1	1	1	0	1	1	0	1	7	Moderate
Kealy & Lee, 2018	1	1	1	1	0	1	1	1	0	7	Moderate
Lu et al. 2008	1	1	1	1	0	1	1	1	1	8	High
Lysacker et al. 2001	0	0	0	1	0	1	1	1	1	5	Low
Marshall, et al. 2018	1	1	0	1	1	1	1	0	1	7	Moderate
Meade et al. 2009	1	0	1	1	0	1	1	1	1	7	Moderate
Michal et al. 2016	0	1	1	1	0	1	1	0	0	5	Low
Moodley et al. 2023	0	0	1	1	0	1	1	1	1	6	Moderate
Mowlds et al. 2010	1	1	0	0	1	1	1	1	1	7	Moderate
Mueser et al. 1998	1	0	1	1	1	1	1	0	1	7	Moderate
Mulligan et al. 2025	0	0	1	1	0	1	1	0	1	5	Low
Nagar et al. 2020	1	0	1	0	0	1	1	1	1	6	Moderate
Ohre et al. 2015	1	1	0	1	1	0	0	0	1	5	Low
Rienecke et al. 2022	1	1	1	1	1	1	1	0	1	8	High
Rosenberg et al. 2007	0	0	1	1	0	1	1	1	1	6	Moderate
Rossiter et al. 2015	1	1	1	1	0	1	1	1	1	8	High

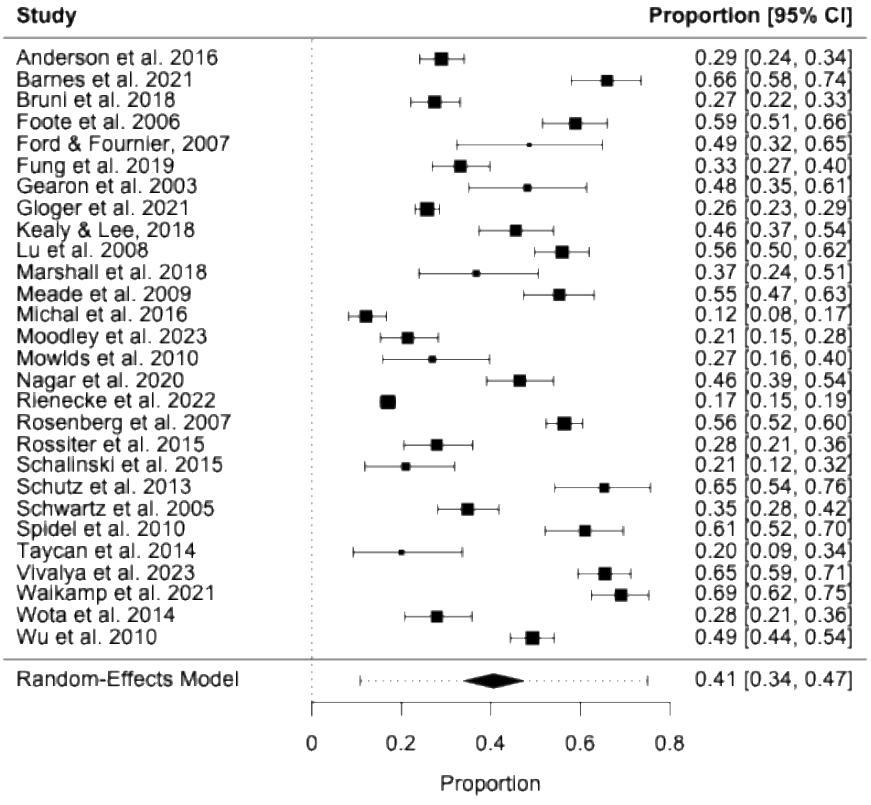
	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7	Item 8	Item 9	Total score	Quality rating
Schalinski et al. 2015	0	0	0	1	0	1	1	0	0	3	Low
Schutz et al. 2013	1	1	1	1	1	1	1	1	1	9	High
Schwartz et al. 2005	0	1	1	1	1	1	1	1	1	8	High
Shah et al. 2014	1	1	1	1	1	0	1	1	1	8	High
Sideli et al. 2018	1	1	1	1	0	1	1	0	1	7	Moderate
Spidel et al. 2010	1	1	1	1	0	1	1	0	0	6	Moderate
Steel et al. 2004	1	0	1	1	1	0	1	1	1	7	Moderate
Taycan et al. 2014	1	1	0	1	1	1	1	1	1	8	High
Vivalya et al. 2023	0	1	1	1	0	1	1	1	1	7	Moderate
Vrijsen et al. 2017	0	1	1	0	0	1	1	1	0	5	Low
Waikamp et al. 2021	1	1	1	1	1	1	1	0	1	8	High
Wota et al. 2014	1	1	1	1	0	1	1	1	1	8	High
Wu et al. 2010	1	0	1	1	0	1	1	1	1	7	Moderate

Appendix E – Systematic Review Supplementary Figures 1-6 (Forest Plots)

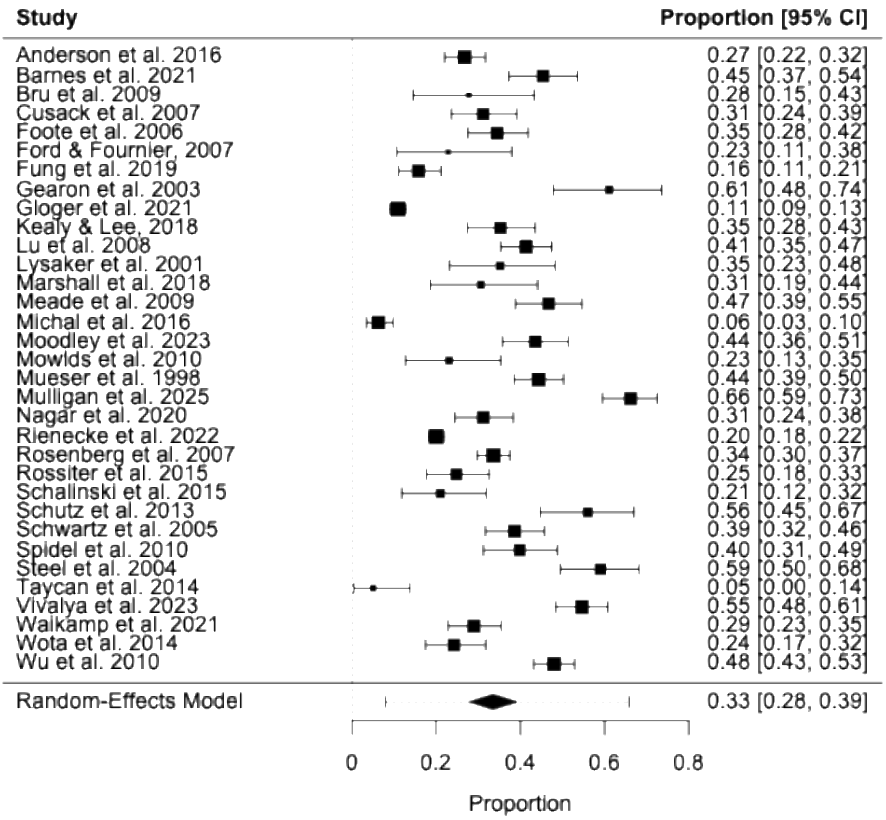
Appendix E.I – Any type of abuse/neglect



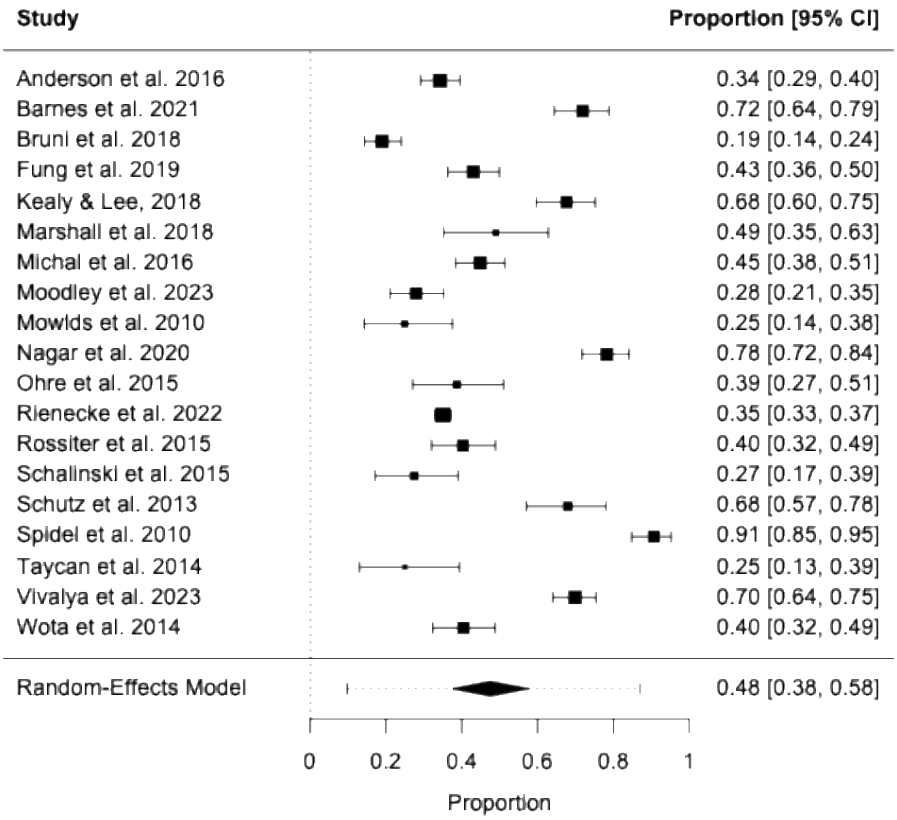
Appendix E.II – Physical Abuse



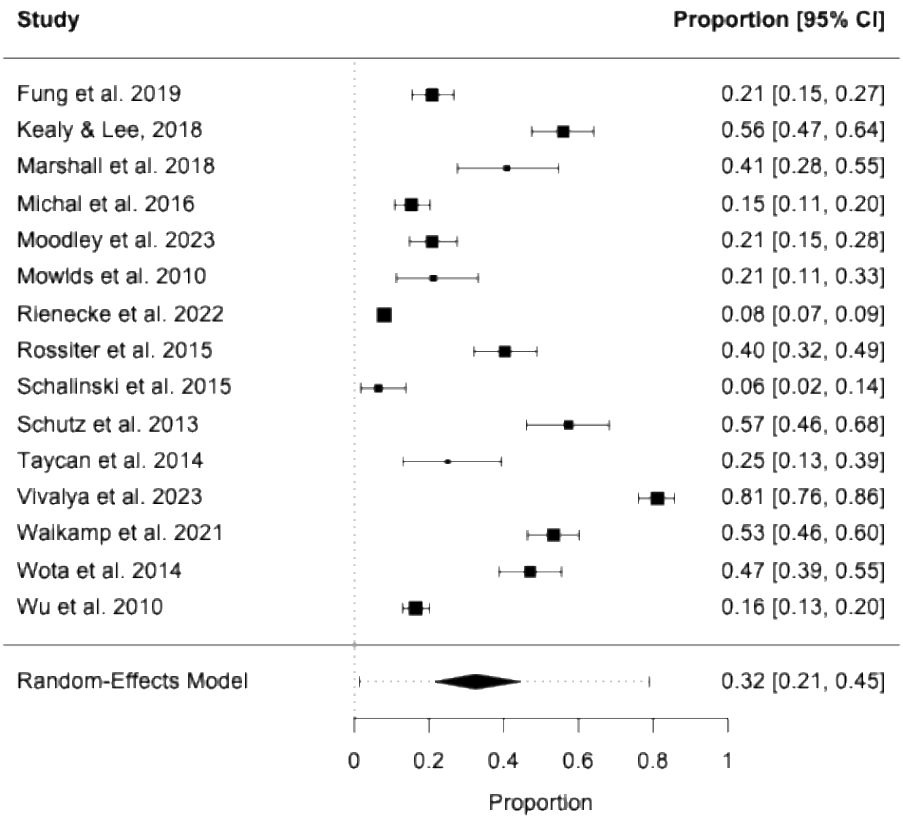
Appendix E.III – Sexual Abuse



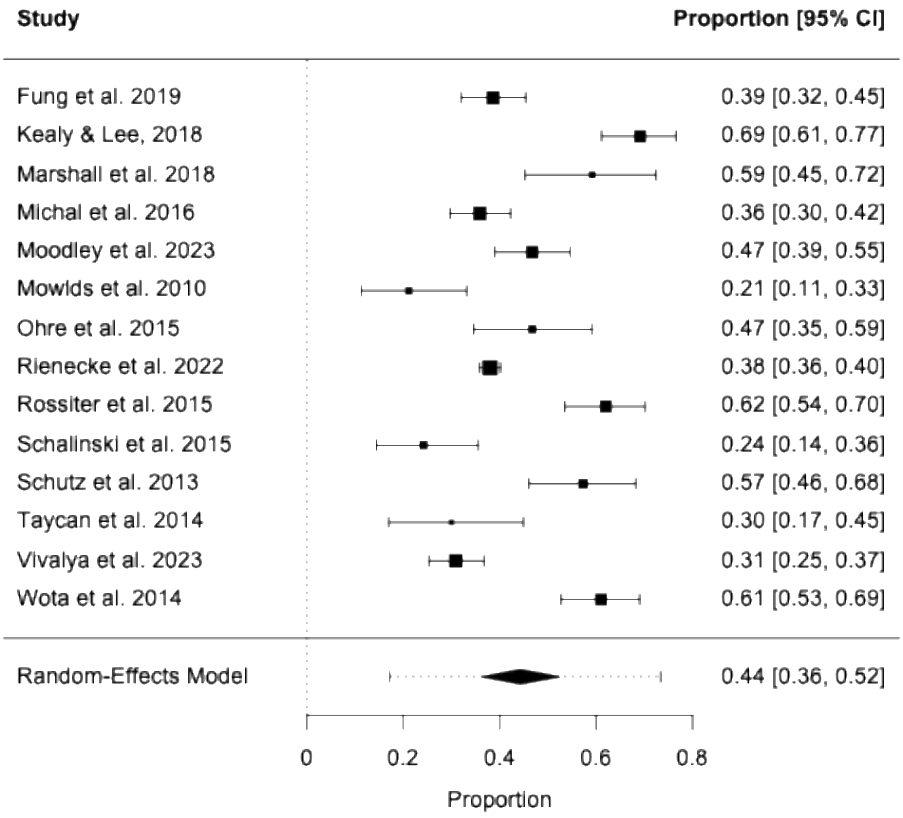
Appendix E.IV – Emotional Abuse



Appendix E.V – Physical Neglect

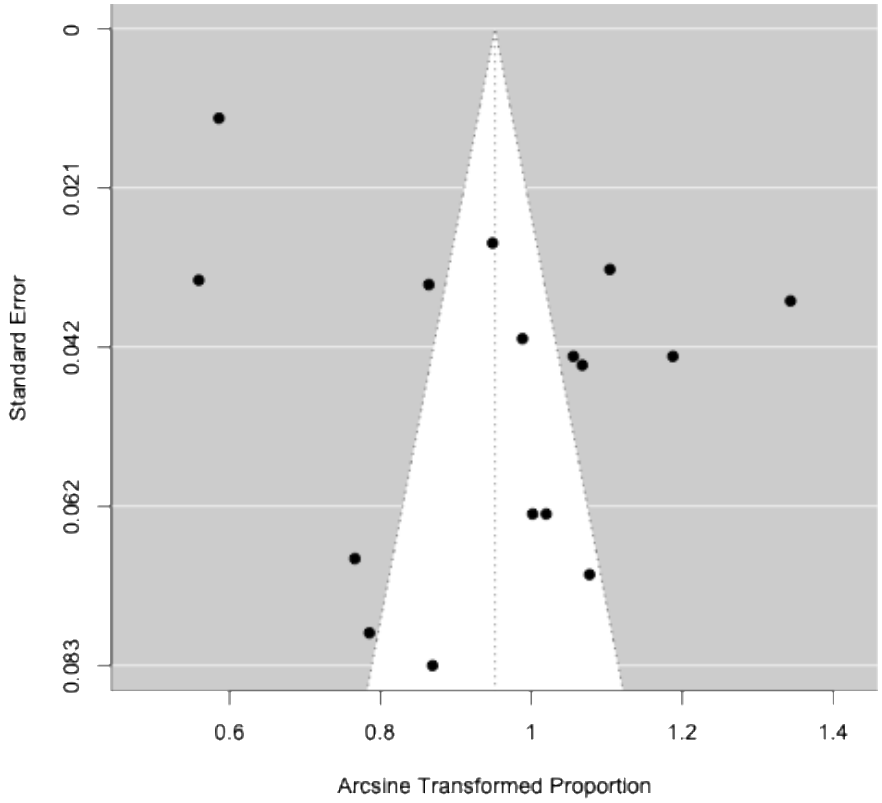


Appendix E.VI – Emotional Neglect



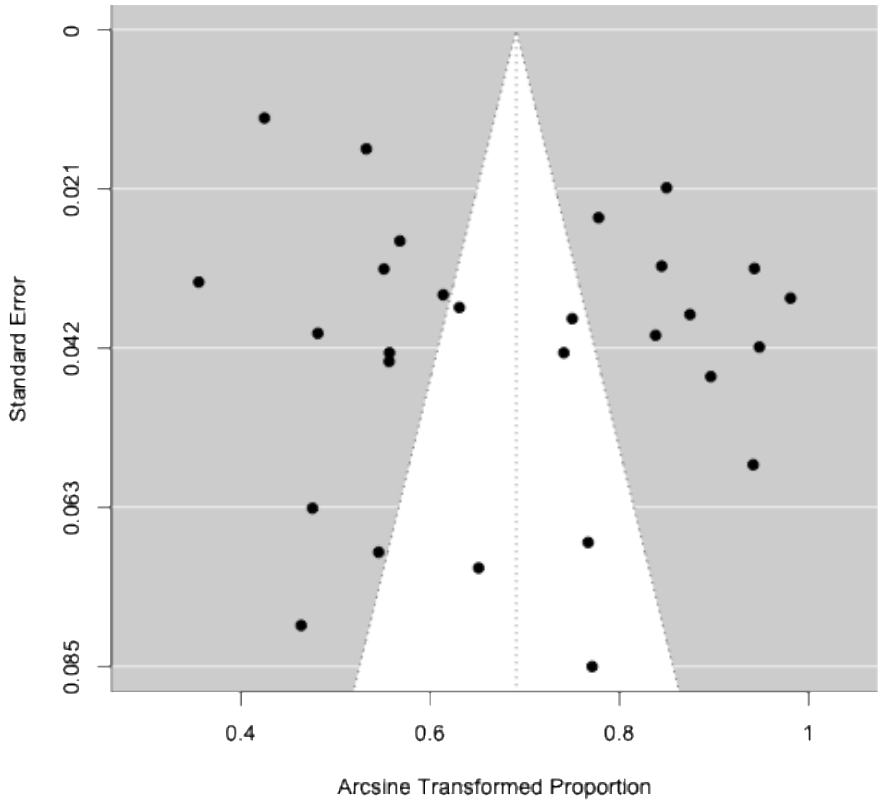
Appendix F – Systematic Review Supplementary Figures 7-12 (Funnel Plots and Regression Tests)

Appendix F.I – Any type of abuse/neglect



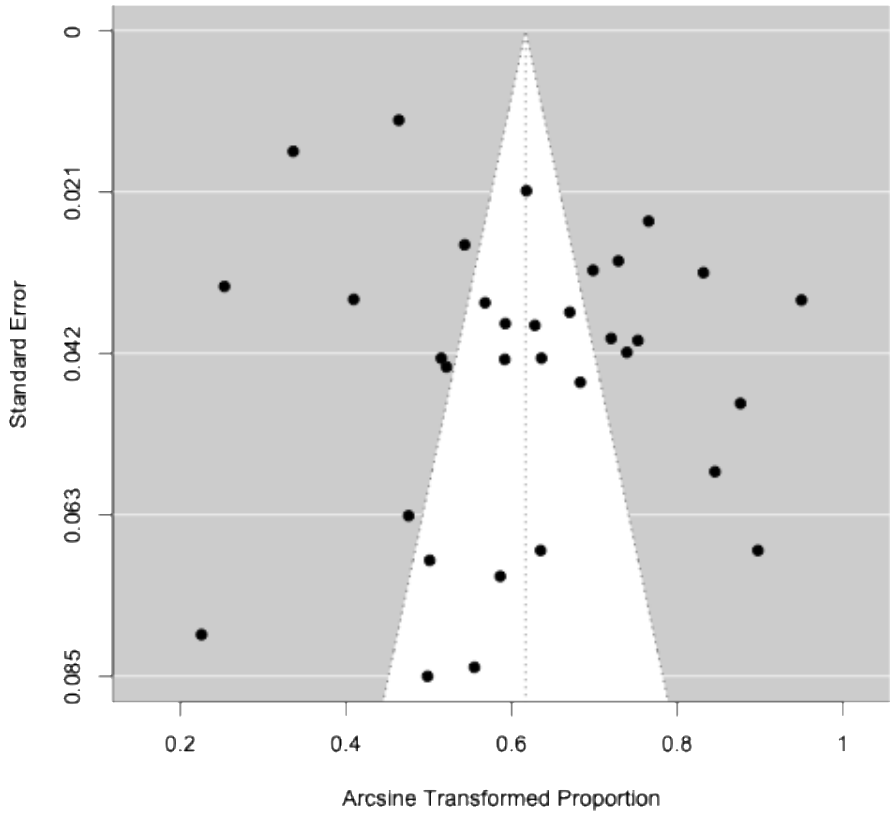
Publication bias was assessed using visual inspection of funnel plots and Egger's regression test. Egger's test indicated no evidence of funnel plot asymmetry (z = 0.27, p = .79). The estimated effect size at the limit of zero standard error was *b* = 0.92 (95% CI [0.64, 1.19]), suggesting no small-study effects.

Appendix F.II – Physical Abuse



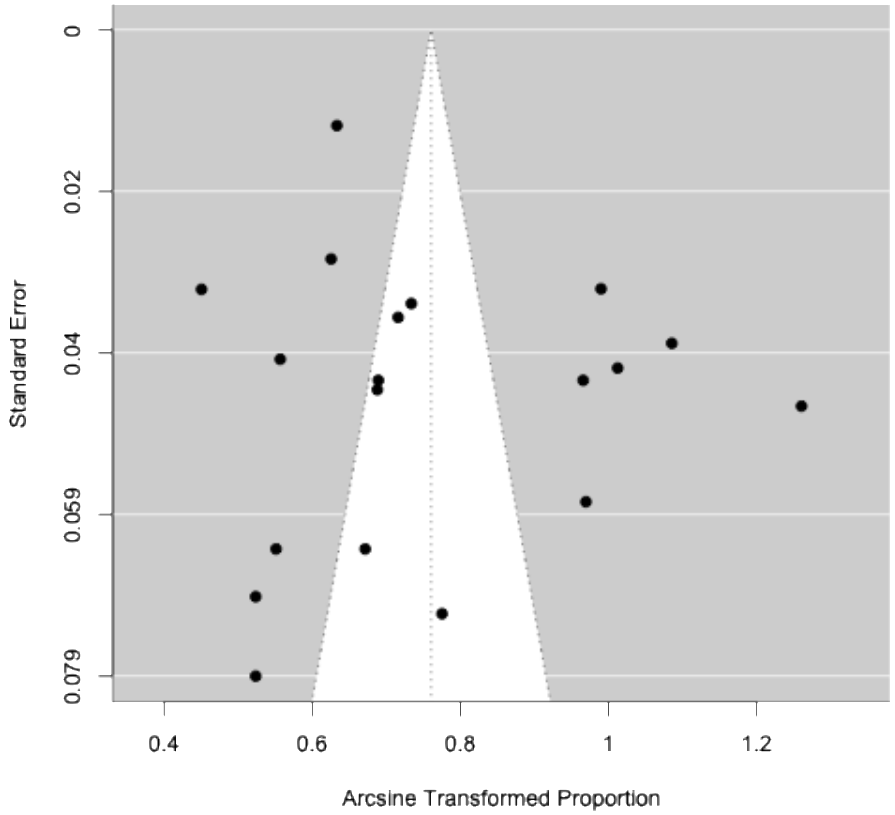
Publication bias was assessed using visual inspection of funnel plots and Egger's regression test. Egger's test indicated no evidence of funnel plot asymmetry (z = 0.01, p = .99). The estimated effect size at the limit of zero standard error was *b* = 0.69 (95% CI [0.51, 0.87]), suggesting no small-study effects.

Appendix F.III – Sexual Abuse



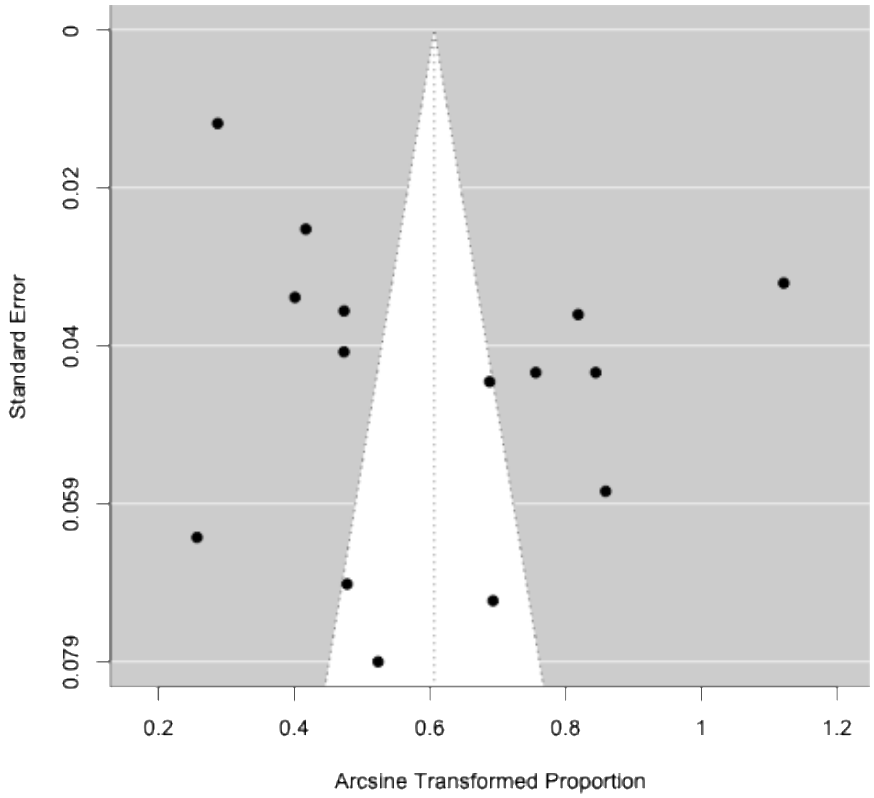
Publication bias was assessed using visual inspection of funnel plots and Egger's regression test. Egger's test indicated no evidence of funnel plot asymmetry (z = -0.27, p = .79). The estimated effect size at the limit of zero standard error was *b* = 0.64 (95% CI [0.48, 0.79]), suggesting no small-study effects.

Appendix F.IV – Emotional Abuse



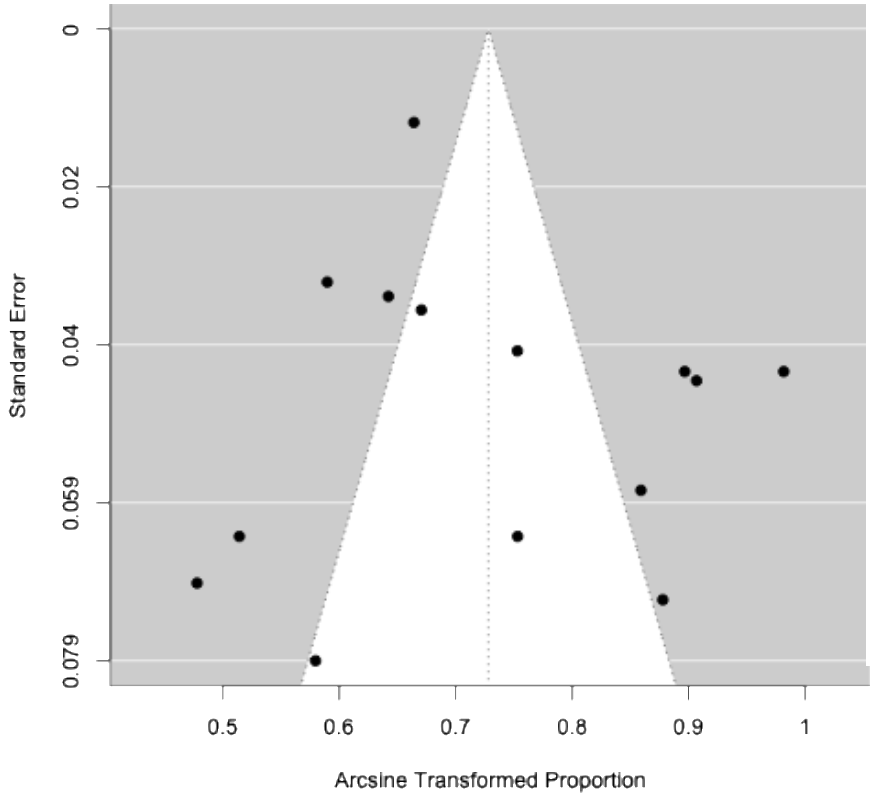
Publication bias was assessed using visual inspection of funnel plots and Egger's regression test. Egger's test indicated no evidence of funnel plot asymmetry (z = -0.52, p = .61). The estimated effect size at the limit of zero standard error was *b* = 0.83 (95% CI [0.53, 1.13]), suggesting no small-study effects.

Appendix F.V – Physical Neglect



Publication bias was assessed using visual inspection of funnel plots and Egger's regression test. Egger's test indicated no evidence of funnel plot asymmetry (z = 0.15, p = .88). The estimated effect size at the limit of zero standard error was *b* = 0.58 (95% CI [0.24, 0.93]), suggesting no small-study effects.

Appendix F.VI – Emotional Neglect



Publication bias was assessed using visual inspection of funnel plots and Egger's regression test. Egger's test indicated no evidence of funnel plot asymmetry (z = -0.31, p = .76). The estimated effect size at the limit of zero standard error was *b* = 0.76 (95% CI [0.52, 1.00]), suggesting no small-study effects.

Appendix G – Author Guidelines for Psychology and Psychotherapy: Theory, Research, and Practice

1. SUBMISSION

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

New submissions should be made via the Research Exchange submission portal. You may check the status of your submission at any time by logging on to submission.wiley.com and clicking the "My Submissions" button. For technical help with the submission system, please review our FAQs or contact submissionhelp@wiley.com.

All papers published in the *Psychology and Psychotherapy: Theory Research and Practice* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

Data protection:

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at https://authorservices.wiley.com/statements/data-protection-policy.html.

Preprint policy:

This journal will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

2. AIMS AND SCOPE

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological and social processes that underlie the development and improvement of psychological problems and mental wellbeing, including:

• theoretical and research development in the understanding of cognitive and emotional factors in psychological problems;
• behaviour and relationships; vulnerability to, adjustment to, assessment of, and recovery

(assisted or otherwise) from psychological distresses;
• psychological therapies, including digital therapies, with a focus on understanding the processes which affect outcomes where mental health is concerned.

The journal places particular emphasis on the importance of theoretical advancement and we request that authors frame their empirical analysis in a wider theoretical context and present the theoretical interpretations of empirical findings.

We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds both within the UK and internationally.

In addition to more traditional, empirical, clinical research we welcome the submission of

- systematic reviews following replicable protocols and established methods of synthesis
- qualitative and other research which applies rigorous methods
- high quality analogue studies where the findings have direct relevance to clinical models or practice.

Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

All papers published in *Psychology and Psychotherapy: Theory, Research and Practice* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

- Articles should adhere to the stated word limit for the particular article type. The word limit excludes the abstract, reference list, tables and figures, but includes appendices.

Word limits for specific article types are as follows:

- Research articles: 5000 words
- Qualitative papers: 8000 words
- Review papers: 6000 words
- Special Issue papers: 5000 words

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Please refer to the separate guidelines for Registered Reports.

All systematic reviews must be pre-registered and an anonymous link to the pre-registration must be provided in the main document, so that it is available to reviewers. Systematic reviews without pre-registration details will be returned to the authors at submission.

Brief-Report COVID-19

For a limited time, the *Psychology and Psychotherapy: Theory, Research and Practice* are accepting brief-reports on the topic of Novel Coronavirus (COVID-19) in line with the journal's main aims and scope (outlined above). Brief reports should not exceed 2000 words and should have no more than two tables or figures. Abstracts can be either structured (according to standard journal guidance) or unstructured but should not exceed 200 words. Any papers that are over the word limits will be returned to the authors. Appendices are included in the word limit; however online supporting information is not included.

4. PREPARING THE SUBMISSION

Free Format Submission

Psychology and Psychotherapy: Theory, Research and Practice now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer (if you do submit separate files, we encourage you to also include your figures within the main document to make it easier for editors and reviewers to read your manuscript, but this is not compulsory). All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

Important: the journal operates a double-anonymous peer review policy. Please anonymise your manuscript and prepare a separate title page containing author details. *(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)*

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

To submit, login at https://wiley.atyponrex.com/journal/PAPT and create a new submission. Follow the submission steps as required and submit the manuscript.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

Revised Manuscript Submission

Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

Title Page

You may like to use this template for your title page. The title page should contain**:**

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
- A short running title of less than 40 characters;
- The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Abstract;
- Keywords;
- Data availability statement (see Data Sharing and Data Accessibility Policy);
- Acknowledgments.

Author Contributions

For all articles, the journal mandates the CRediT (Contribution Roles Taxonomy)—more information is available on our Author Services site.

Abstract

Please provide an abstract of up to 250 words. Articles containing original scientific research should include the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use the headings: Purpose, Methods, Results, Conclusions.

Keywords

Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet point with the heading 'Practitioner Points'. They should briefly and clearly outline the relevance of your research to professional practice.

Main Text File

As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors. Links to repositories (e.g., OSF) should also be anonymized.

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

If submitting your manuscript file in LaTex format via Research Exchange, select the file designation "Main Document – LaTeX .tex File" on upload. When submitting a LaTex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as "Main Document - LaTeX PDF." All supporting files that are referred to in the LaTex Main Document should be uploaded as a "LaTeX Supplementary File."

LaTex Guidelines for Post-Acceptance:

Please check that you have supplied the following files for typesetting post-acceptance:

- PDF of the finalized source manuscript files compiled without any errors.

- The LaTeX source code files (text, figure captions, and tables, preferably in a single file), BibTex files (if used), any associated packages/files along with all other files needed for compiling without any errors. This is particularly important if authors have used any LaTeX style or class files, bibliography files (.bbl, .bst. .blg) or packages apart from those used in the NJD LaTex Template class file.
- Electronic graphics files for the illustrations in Encapsulated PostScript (EPS), PDF or TIFF format. Authors are requested not to create figures using LaTeX codes.

Your main document file should include:

- A short informative title containing the major key words. The title should not contain abbreviations;
- Abstract structured (intro/methods/results/conclusion);
- Up to seven keywords;
- Practitioner Points Authors will need to provide 2-4 bullet points, written with the practitioner in mind, that summarize the key messages of their paper to be published with their article;
- Main body: formatted as introduction, materials & methods, results, discussion, conclusion;
- References;
- Tables (each table complete with title and footnotes);
- Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below);
- Statement of Contribution.

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors. Please do not mention the authors' names or affiliations and always refer to any previous work in the third person.
- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

This journal uses APA reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

Tables

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

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Supporting Information

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

Click here for Wiley's FAQs on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

General Style Points

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association. The following points provide general advice on formatting and style.

- **Language:** Authors must avoid the use of sexist or any other discriminatory language. The BPS's Inclusive Language Guidance provides a set of recommendations to support the key principles of inclusivity in writing.
- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

Wiley Author Resources

Manuscript Preparation Tips: Wiley has a range of resources for authors preparing manuscripts for submission available here. In particular, we encourage authors to consult Wiley's best practice tips on Writing for Search Engine Optimization.

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Also, check out our resources for Preparing Your Article for general guidance and the BPS Publish with Impact infographic for advice on optimizing your article for search engines.

ECR Best Paper Award

The BPS Early Career Researcher Best Paper Award is open to researchers and practitioners who completed their highest degree no more than five years ago. Please read full terms and criteria before applying. Those who wish to apply can opt-in to the question when submitting their manuscript for peer review.

5. EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

Peer Review and Acceptance

Except where otherwise stated, the journal operates a policy of anonymous (double-anonymous) peer review. Please ensure that any information which may reveal author identity is anonymized in your submission, such as institutional affiliations, geographical location or references to unpublished research. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review. Before submitting, please read the terms and conditions of submission and the declaration of competing interests.

We aim to provide authors with a first decision within 90 days of submission.

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The journal requires that clinical trials are prospectively registered in a publicly accessible database and clinical trial registration numbers should be included in all papers that report their results. Authors are asked to include the name of the trial register and the clinical trial registration number at the end of the abstract. If the trial is not registered, or was registered retrospectively, the reasons for this should be explained.

Research Reporting Guidelines

Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it. Authors are encouraged to adhere to recognised research reporting standards.

We also encourage authors to refer to and follow guidelines from:

- Future of Research Communications and e-Scholarship (FORCE11)
- The Gold Standard Publication Checklist from Hooijmans and colleagues
- FAIRsharing website

Conflict of Interest

The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. If the authors have no conflict of interest to declare, they must also state this at submission. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

Funding

Authors should list all funding sources in the Acknowledgments section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: https://www.crossref.org/services/funder-registry/

Authorship

All listed authors should have contributed to the manuscript substantially and have agreed to the final submitted version. Authorship is defined by the criteria set out in the APA Publication Manual:

"Individuals should only take authorship credit for work they have actually performed or to which they have substantially contributed (APA Ethics Code Standard 8.12a, Publication Credit). Authorship encompasses, therefore, not only those who do the actual writing but also those who have made substantial scientific contributions to a study. Substantial professional contributions may include formulating the problem or hypothesis, structuring the experimental design, organizing and conducting the statistical analysis, interpreting the results, or writing a major portion of the paper. Those who so contribute are listed in the byline." (p.18)

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The journal expects that where possible all data supporting the results in papers published are archived in an appropriate public archive offering open access and guaranteed preservation. The archived data must allow each result in the published paper to be recreated and the analyses reported in the paper to be replicated in full to support the conclusions made. Authors are welcome to archive more than this, but not less.

All papers need to be supported by a data archiving statement and the data set must be cited in the Methods section. The paper must include a link to the repository in order that the statement can be published.

It is not necessary to make data publicly available at the point of submission, but an active link must be included in the final accepted manuscript. For authors who have pre-registered studies, please use the Registered Report link in the Author Guidelines.

In some cases, despite the authors' best efforts, some or all data or materials cannot be shared for legal or ethical reasons, including issues of author consent, third party rights, institutional or national regulations or laws, or the nature of data gathered. In such cases, authors must inform the editors at the time of submission. It is understood that in some cases access will be provided under restrictions to protect confidential or proprietary information. Editors may grant exceptions to data access requirements provided authors explain the restrictions on the data set and how they preclude public access, and, if possible, describe the steps others should follow to gain access to the data.

If the authors cannot or do not intend to make the data publicly available, a statement to this effect, along with the reasons that the data is not shared, must be included in the manuscript.

Finally, if submitting authors have any questions about the data sharing policy, please access the FAQsfor additional detail.

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Recognizing the importance of research transparency and data sharing to cumulative research, *Psychology and Psychotherapy: Theory, Research and Practice* encourages the following Open Research practices.

Sharing of data, materials, research instruments and their accessibility. Psychology and Psychotherapy: Theory, Research and Practice encourages authors to share the data, materials, research instruments, and other artifacts supporting the results in their study by archiving them in an appropriate public repository. Qualifying public, open-access repositories are committed to preserving data, materials, and/or registered analysis plans and keeping them publicly accessible via the web into perpetuity. Examples include the Open Science Framework (OSF) and the various Dataverse networks. Hundreds of other qualifying data/materials repositories are listed at the Registry of Research Data Repositories (http://www.re3data.org). Personal websites and most departmental websites do not qualify as repositories.

Publication Ethics

Authors are reminded that *Psychology and Psychotherapy: Theory, Research and Practice* adheres to the ethics of scientific publication as detailed in the ***Ethical principles of psychologists and code of conduct*** (American Psychological Association, 2010). The Journal generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (**ICJME**) and is also a member and subscribes to the principles of the Committee on Publication Ethics (**COPE**). Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study county.

Note this journal uses iThenticate's CrossCheck software to detect instances of overlapping and similar text in submitted manuscripts. Read Wiley's Top 10 Publishing Ethics Tips for Authors **here**. Wiley's Publication Ethics Guidelines can be found **here**.

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As part of the journal's commitment to supporting authors at every step of the publishing process, the journal requires the submitting author (only) to provide an ORCID iD when submitting a manuscript. This takes around 2 minutes to complete. Find more information here.

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- The link to the published article can be shared through social media.
- The author will have free access to the paper (after accepting the Terms & Conditions of use, they can view the article).
- For non-open access articles, the corresponding author and co-authors can nominate up to ten colleagues to receivea publication alert and free online access to the article.

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Wiley also helps authors measure the impact of their research through specialist partnerships with Kudos and Altmetric.

Appendix H – Recruitment Poster for Empirical Paper



Appendix I – Participant Information Sheet for Empirical Paper

NHS Cambridgeshire and Peterborough NHS Foundation Trust

University of East Anglia

Study Title: What Role do Therapeutic Support Workers Play in Services offering Therapy to People with a History of Complex Trauma?

You have been invited to take part in a research study being supported by The University of East Anglia and Cambridgeshire and Peterborough NHS Foundation trust. The below leaflet will tell you what this research is about and provide information as to what to do and who to contact if you would like to take part.
Please take some time to read through the following information carefully. If there is anything that is not clear or if you would like more information, please do not hesitate to contact us using the details at the end of this leaflet.
This study is being undertaken as part fulfilment for the Doctorate in Clinical Psychology at the University of East Anglia and the Chief Investigator is Zoe Ryan.

What is the purpose of this study?
Complex trauma is defined as traumatic experiences involving multiple events with interpersonal threats during childhood and adolescence such as abuse, neglect, discrimination, war, violence, and racism. Complex trauma has been shown to have significant negative effects on a person's mental health throughout their life.
This study would like to hear from support workers in adult mental health services, such as yourselves, who work with individuals who have a history of complex trauma. We want to learn from you about the experiences of support workers' role in working with these individuals.
We would like to explore this so that we can have a better understanding of the role of support workers within these services, the value that they bring to teams and service users, and the training and supervision requirements of this staff group. We believe that learning such information will help us to improve these services for the people using them and for the staff working within them.

Why am I being sent this information?
You are being invited to take part in this research project as you are a support worker in an adult mental health service that is likely to be accessed by individuals with a history of complex trauma, and therefore are likely to have worked with these individuals in a direct manner.

What will happen if I decide to take part?
If you decide to take part you will be asked to sign and return a consent form. The researcher will then be in contact to arrange the best time to conduct the interview. The interview will be conducted online via Microsoft Teams in order to be as flexible as possible. The interview will take approximately one hour and will be recorded using Microsoft Teams video conferencing software and the audio will later be transcribed.

Do I have to take part?
No. Taking part in this research is entirely voluntary and it is up to you whether or not you would like to take part. If you do agree to participate you can stop being a part of the study at any time, without giving a reason. You have the right to ask us to remove, change, or delete data we hold about you for the purposes of the study. We might not always be able to do this if it means we cannot use your data to do the research. If so, we will tell you why we cannot do this.

If you choose to withdraw from the study at any point this will not have any impact on your employment rights and your employer will not be made aware of your involvement in the study at any point.

What are the possible benefits of taking part?

If you do take part, you will contribute towards our knowledge and understanding of the role that support workers play in adult mental health services for people who have experienced complex trauma. We will also gift you a £10 Amazon voucher as a token of appreciation for your time.

What are the possible disadvantages of taking part?

The interview will take approximately one hour of your time. We do not expect any of the interview questions to cause any distress but we understand that some people may find it harder to talk about their experiences than others, especially if these have not been positive. We aim to always be sensitive and considerate and can signpost you to supporting organisations if needed.

What if there is a problem?

If you have a concern about any aspect of this study, you can speak to the researcher who will do their best to answer your questions. Contact details are listed at the bottom of this sheet.

If you wish to make a complaint (or talk about making a complaint) you can contact one of the study supervisors below

Dr Melanie Staley (melanie.staley@cpft.nhs.uk)
Dr Richard Meiser-Stedman (r.meiser-stedman@uea.ac.uk)

You can also contact Professor Sian Coker (s.coker@uea.ac.uk) who is independent from the study.

Will taking part in this study be confidential?

What you say in the interviews will be kept strictly confidential, in that the recordings will not be shared with anyone other than those within the research team. By signing the consent form you agree that we may quote some of the things you have said when we write up the research. Any information we use in this way would be completely anonymised, your name will not appear in any reports or publications. Your employer will not be made aware of your involvement in the study.

The only instance in which we would break confidentiality is if you were to mention something that suggested you or someone else was at risk of harm. In this case we would have a duty of care to contact the safeguarding team at your employing trust. If this were to be the case we would endeavour to have an open and honest conversation with you at the time to inform you that this was happening.

How will we use information about you

We will need to use information from you in this research study. This information will include:

- Your name/initials
- Contact details

People will use this information to do the research or to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. Your data will not be shared outside of the UK.

Once we have finished the study we will keep some of the data so we can check the results. We will write our reports in a way that no one can work out that you took part in the study. We will keep your study data for a maximum of 10 years. The fully anonymised study data will then be securely archived or destroyed.

You can find out more about how we use your information from the following sources:

- By contacting a member of the research team whose details are included in this information sheet.
- By sending an email to researchsponsor@uea.ac.uk
- By visiting www.hra.nhs.uk/patientdataandresearch

How will data be kept secure?

Digital data, such as the recordings and transcription as well as any demographic information, will be kept securely in password protected files, on the University of East Anglia secure One Drive. This will only be accessible to the research team. The recordings and transcription will be destroyed upon completion of the research.

Identifiable information will be also be stored securely on the one drive system but will be stored in a separate password protected file from the research data. This will only be used for the purpose of participant contact during the study and will be destroyed at the end of the research.

The University of East Anglia is the sponsor of this research and will act as the Data Controller for this study and they are responsible for looking after your information, using it properly, and ensuring this research project is compliant with GDPR.

Who is organising the research?

This research is being organised and sponsored by the University of East Anglia as part of the researcher's professional doctorate in Clinical Psychology. The research is also being supported by Cambridgeshire and Peterborough NHS Foundation Trust.

Who has reviewed this study?

All research is looked at by an independent group of people called a Research Ethics Committee to protect your interests. This study has been reviewed and given approval by the University of East Anglia Faculty of Medicine and Health Sciences Research Ethics Committee. Approval has also been obtained from the Health Research Authority (IRAS Project ID: 351885) and the Research and Development department within Cambridgeshire and Peterborough NHS Foundation Trust.

Contact for further information:

If you would like to hear more about this study or you would like to take part, please contact:

Zoe Ryan
Trainee Clinical Psychologist
z.ryan@uea.ac.uk

Appendix J – Participant Consent Form for Empirical Paper

NHS Cambridgeshire and Peterborough NHS Foundation Trust

University of East Anglia

What Role do Therapeutic Support Workers Play in Services offering Therapy to People with a History of Complex Trauma?

CONSENT FORM

Please tick box

1. I have read the Participant Information sheet for the above study. ☐
2. I have had the opportunity to consider the information above, ask questions and feel that these have been answered satisfactorily. ☐
3. I understand that taking part in this study is voluntary and know that I am free to withdraw at any time without giving a reason and that there will be no consequences of doing so. ☐
4. I understand that my interview will be video recorded using Microsoft teams but only the audio will be transcribed. ☐
5. I understand that this recording and further information collected about me for the purposes of this study will be stored securely. ☐
6. I understand that anonymised quotes from my interview may be used in the dissemination of research. ☐
7. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

Appendix K – Interview Topic Guide for Empirical Paper

Interview Guide

How do support workers view their role when working with survivors of complex trauma?

Can you tell me a bit about your role and your experience of working in adult mental health services?

Could you tell me about the work you do with service users who have experienced complex trauma?
- What are you main responsibilities?
- Do you deliver any specific interventions?

How do you feel when you are allocated to work with an individual that has a history of complex trauma?
- Does this impact the way which you work with them from a practical perspective?

The perceived value of support workers and support work interventions

What do you feel is unique about support worker interventions compared to interventions offered by other members of the team that you work in?

What would be the impact on staff and service users if support workers were not available within your team?

Can you tell me about a time that you felt you made a significant difference to a person you were working with?
- How did you know you had made a difference?
- Was this work recognised by other members of the team/in what way?

Support, supervision, and training

What types of support or supervision are available to you when working with individuals who have experienced complex trauma?
- How effective do you find this support in helping you to manage your responsibilities and well-being?

Has there been a time when you have been asked to deliver an intervention that you did not feel was part of your role or you did not feel confident in? Could you tell me about that situation?
- Is there anything that would've meant you did feel confident to complete that work?

Is there anything that you feel would improve your ability to provide interventions for people who have a history of complex trauma?

Additional reflections

Is there anything you would like to add or something you feel you have not had the opportunity to say?

Interview Topic Guide Version 2 02/08/2024

Appendix L – Participant Demographic Questionnaire for Empirical Paper

NHS Cambridgeshire and Peterborough NHS Foundation Trust

University of East Anglia

What Role do Therapeutic Support Workers Play in Services offering Therapy to People with a History of Complex Trauma?

Demographics Questionnaire

1. Please state your age

2. Please state your gender

3. What is the title of your current role?

4. Which type of service do you currently work in?
   a. Community Mental Health Team
   b. Early Intervention Service
   c. Psychological Skills Service/Specialist Community Trauma Service

5. How long have you worked within your current role?

6. Do you have any previous experience or training in relation to complex trauma? Please provide details (e.g. previous roles, academic qualifications, professional training)

7. How would you rate your knowledge and understanding of complex trauma? (1 = I have no understanding of this term; 10 = I have a very thorough understanding of complex trauma and the impact that it has on people)

   1 2 3 4 5 6 7 8 9 10

8. How would you rate your confidence of working with individuals who have a history of complex trauma? (1 = I would not feel at all confident; 10 = I feel extremely confident in working with these individuals)

   1 2 3 4 5 6 7 8 9 10

Appendix M – Evidence of Ethical Approval for Empirical Paper

University of East Anglia
Norwich Research Park
Norwich. NR4 7TJ

Email: ethicsmonitor@uea.ac.uk
Web: www.uea.ac.uk

Study title: What Role do Therapeutic Support Workers Play in Services offering Therapy to People with a History of Complex Trauma?

Application ID: ETH2425-0248

Dear Zoe,

Your application was considered on 21st January 2025 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

If your study involves NHS staff and facilities, you will require Health Research Authority (HRA) governance approval before you can start this project (even though you did not require NHS-REC ethics approval). Please consult the HRA webpage about the application required, which is submitted through the IRAS system.

This approval will expire on **31st March 2027**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Dr Paul Linsley

Appendix N – Health Research Authority Approval for Empirical Paper

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Zoe Ryan
4 The Moorings, Bridge Street
Deeping St James
Peterborough
PE6 8FF

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

06 February 2025

Dear Miss Ryan

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**What Role do Therapeutic Support Workers Play in Services offering Therapy to People with a History of Complex Trauma?**
IRAS project ID:	**351885**
Protocol number:	**N/A**
REC reference:	**25/HRA/0270**
Sponsor	**University of East Anglia**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **351885**. Please quote this on all correspondence.

Yours sincerely,
Kathryn Davies

Approvals Manager

Email: approvals@hra.nhs.uk

Copy to: *Ms Katt Riley*

Appendix O – Frequency of Codes by Theme and Subtheme

Themes and subthemes	Codes	Participants	Total references
Theme 1: Developing competence, confidence, and professional identity		***N = 13***	
1.1 Inconsistent access to training, supervision, and team support	Access to training	13	36
	Supervision availability	13	36
	Access to shared resources	7	9
	Reflective practice and team support	12	22
1.2 Developing through experience	Constant learning	10	20
	The benefit of experience	8	18
	Awareness of role and limitations	7	29
1.3 Gaps in preparation and aspirations for progression	Desire for progression	7	10
	A need for more specific training	12	37
Theme 2: Flexibility without clarity: Navigating poorly defined roles		***N = 12***	
2.1 The benefits of role flexibility and breadth	Jack of all trades	9	19
	The ability to be flexible	12	44
	Valued by other team members	11	25
	Recognition of need for service users	10	26
	Providing support to other professionals	11	18
	Practical support and meeting basic needs	10	18
2.2 The cost of poorly defined roles	Confusion about the role	12	40
	Variety between roles and services	12	37
	Viewed as less than	10	27

Themes and subthemes	Codes	Participants	Total references
Theme 3: The emotional and professional impact of working with trauma and complexity		***N = 11***	
3.1 Working at the sharp end of complexity and risk	Holding responsibility for patients	4	8
	Working with high risk and crisis cases	5	16
	Working with complexity	7	13
3.2 Anxiety, uncertainty, and fear of causing harm	Anxiety or uncertainty about the work	10	37
	Fear of making things worse	6	13
	Professional anxiety and fear of causing harm	5	16
3.3 Carrying the emotional weight of the work	Managing personal wellbeing	8	17
	Emotional impact	11	26
	Hopelessness and frustration	7	22
Theme 4: Bridging gaps between people, professionals, and systems		***N = 13***	
4.1 Navigating and connecting systems	A bridge between service users and clinicians	7	12
	Liaison with other professionals	12	41
	Signposting and support to access other services	7	16
	Advocacy and representing service user needs	7	18
4.2 Filling therapeutic gaps	Psychological work	13	35
	Goal based interventions	6	9
	Support, enabling, or preparation for therapy	9	32
	Understanding of therapeutic interventions delivered by clinicians	5	5

Themes and subthemes	Codes	Participants	Total references
Theme 5: Relational safety as the foundation of engagement and recovery		***N = 13***	
5.1 When relationships become the intervention	Small things can make a big difference	10	23
	Benefit of informal support	12	35
	Focus of relational connection rather than formal expertise	12	42
	Promoting social connection and community engagement	10	23
	Higher frequency of contact	6	14
5.2 Hope, validation, and creating safety	Providing emotional support to service users	5	7
	Creating safety	10	16
	Building trust as a foundation	12	27
	Holding hope	4	6
	Positive feedback and gratitude from service users	8	21
5.3 Making sense of behaviour through a trauma informed lens	Trauma isn't something to be feared/the work is no different	7	12
	Understanding behaviour through a trauma lens	13	34
	Individualised support	10	27

Appendix P – Additional Illustrative Quotes for Empirical Paper

Subtheme	Additional Illustrative Quotes
Theme 1: Developing competence, confidence, and professional identity.	
1.1 Inconsistent access to training, supervision, and team support	*"I was trained by a psychologist there to do talking therapy as well. Which is beneficial to get some patients to engage with you a little bit better. Maybe, you know, talk, how to ask the correct questions to get a bit more of an open answer rather than closed questions, which is, it doesn't help you at all." P2*
	"It's meant to be sort of like a monthly. Sometimes it doesn't happen." P1
1.2 Developing through experience	*"So it's constantly a revolving method of learning and yeah, it's. But it's invaluable to be able to do that as well because you always want to see the best outcomes." P12*
1.3 Gaps in preparation and aspirations for progression	*"No, it's bonkers really. If you really think about it, you're tasked with this really important work with people, but you're not given any training really around delivering, not proper training around delivering these things." P13*
	"Myself and some of my other colleagues. We do want to go further, we want to be a clinician, so that's why this is such a nice job. And for us we're learning, we're putting, we're applying our knowledge in practise, so it's amazing." P10
Theme 2: Flexibility without clarity: Navigating poorly defined roles.	
2.1 The benefits of role flexibility and breadth	*"Yeah, because every job description for a support worker has on the bottom of it, and anything else that, and it's like, well, yeah." P12*
	"And maybe, maybe there's something about the role itself being so fluid and varied that like I can fill multiple shoes for somebody. And if they need multiple shoes filled because they have complex PTSD, that might be extra useful." P11
	"We sometimes, instead of meeting in a clinic room which really upped her anxiety, I said, why don't we meet for coffee? You know, tell me more about yourself, we can go out for a walk and took baby steps for her to kind of understand that I'm here to support her." P3
	"I guess because I do just so many different things I kind of like, kind of almost feel like I'm an assistant to everyone like, or especially the care coordinators possibly." P11

Subtheme	Additional Illustrative Quotes
2.2 The cost of poorly defined roles	*"I suppose I've heard care co's go OK well, what do they know? What do they know about this person, you know? So I suppose sometimes there is that, you know, when, when the stress rises, maybe some different perspectives come out" P13*
	"I do sometimes feel like as a support worker, you don't really have as much of a voice." P7
	"I'm like the very bottom of the totem pole in terms of the team and like pay and stuff" P11
Theme 3: The emotional and professional impact of working with trauma and complexity.	
3.1 Working at the sharp end of complexity and risk	*"So I think we see, especially in support work when it's kind of at the stabilisation stage, we see a lot of emotional dysregulation, dissociation and things like that sort of distress at that stabilisation level." P7*
	"He'd just come off crisis team when I met him and I had quite frequent contact with him at the start, purely because his risk to himself. He was very suicidal." P2
	"Not everyone has a support worker involved, but. But where they are, I think generally support workers are left to get on with that" P13
3.2 Anxiety, uncertainty, and fear of causing harm	*"And it's quite hard sometimes, and it makes us doubt ourselves sometimes. And are we doing enough? Are we doing the right skill at the right time?" P10*
	"And I think sometimes with support work roles, you don't, it doesn't come with the same sort of training or kind of knowledge around, OK? Well, if that isn't going smoothly, what, what does that mean? Like if someone's a bit more resistant to, to spend their time with you or resistant or doesn't want to see you. How do you interpret that you know?" P13
3.3 Carrying the emotional weight of the work	*"Yeah, I constantly remind myself that I can't be helpful to them if I'm not doing well." P11*
Theme 4: Bridging gaps between people, professionals, and systems.	
4.1 Navigating and connecting systems	*"So I'll talk to the care coordinators, psychologist if they're involved or not, and the doctors will have like a meeting to see how best we think we need to start looking at this and start planning" P12*
	"So I think that we have the chance to sort of, erm, make other professionals more aware of like what this

Subtheme	Additional Illustrative Quotes
	person needs support with and give more detail in that sense." P1
4.2 Filling therapeutic gaps	*"So yeah, and it's like teaching them how to do mindfulness, and lots of the different skills in mindfulness. And letting them know that actually this needs to be practised all the time for it to become effective, not just when you're stressed." P4*
	"It's that practical step because we can all talk about something, but the it's the actual doing that is necessary, isn't it, to, to, to retrain your thoughts on anxiety" P8
Theme 5: Relational safety as the foundation of engagement and recovery.	
5.1 When relationships become the intervention	*"It's about having, support workers spend most time with people." P13*
	"It's not always just about the intervention itself, it's the process of making them feel secure to be able to do it" P10
5.2 Hope, validation, and creating safety	*"I think it comes down to like how you how you build trust with a person more than like your actual role sometimes." P1*
5.3 Making sense of behaviour through a trauma informed lens	*"They're too wrapped up in themselves to be able to adapt to that, or they're too traumatised and think they don't deserve it, depending on what's been said to them." P12*