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Abstracts

Systematic Review of the Literature

Mental health professionals can be exposed to emotionally demanding clinical work, which may contribute to reduced personal and professional-related wellbeing. Adult attachment orientations may influence how clinicians experience, regulate, and seek support for occupational stress, yet the evidence base for this remains fragmented. This systematic review aimed to synthesise quantitative evidence examining associations between adult attachment and wellbeing outcomes in mental health professionals. A systematic search of PsycINFO, CINAHL, Scopus, PubMed, and Web of Science identified 16 eligible peer-reviewed studies. Study quality was assessed using the Standard Quality Assessment Criteria, and findings were synthesised narratively due to heterogeneity in professional groups, measures, and outcome constructs. Overall, attachment insecurity was generally associated with poorer clinician wellbeing. Attachment anxiety showed the most consistent associations, particularly with emotional exhaustion, total burnout, psychological distress, and reduced general wellbeing. Attachment avoidance was also implicated, especially in trauma-related outcomes and some burnout subcomponents, although findings were less consistent across broader wellbeing outcomes. The evidence base was moderate-to-high quality, but conclusions were limited by predominantly cross-sectional designs, reliance on self-report measures, heterogeneous outcome definitions, and limited control of organisational and contextual factors. Findings suggest that attachment-informed approaches may be useful within supervision, training, and reflective practice, but should be embedded within wider systemic efforts to support clinician wellbeing.

Keywords: *mental health professionals; attachment; wellbeing; burnout; systematic review*

Service Improvement Project

Background: Asylum-seeker and refugee (ASR) individuals receive reduced referral and access to mental health services, despite elevated need. The focus for this project was a specialist NHS traumatic stress service providing evidence-based treatment for complex post-traumatic stress disorder. The service receives few referrals for ASR individuals relative to total referrals. This project aimed to understand barriers to referral and access, and to make recommendations from findings based on referrer and client perspectives.

Method: Semi-structured interviews were conducted with six common referrers, and four ASR clients accessing the service. These were analysed using reflexive thematic analysis.

Results: Data for referrer and ASR interviewees were analysed separately and themes generated separately. 5 key themes were identified from referrers: i) Perceived Inaccessibility of the Service, ii) Confusion about Eligibility, iii) Stability as a Prerequisite for Referral, iiii) Interpreters as Necessary but Challenging, v) Cross-Service Collaboration as a Facilitator. 4 key themes were identified from ASR clients: i) Fears of Judgement and Stigma, ii) Uncertainty Around Entitlement, iii) Importance of Establishing Safety and Trust, iiii) Value of Flexibility and Empathy. Recommendations were drawn from the themes including increased internal and external collaboration, clarification of ASR eligibility and entitlement criteria, person-centred care accounting for individual client needs, and increased visibility of the service.

Conclusion: This project highlights the barriers to referral and access to a specialist traumatic stress service for ASR clients. Findings may be of interest and utility to mental health services. Recommendations made may improve access for this minoritised group.

Keywords: *asylum seekers, refugees, posttraumatic stress disorder, access, inclusivity*

Theoretically Driven Research Project

Religious schemata may shape how traumatic experiences are interpreted, but little research has examined religious trauma appraisals in Muslim populations. This cross-sectional study examined associations between maladaptive religious schemata, negative post-traumatic religious appraisals, and PTSD symptom severity in 157 Muslim adults living in the UK who had experienced trauma. Participants completed online measures of trauma exposure, PTSD symptoms, religious schemata, negative religious trauma appraisals, general non-religious trauma-related appraisals, depression, and anxiety. Sixty-eight participants scored above the PCL-5 threshold and reported higher negative religious trauma appraisals and maladaptive religious schemata than those below threshold. Across the full sample, negative religious trauma appraisals statistically mediated the association between maladaptive religious schemata and PTSD symptom severity. Maladaptive religious schemata explained additional variance in negative religious trauma appraisals beyond general non-religious trauma appraisals, distress, and trauma load. Findings suggest that culturally specific religious meanings may be clinically relevant in trauma formulation, although causal conclusions cannot be drawn.

Keywords: *PTSD, trauma, Muslim mental health, religious appraisals, religious schemata*

Systematic Review of the Literature

Mental Health Professionals' Attachment Style and Associations with their Wellbeing Outcomes: A Systematic Review and Narrative Synthesis

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Proposed Journal: Research in Psychotherapy, as the review concerns therapist factors and wellbeing in clinical work, with implications for psychotherapy training, supervision, and reflective practice. The review has been prepared in accordance with the journal's guidelines.

Abstract

Mental health professionals can be exposed to emotionally demanding clinical work, which may contribute to reduced personal and professional-related wellbeing. Adult attachment orientations may influence how clinicians experience, regulate, and seek support for occupational stress, yet the evidence base for this remains fragmented. This systematic review aimed to synthesise quantitative evidence examining associations between adult attachment and wellbeing outcomes in mental health professionals. A systematic search of PsycINFO, CINAHL, Scopus, PubMed, and Web of Science identified 16 eligible peer-reviewed studies. Study quality was assessed using the Standard Quality Assessment Criteria, and findings were synthesised narratively due to heterogeneity in professional groups, measures, and outcome constructs. Overall, attachment insecurity was generally associated with poorer clinician wellbeing. Attachment anxiety showed the most consistent associations, particularly with emotional exhaustion, total burnout, psychological distress, and reduced general wellbeing. Attachment avoidance was also implicated, especially in trauma-related outcomes and some burnout subcomponents, although findings were less consistent across broader wellbeing outcomes. The evidence base was moderate-to-high quality, but conclusions were limited by predominantly cross-sectional designs, reliance on self-report measures, heterogeneous outcome definitions, and limited control of organisational and contextual factors. Findings suggest that attachment-informed approaches may be useful within supervision, training, and reflective practice, but should be embedded within wider systemic efforts to support clinician wellbeing.

Keywords: *mental health professionals; attachment; wellbeing; burnout; systematic review*

Introduction

Clinician wellbeing has become an increasingly prominent concern within mental health services due to its implications for workforce sustainability, quality of care, and therapeutic effectiveness. Mental health professionals routinely engage in emotionally demanding work involving sustained interpersonal contact, exposure to psychological distress, and engagement with traumatic experiences. These occupational demands have been associated with a range of adverse outcomes for clinicians, including burnout, compassion fatigue, secondary traumatic stress, and psychological distress (Elwood et al., 2011; Van Hoy & Rzeszutek, 2022). These experiences not only affect the wellbeing of clinicians but may in turn influence therapeutic effectiveness, professional functioning, and service provision.

Mental health professionals often operate within complex and resource-constrained healthcare systems, where increasing service demand and limited resources place additional strain on clinicians. Reports examining healthcare systems have emphasised the importance of staff wellbeing in supporting compassionate, effective care and maintaining service quality. For example, policy developments within the National Health Service (NHS) have highlighted the need to prioritise staff wellbeing as a central component of safe, effective healthcare delivery. Such developments reflect growing recognition that clinician wellbeing is closely linked to patient outcomes, staff retention, and organisational functioning (Hall et al., 2016; NHS England, 2014).

Within the literature, several constructs have been used to conceptualise adverse psychological outcomes associated with clinical work. Burnout is among the most widely studied of these constructs and is typically defined as consisting of depersonalisation, reduced personal accomplishment, and emotional exhaustion, resulting from chronic occupational stress due to emotionally demanding situations (Maslach et al., 1996; Maslach & Leiter, 2016). Burnout has been associated with reduced job satisfaction, increased absenteeism, and

decreased professional efficacy (Pines & Maslach, 1978). Alongside burnout, constructs such as compassion fatigue, secondary traumatic stress (STS), and vicarious trauma have been used to describe the emotional impact of working closely with individuals who have experienced trauma or suffering.

Compassion fatigue refers to the emotional and psychological exhaustion arising from prolonged exposure to others' distress and the sustained use of empathy in professional relationships (Figley, 1995; Stamm, 2002). STS describes trauma-related symptoms experienced by clinicians following indirect exposure to traumatic material through their clients (Figley, 1995). Vicarious trauma refers more specifically to the cumulative transformation in clinicians' cognitive schemas and worldview resulting from empathic engagement with traumatised individuals (McCann & Pearlman, 1990). Another outcome, shared traumatic stress (SdTS), refers to a combination of compassion fatigue and secondary traumatic stress alongside PTSD symptoms which can occur for practitioners who have themselves been exposed to the collective traumatic events they work with (Tosone et al., 2011). Although these constructs have distinct theoretical origins, they overlap conceptually and are used interchangeably within the literature (Figley, 1995; Newell et al., 2016). Together, they represent forms of occupational strain that may emerge when clinicians repeatedly engage with emotionally demanding material in their work.

Research on clinician wellbeing has identified organisational and environmental predictors of these outcomes, including workload, organisational culture, supervision, and access to professional support (O'Connor et al., 2018; Van Hoy & Rzeszutek, 2022). The Job Demands-Resources model proposes that strain develops when sustained organisational demands, such as workload, exceed resources such as autonomy, staffing, and collegial support (Bakker & Demerouti, 2007). These conditions may amplify or buffer individual vulnerability. Alongside these contextual influences, growing attention has therefore been

given to the role of individual psychological factors that may influence clinicians' vulnerability or resilience in the face of occupational stress. One theoretical framework providing insight into these individual differences is attachment theory.

Attachment theory proposes that individuals develop characteristic patterns of relating to others based on early experiences with caregivers. These early relational experiences shape internal working models of the self and others, which influence expectations about relationships, emotional regulation strategies, and responses to interpersonal stress throughout the lifespan (Ainsworth et al., 2015; Bowlby, 1988). In adulthood, attachment orientations are commonly conceptualised both categorically – such as secure vs. anxious-ambivalent or avoidant, or four-category models based on positive and negative intersections between views of the self and others – and dimensionally, where individuals can vary continuously along dimensions of attachment-related anxiety and attachment-related avoidance (Bartholomew & Horowitz, 1991; Brennan et al., 1998; Fraley et al., 2015; Hazan & Shaver, 1987). Attachment anxiety reflects concerns about rejection and abandonment, leading to heightened sensitivity to relational threat and the use of hyperactivating strategies to maintain closeness. In contrast, attachment avoidance reflects discomfort with dependence and intimacy, often associated with emotional distancing and the use of deactivating strategies to manage distress. Dimensional models move from viewing attachment as a trait of personality, and align with evidence that attachment-related strategies are dynamic and context-sensitive, activated under conditions of relational stress, and shape how individuals appraise threat, regulate distress, and utilise interpersonal support (Kobak & Bosmans, 2019).

These attachment-related strategies may have particular relevance for individuals working in therapeutic professions. Clinical work requires sustained empathic engagement, emotional attunement, and the capacity to tolerate and regulate intense emotional material. From an attachment-informed perspective, clinicians' attachment orientations may influence

how they respond to these relational demands. Individuals with higher attachment anxiety may experience heightened emotional reactivity and difficulty regulating distress when faced with interpersonal stressors in therapeutic work. Conversely, individuals with higher attachment avoidance may rely on emotional distancing and deactivating strategies and reduced support-seeking, which may limit their use of interpersonal support or reflective processes that help buffer occupational stress (Mikulincer & Shaver, 2016).

Empirical research has increasingly explored associations between adult attachment and psychological wellbeing across a range of populations. Insecure attachment has been linked to higher levels of psychological distress, poorer emotional regulation, and reduced wellbeing (Karreman & Vingerhoets, 2012; Mikulincer & Shaver, 2016). Within occupational contexts, attachment orientations have also been associated with workplace functioning, interpersonal behaviour, and responses to stress (Hazan & Shaver, 1990; Yip et al., 2018). It has been proposed that this may occur through the mechanisms of maladaptive emotion regulation strategies, increased negative representations of the self, and recurrent interpersonal difficulties (Mikulincer & Shaver, 2012). These findings suggest that attachment may represent an important individual-level factor influencing how professionals manage emotionally demanding work.

Within mental health professions specifically, research examining attachment has often focused on the therapists' attachment orientations and client outcomes (Bruck et al., 2006; Degnan et al., 2016). However, comparatively less attention has been given to the role of clinicians' attachment orientations in shaping their own wellbeing and psychological functioning. Some empirical studies have begun to investigate this relationship, reporting associations between attachment insecurity and adverse wellbeing outcomes among clinicians. For example, studies have found that attachment anxiety and avoidance may be associated with increased burnout, psychological distress, and reduced wellbeing among

health professionals (West, 2015). Follow-up research has also suggested that attachment insecurity may be associated with subsequent burnout and distress over time (Brugnera et al., 2023). These findings highlight the potential importance of attachment-related processes in shaping clinicians' responses to occupational stress.

Despite the relevance of attachment theory to clinician wellbeing, the existing literature remains relatively fragmented. Previous reviews have examined burnout and wellbeing among psychotherapists broadly, identifying multiple organisational and personal predictors of occupational strain (Van Hoy & Rzeszutek, 2022). Additionally, a systematic review examining attachment style in health and human service workers reported positive associations between attachment insecurity – specifically, attachment anxiety – with compassion fatigue and burnout (West, 2015). However, this review included a wide range of professions and did not specifically focus on mental health professionals, who may face unique interpersonal demands in their work comparative to health workers more broadly. A thesis completed in 2018 proposed to synthesise the existing literature regarding mental health professionals' attachment style and wellbeing outcomes, but a number of the studies included populations of non-mental health professionals specifically (Keith, 2018). Nevertheless, a number of empirical studies investigating attachment and clinician wellbeing have been published since 2018, indicating that the evidence base has continued to develop. Consequently, there is a need for an updated and focused synthesis of the literature examining how adult attachment orientations relate specifically to wellbeing outcomes among mental health professionals.

Aim

The present systematic review therefore aims to synthesise available empirical evidence examining the association between adult attachment orientation and clinician wellbeing outcomes among mental health professionals providing mental health care. In

particular, the review focuses on outcomes including burnout, compassion fatigue, STS, vicarious trauma, and broader indicators of psychological distress and wellbeing. By synthesising the available evidence, this review aims to clarify the role of attachment-related processes in clinician wellbeing and to identify potential implications for training, supervision, and workforce support within mental health services.

Method

Design and Registration

The review protocol was pre-registered on PROSPERO prior to data extraction to enhance transparency and reduce risk of bias in the review process (CRD420261304397). The review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines for the identification, screening, and reporting of studies included in systematic reviews (Page et al., 2021). Given the heterogeneity in study populations, attachment measures, and wellbeing outcomes, a meta-analysis was not possible, and a narrative synthesis approach was used to synthesise findings.

Eligibility Criteria

Eligibility criteria were defined in advance to guide identification and selection of relevant studies. Inclusion criteria were:

Population

Participants were majority mental health professionals or trainees aged 18 years or older who had direct client contact and delivered psychotherapeutic interventions or mental health care. Eligible professions included clinical and counselling psychologists, psychotherapists, counsellors, psychiatrists, mental health nurses, and therapy-delivering social workers.

Exposure Variable

The study included a measure of adult attachment in clinicians. Both dimensional and categorical attachment approaches were considered eligible.

Outcomes

The study reported at least one clinician wellbeing outcome. Primary outcomes were burnout, compassion fatigue, STS, SdTS, and vicarious trauma. Secondary outcomes included psychological distress, personal life stress, general wellbeing, and life satisfaction.

Study Design

Quantitative empirical studies including cross-sectional, longitudinal, or experimental designs.

Publication Characteristics

Studies were required to be peer-reviewed and available in the English language, and could have been published in any year.

Exclusion Criteria

Studies were excluded if attachment was measured only in clients; if samples were of professionals without direct therapeutic, psychological, or mental-health related client contact, such as providing only physical health support or administrative-only roles; if the study was qualitative-only, theoretical, a review article, thesis, editorial, or case report; or if the study did not report a wellbeing outcome for clinicians.

Search Strategy

A systematic search of the literature was conducted in February 2026 across five electronic databases: PsycINFO, PubMed, Scopus, CINAHL, and Web of Science. These databases were selected due to their coverage of psychological and health services research relevant to the topic. Searches were conducted without restrictions on publication year to capture the full range of available research.

Search terms were developed with librarians at Oxford Health NHS Trust based on prior reviews in this area. Search terms combined keywords relating to mental health professionals, (examples: therapist* OR psychotherapist* OR counsel?or* OR "clinical psychologist*" OR "counselling psychologist*" OR "mental health nurse*"), attachment (examples: attach* OR "adult attachment" OR "attachment anx*") and wellbeing (examples: burnout OR "emotional exhaustion" OR "compassion fatigue" OR "secondary traumatic stress" OR "vicarious trauma" OR "vicarious traumatization" OR wellbeing OR "well-being" OR distress). Full search strategy is provided in Appendix B.

The search strategy was adapted for each database to reflect differences in indexing systems and subject headings, such as MeSH terms in PubMed (Appendix C). Additionally, backward citation searching was conducted by reviewing references of relevant studies and reviews, and forward citation searching using Google Scholar to identify additional studies citing included papers. No additional papers were identified.

Study Selection

Search results were exported to EndNote reference management software, where duplicate records were removed; no automation tools other than this were used. The remaining records were then uploaded to Rayyan (Ouzzani et al., 2016), a systematic review screening tool, to facilitate the screening process of title and abstract screening then full text review. To reduce risk of bias, a subset of 20% of titles and abstracts (total 493) and 25% of full-text studies (total 38) were independently screened by a second reviewer who was blind to the first author's responses. Inter-rater agreement was assessed using Cohen's kappa coefficient (Cohen, 1960), which was .93 for title and abstract screening, and .98 for full text screening – this is considered excellent agreement. Discrepancies were resolved through discussion to reach consensus. A total of 16 studies were included in the final review. The PRISMA flow diagram illustrates the selection process (Figure 1).

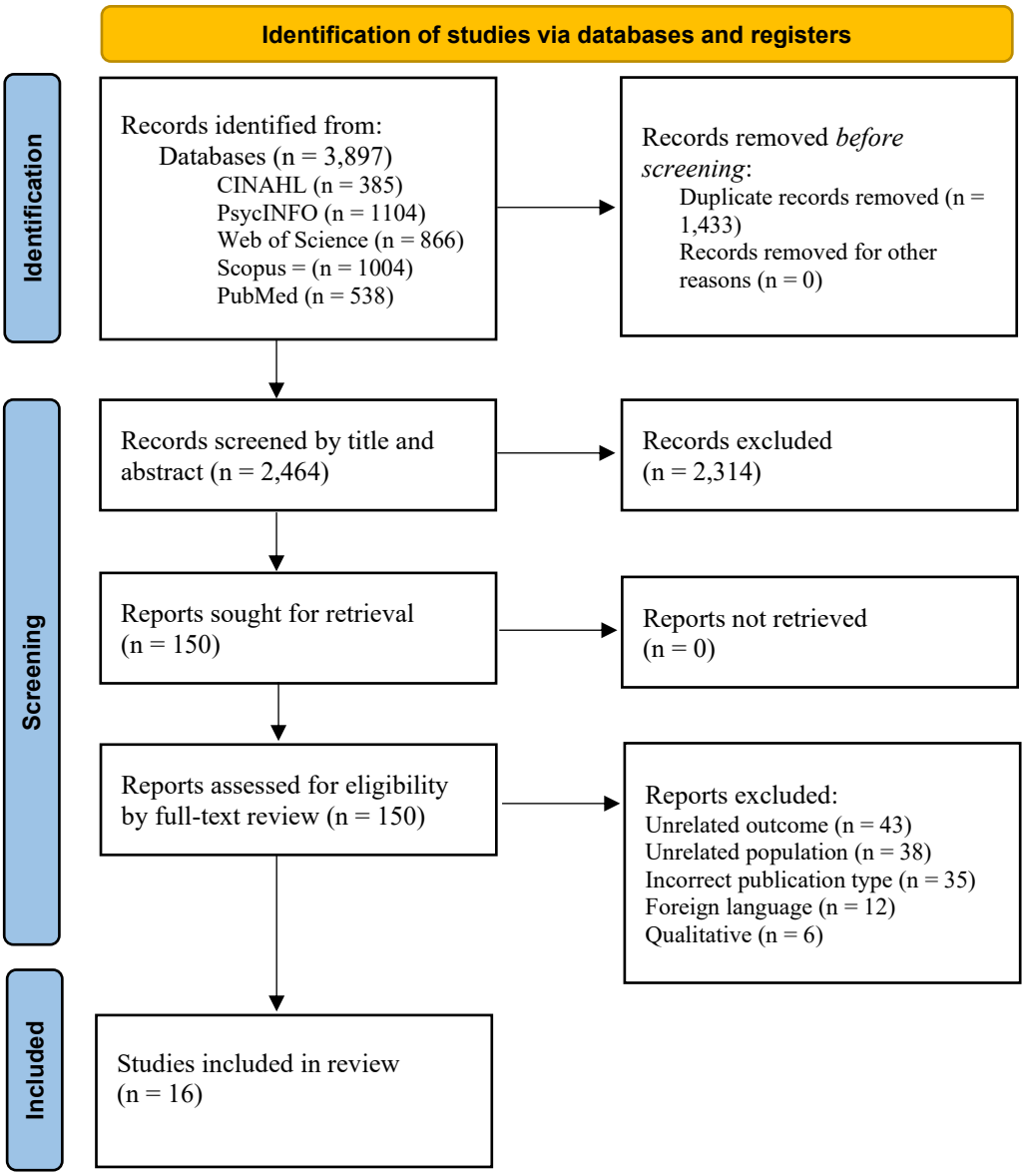


Figure 1. PRISMA flowchart of study selection

Quality Assessment

The methodological quality of studies was assessed using the Standard Quality Assessment Criteria (Kmet et al., 2004), due to its suitability for evaluating quantitative studies across research designs used in psychological and health research. The Kmet checklist consists of 14 criteria assessing quality across domains including study design, sampling, measurement validity, statistical analysis, and reporting clarity. Each criterion is rated on a

three-point scale (0 = no, 1 = partial, 2 = yes) unless not possible to score (N/A), producing a total score from 0-28. The total score is divided by the maximum possible score, and each study assigned into low (0.55 or below), medium (0.56-0.75), or high (0.76 or above) quality categories. Assessment was conducted by the first author and 50% independently rated by a second reviewer, with discrepancies resolved through discussion. Quality assessment results were used to inform interpretation of findings but not to exclude studies.

Data Extraction and Synthesis

Data were extracted from included studies using a structured data extraction form developed for the purposes of this review, piloted and refined prior to full data extraction. The information extracted included the study characteristics of country, setting, design, sampling method, sample profession, sample size, sample gender, sample mean age, ethnicity, attachment assessment instrument used, and wellbeing outcome instrument used. For findings, the statistical methods used, analytic notes, main findings of the attachment-outcomes associations, and direction of association were reported. To enhance reliability, 50% of studies were extracted by a second reviewer with discrepancies resolved through discussion.

Given conceptual and methodological heterogeneity across studies in terms of professional populations, attachment measures, wellbeing outcomes, and study designs, a meta-analysis was not considered appropriate. Instead, findings were synthesised using a structured narrative synthesis approach (Popay et al., 2006) – involving development of theory, conducting a preliminary synthesis, exploring relationships in the data, and reflecting on the robustness and quality of the data – and following principles outlined in the Synthesis Without Meta-Analysis (SWiM) reporting guidance (Campbell et al., 2020) which provides a framework for systematically summarising quantitative findings. This included grouping by

outcome domain, describing the synthesis method, and summarising synthesis findings. Further details of guidelines followed are provided in Appendix G.

Results

Description of Studies

Following study selection, a total of 16 studies were included. These were published between 2003 and 2025 and conducted across a range of national contexts, including the UK, Italy, Egypt, Türkiye, Australia, the USA, Israel, and three studies utilising multinational samples (Heinonen et al., 2022; Racanelli, 2005; Nissen-Lie et al., 2021). Overall, the literature was weighted towards Western settings, although two studies were conducted in non-Western contexts (Elsayes et al., 2023; Yilmaz & Bekaroglu, 2025). Two sets of two studies used the same sample; one set is reported together in the table below (Tosone et al., 2010 and Tosone et al., 2011), and the other reported separately due to measuring different outcome domains (Brugnera et al., 2021 and Brugnera et al., 2023). Key characteristics are summarised in Table 1; studies are ordered by outcome measure, with burnout reported first, followed by STS, compassion fatigue, SdTS, vicarious traumatisation, personal burdens, psychological distress, and life satisfaction.

All studies employed cross-sectional designs, with the exception of Brugnera and colleagues' 2023 study which followed up a smaller subsample of Brugnera and colleagues' 2021 study one year later; however, the 2023 study used new baseline outcome measures and is therefore interpreted in this review as cross-sectional. Sample sizes varied considerably, ranging from 40 to 1,243 participants. Recruitment methods were commonly based on convenience or volunteer sampling through professional networks, training programmes, or online advertisement. Samples were predominantly female, with one exclusively female sample (Marmaras et al., 2003). Reporting of age was variable, with most studies providing

standard deviations and means of age – ranging from 26.97 to 59.8 – and two reporting limited or no age data (Marmaras et al., 2003; Racanelli, 2005). The majority of studies did not report ethnicity demographics, with only six studies doing so – four of these were the aforementioned studies utilising the same samples.

The professional groups represented were diverse and included psychotherapists, psychologists, psychiatrists, therapy-delivering social workers, mental health nurses, and other multidisciplinary mental health staff. Several studies focused solely on single professions, whereas others utilised mixed clinician samples. The clinical settings represented were similarly varied, with the majority recruiting participants working in any therapeutic setting and others including inpatient services, trauma-focused services, psychosis services, and with survivors of terrorism or intimate partner violence (IPV).

Quality Assessment

The quality scores of the studies (Kmet et al., 2004) ranged from 0.59 to 0.90, with a mean score of 0.78. Nine studies were rated high-quality and seven were rated medium-quality. No studies were rated low-quality. The breakdowns of item scoring for each study are detailed in Appendix F, and final quality ratings are in Table 2 below. Overall, the evidence base was of moderate-to-high methodological quality. Common strengths across most studies included clearly stated aims, the use of standardised and validated attachment and wellbeing measures with internal reliability scores reported, statistical analyses that were broadly appropriate to the research questions, and conclusions that were broadly supported by findings.

However, several recurring limitations were identified. All studies used cross-sectional designs, limiting causal inference, and many relied on convenience or volunteer sampling, which may have reduced representativeness and generalisability. Some studies included small sample sizes without power analysis justification which may have impacted

on appropriateness of analytic methods. The majority of studies had incomplete reporting of participant characteristics, particularly regarding ethnicity. Many of the studies acknowledged but had limited control for potential confounding variables, resulting in the possibility of significant associations between main variables which may have been confounded by other variables. In addition, all studies relied solely on self-report measures, increasing the possibility of shared method variance and response bias. One study did not use established and standardised outcome measures, instead relying on two researcher-created single item questions to establish life quality (Heinonen et al., 2022). Two studies used an exploratory approach to study the construct of SdTS, utilising a measure developed by the researchers; however, established and validated measures for compassion fatigue and PTSD were used to create this measure (Tosone et al., 2011; Tosone et al., 2015).

Quality ratings were not used to exclude studies or apply statistical weighting. Instead, ratings were reported in Table 2 and informed the narrative synthesis: findings replicated in higher-quality studies were given greater interpretive weight, while findings from medium-quality studies were retained but assessed according to specific issues such as sampling, measurement reliability, and control of confounders. These judgements informed assessments of robustness within each outcome domain and informed the review's overall conclusions.

Summary of Measures

Attachment Measures

Studies all utilised quantitative, self-report measures of adult attachment. Attachment was most commonly conceptualised dimensionally (n =15), typically in terms of attachment anxiety/ambivalence and attachment avoidance. The majority of studies (n = 9) used variants of the Experiences in Close Relationships measure which assesses two dimensions of anxiety and avoidance (Brennan et al., 1998), and others (n = 4) used the Adult Attachment Questionnaire which assesses dimensions of security, ambivalence, and avoidance (Simpson

et al., 1996). One study (Elsayes et al., 2023) used the Attachment Style Questionnaire (Feeney et al., 1994); and one study (Hartley et al., 2016) used The Attachment Measure (Berry et al., 2006). Only one study (Marmaras et al., 2003) conceptualised attachment categorically, utilising the Relationships Questionnaire (Bartholomew & Horowitz, 1991). Higher scores on dimensional measures reflected greater attachment insecurity (avoidance or anxiety/ambivalence), whereas lower scores indicated greater attachment security. For synthesis, findings are therefore reported primarily in relation to anxiety/ambivalence and avoidance, with categorical attachment styles described separately.

Wellbeing Measures

Studies utilised a range of quantitative self-report measures of wellbeing outcomes. The most commonly assessed were burnout, compassion fatigue, STS, SdTS, and vicarious trauma. Burnout was most often measured using variants of the Maslach Burnout Inventory (MBI; Maslach et al., 1996) which has the subscales emotional exhaustion (EE), depersonalisation (DP), and personal accomplishment (PA). The MBI has been critiqued for treating burnout as a unitary concept while using a three-subscale conceptualisation, as well as whether reduced personal accomplishment represents a core component of burnout (Kristensen et al., 2005). Different versions and subscale reporting practices across studies also limit comparability.

Trauma-related occupational strain was commonly assessed using the Professional Quality of Life Scale (ProQOL) or related trauma symptom measures (Stamm, 2000; Bride et al., 2004). A smaller number of studies examined broader indices of clinician wellbeing, including psychological distress, general wellbeing, quality of life, and personal burdens. Some studies measured more than one outcome, such as burnout and general wellbeing.

Study	Location and setting	Design	Sampling method	Sample profession	N	Gender	Age mean (SD)	Ethnicity	Attachment measure	Wellbeing outcome(s)
Hartley et al. (2016)	UK; three NHS adult psychosis inpatient mental health sites in North West England	Cross-sectional	Convenience sampling, self-selecting self-report survey	Inpatient mental health staff: mental health nurses (25%), support workers (20%), psychologists (18%), occupational therapists (16%), psychiatrists (10%)	50	17 M (34%), 33 F (66%)	37.5 (10.64)	N/R	The Attachment Measure	Burnout: MBI-HSS
Carr and Egan (2017)	Ireland; therapists recruited online in any therapeutic setting	Cross-sectional	Self-selecting, online self-report survey after random emailing by researchers	Psychological therapists	137	25 M (18%), 112 F (82%)	52 (9.9)	N/R	AAQ	Burnout: MBI General stress/ wellbeing: GHQ-12
Hiebler-Ragger et al. (2021)	Austria; health professionals in any setting	Cross-sectional	Self-selecting, online self-report survey after seeing advert in professional networks, social media, email lists	Mixed; psychotherapists or psychologists (41.3%), social workers/educators (42.8%), medical professionals (14.2%), related professions (20.5%).	346	63 M (18.8%), 283 F (81.2%)	45.68 (11.46)	N/R	ECR-RD (ECR-R in German language)	Burnout: MBI. Sense of coherence related to mental and bodily health: SOC-13
Brugnera et al. (2023)	Italy; psychotherapists in any therapeutic setting	Cross-sectional: one-year follow-up of Brugnera et al. (2021) sub-sample but with new outcome measures	Self-selecting, online self-report survey after providing contact details and consent to contact during 2021 study	Qualified psychotherapists with postgraduate psychotherapy training	40	11 M (27.5%), 29 F (72.5%)	47.40 (9.48)	100% white Italian	ECR-R	Burnout: MBI Psychological distress: K10 General wellbeing PGWBI scores from 2021 study used as predictor of MBI and K10 in 2023 study

Castellini et al. (2024)	Italy; multicentre study across psychiatry programmes, with other medical residents as controls, in any setting	Cross-sectional analysis of data from a multicentric longitudinal study	Self-selecting, online self-report survey after being contacted by researchers	Medical residents: focal group was psychiatry residents compared with other medical residents as controls	936 total (645 psychiatry residents; 291 other medical residents)	Psychiatry residents: 252 M (39.07%), 378 F (58.6%), 15 other (2.33%)	29.57 (3.92)	N/R	ECR	Burnout: MBI
Wong and Denson (2025)	Australia; mental health professionals working with IPV victims and/or perpetrators in any therapeutic setting	Cross-sectional	Self-selecting online self-report survey after contact through mailing lists of IPV orgs or adverts on social media groups	Mixed: social workers (26.26%), case workers (21.23%), counsellors (15.92%) registered psych (5.31%), clinical psych (1.68%), trainee psych (0.83%), nurses (0.83%), psychiatrists (0.56%), other (6.98%)	358	44 M (7.54%), 314 F (87.71%), 2 non-binary (0.56%)	39.56 (11.14)	N/R	ECR	Burnout: CBI. Secondary traumatic stress: STSS
Yilmaz and Bekaroglu (2025)	Türkiye; psychologists providing psychotherapy services during COVID-19, in any therapeutic setting	Cross-sectional	Self-selecting, self-report online survey after seeing advertisements	Psychologists actively providing psychotherapy services in Türkiye	80	8 M (10%), 72 F (90%)	32.05 (5.52)	N/R	ECR-R	Secondary traumatic stress: STSS
Racanelli (2005)	Israel and USA (New York metropolitan region); clinicians working with victims of terrorism	Cross-sectional	Self-selecting, online self-report survey after being emailed through society membership or residence address or other advert	Clinical psych (30.3%), clinical social workers (37.9%), psychiatrists (4.5%), counselling psych (7.6%), nurses (7.6%), family therapists (1.5%), other (10.6%)	66 (Israel subsample: 31, USA subsample: 35)	Israel: 15 M (48.4%), 16 F (51.6%); USA: 10 M (28.6%), 25 F (71.4%)	N/R	N/R	ECR-R	Compassion fatigue, satisfaction, burnout: ProQOL: CFS-R-III

Tosone et al. (2010)	USA; Manhattan social workers after 9/11 in any therapeutic setting with survivors of trauma	Cross-sectional	Self-selecting, paper self-report survey after contact through mailing list of associations; quasi-random sample by zip code	Clinical/therapy-delivering social workers exposed to post-9/11 trauma work	481	94 M (19.5%), 383 F (79.6%), 4 N/R (0.8%)	59.83 (9.3)	White: 92.7% Hispanic: 1.9% Mixed race:1.5% Black: 1.2% Asian: 0.6% Other: 0.6%	AAQ	Compassion fatigue: ProQOL: CFS-R-IV compassion fatigue subscale only
Tosone et al. (2011)		Cross-sectional, same sample of Tosone et al. (2010), but different outcomes							AAQ	Shared traumatic stress: mean of scores derived from combined ProQOL: CFS-R-IV compassion fatigue subscale and PCL-C
Tosone et al. (2015)	USA; Gulf Coast after Hurricane Katrina, in any therapeutic setting	Cross-sectional	Self-selecting, self-report online survey after email to participation through university alumni mailing list	Clinical/therapy-delivering social workers	244	44 M (18%), 200 F (82%)	48 (13)	White: 86%, remainder N/R	AAQ	Shared traumatic stress: mean of scores derived from combined ProQOL: CFS-R-IV compassion fatigue subscale and PCL-C
Marmaras et al. (2003)	USA; national sample, trauma therapists for adult outpatient trauma survivors	Cross-sectional	N/R	Female trauma therapists, majority with psychology PhD (72.5%)	375	Female-only sample (100%)	Only categories: 46-55: 48.3% 36-45: 20.5% 56-65: 20.3% 25-35: 8% 66+: 2.9%	Caucasian: 93.6% Hispanic: 2.4% Native Amc: 1.6% Asian 1.1% African Amc:.8% Other: .5%	RQ	Vicarious traumatization: TSI-R-L and IES-R
Brugnera et al. (2021)	Italy; psychotherapists in any therapeutic setting	Cross-sectional	Self-selecting, online self-report survey after seeing advert for study through email, social media, word-of-mouth	Qualified psychotherapists with postgraduate psychotherapy training	416	96 M (20.4%), 320 F (79.6%)	43.94 (10.37)	100% white Italian	ECR-R	General wellbeing: PGWBI

Nissen-Lie et al. (2021)	Multinational sample >30 countries: Australia (77%), Canada (15%), USA (7%); any therapeutic setting	Cross-sectional analysis of international database	Self-selecting, online self-report survey after being invited through conferences, societies, training programs, mailing lists	Counsellors (51%), psychologists (27%), psychotherapists (11%), others (11%)	1,243 in attachment subsample	311 M (25%), 932 F (75%)	53.0 (10.1)	N/R	ECR-S (ECR short form adaptation)	Personal burdens / emotional distress: Personal Burdens scale
Heinonen et al. (2022)	Multinational sample, any therapeutic setting; Europe (89.3%), South Amc (8.5%), North Amc (2.1%)	Cross-sectional analysis of data from broader longitudinal training study	Self-selecting, online or paper self-report survey after being invited to participate through publications, conferences, societies	All trainees: Psychotherapist (83%), psychologist (6.1%), counsellor (3.7%), psychoanalyst (3.8%), marital therapist (3.4%)	1,214	194 M (15.5%), 1,055 F (84.5%)	35.8 (9.3)	N/R	ECR-S (ECR short form adaptation)	Life satisfaction and life stress, created with two single-item q's to compose life-quality patterns of Fortunate/Happy Low-Key/Subdued Intense/Impassioned Distressed/Troubled
Elsayes et al. (2023)	Egypt; Tanta Mental Health Hospital inpatient ward during COVID-19 pandemic	Cross-sectional	Convenience sampling, self-selecting, self-report online survey	Mental health nurses providing direct inpatient psychiatric care	100	42 M (42%), 58 F (58%)	26.97 (5.16)	N/R	ASQ	Psychological distress: K10

Abbreviations. AAQ = Adult Attachment Questionnaire (Simpson et al., 1996); ASQ = Attachment Style Questionnaire (Feeney et al., 1994); The Attachment Measure (Berry et al., 2006); ECR = Experiences in Close Relationships (Brennan et al., 1998); ECR-R = Experiences in Close Relationships–Revised (Fraley et al., 2000); ECR-S = Experiences in Close Relationships—Short (Wei et al., 2007); ECR-RD = German version of the Experiences in Close Relationships–Revised (Ehrenthal et al., 2009); RQ = Relationship Questionnaire (Bartholomew & Horowitz, 1991); GHQ-12 = General Health Questionnaire-12 (Goldberg & Williams, 1988); K10 = Kessler Psychological Distress Scale (Kessler et al., 2003); MBI = Maslach Burnout Inventory (Maslach et al., 1996); MBI-HSS = Maslach Burnout Inventory–Human Services Survey (Maslach & Jackson, 1996); PGWBI = Psychological General Well-Being Index (Dupuy, 1984); ProQOL: CFS-R-IV = Professional Quality of Life Scale: Compassion Fatigue and Compassion Satisfaction subscales Revised (Stamm, 2002); ProQOL CSF-R-III = Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales – Revision III (Stamm, 2002); SOC-13 = Sense of Coherence Scale (Hannover et al., 2004); TSI-R-L = The Trauma Stress Institute Belief Scale-Revision L (Pearlman, 1996); IES-R = Impact of Events Scale-Revised (Weiss & Marmar, 1997); PCL-C = PTSD Checklist-Civilian Version (Ruggiero et al., 2003); STSS = Secondary Traumatic Stress Scale (Bride et al., 2004); CBI = Copenhagen Burnout Inventory (Kristensen et al., 2005); N/R = not reported; IPV = Intimate Partner Violence; Amc = American; M = Male; F = Female

Study Findings and Narrative Synthesis

The summarised findings of the 16 included studies are outlined in Table 2. The table and narrative synthesis are grouped according to outcome domain, with findings organised into the following three categories of: burnout; compassion fatigue, STS, SdTS, vicarious trauma; psychological distress, personal burdens, quality of life, general wellbeing. Within each outcome domain, results were further examined in relation to attachment constructs of anxiety/ambivalence and avoidance. This approach allowed for identification of patterns across studies and facilitated comparison of findings across different methodologies, and follows narrative synthesis guidance regarding grouping conceptually similar findings and assessing the robustness of synthesis (Popay et al., 2006).

Table 2. *Main findings on associations between attachment and wellbeing outcomes*.

Study	Wellbeing outcome measure	Main relevant finding	Statistical evidence reported	Analysis/covariate notes	Direction of association	Quality rating
Hartley et al. (2016)	Burnout: EE, DP, PA subscales	Anxiety significantly positively associated with EE and DP, but not PA. Avoidance not significantly associated with any burnout subscale.	Anxiety-EE $r = .30$, $p < .05$; anxiety-DP $r = .44$, $p < .01$; anxiety-PA $r = .21$, ns. Avoidance: no significant associations.	Pearson's correlations, no adjusted model. Low reliability for MBI-HSS in this sample.	Higher anxiety → greater burnout, specifically EE and DP. Avoidance not significant.	0.68 (Medium)
Carr & Egan (2017)	Burnout: EE, DP subscales General stress/ wellbeing	Anxiety significantly predicted higher stress and EE but not DP. Avoidance significantly predicted higher DP but not stress or EE.	Anxiety-stress $\beta = .35$, $p < .001$, adj. $R^2 = .20$. Anxiety-EE $\beta = .22$, $p < .05$, adj. $R^2 = .12$. Avoidance-DP $\beta = .23$, $p < .05$, adj. $R^2 = .17$.	Hierarchical regressions controlling for demographics, professional variables, perceived social support.	Higher anxiety → higher stress and emotional exhaustion. Higher avoidance → higher depersonalisation.	0.72 (Medium)
Hiebler-Ragger et al. (2021)	Burnout: total Sense of coherence (SOC)	Overall insecurity associated with overall poorer wellbeing. Anxiety clearest adjusted predictor, predicting higher burnout and lower SOC; avoidance predicted lower SOC, weaker evidence for burnout.	Burnout: anxiety $r = .43$, $\beta = .30$, $p < .01$; avoidance $r = .30$, $\beta = .12$, $p < .05$. SOC: anxiety $r = -.54$, $\beta = -.40$, $p < .01$; avoidance $r = -.39$, $\beta = -.17$, $p < .01$.	Hierarchical regressions; controls: experience and supervision. Models explained 30% of burnout variance, 41% of SOC variance.	Higher anxiety → higher burnout, lower SOC. Higher avoidance → lower SOC; burnout association weaker.	0.90 (High)
Brugnera et al. (2023)	Burnout Psychological distress	Baseline anxiety, but not avoidance, predicted greater burnout and psychological distress one year later. Lower baseline wellbeing also predicted both burnout and psychological distress.	Anxiety-burnout: $r = .54$, BF10 = 106.44; anxiety-distress: $r = .62$, BF10 = 1098.71. Burnout model: BF10 = 2741.99, $R^2 = .514$. Distress model: BF10 = 5503.66, $R^2 = .494$.	Small sample but used Bayesian longitudinal regression; predictors at baseline, outcomes at one-year follow-up.	Higher anxiety → greater burnout and distress one year later. Avoidance not a predictor.	0.72 (Medium)
Castellini et al. (2024)	Burnout: EE, DP, PA subscales	Avoidance, but not anxiety, significantly predicted lower PA only. No significant avoidance or anxiety associations found for EE or DP.	Avoidance-PA: $\beta = -.113$, $p = .01$. Anxiety not significant for PA, EE, or DP.	Linear regressions adjusted for age, gender, site of enrolment.	Higher avoidance → lower PA. Anxiety not associated.	0.90 (High)
Wong & Denson (2025)	Burnout STS	Anxiety and avoidance associated with higher burnout and STS, but only correlational. In path model, only avoidance showed significant indirect effects on burnout and STS. No effects found for anxiety.	Anxiety-burnout $r = .35$, $p < .05$; anxiety-STS $r = .37$, $p < .05$; avoidance-burnout $r = .19$, $p < .05$; avoidance-STS $r = .29$, $p < .05$. Significant indirect effects for avoidance: $\beta = .006–.009$, 95% CIs excluding zero.	Path analysis with Monte Carlo mediation; final model showed very good fit: CFI = .995, RMSEA = .029, SRMR = .034.	Higher avoidance → higher burnout and STS indirectly; anxiety correlated with outcomes but was not supported in mediation model.	0.86 (High)
Yilmaz & Bekaroglu (2025)	STS	Anxiety and avoidance associated with higher STS. Coping strategies explained these associations: self-confident coping was protective, whereas helpless coping increased STS risk.	Anxiety-STS: $r = .39$, $p < .01$; avoidance-STS: $r = .29$, $p < .01$.	Multiple linear regression analyses and PROCESS mediation analyses.	Higher anxiety and avoidance → higher STS through coping strategies.	0.82 (High)

Racanelli (2005)	Compassion fatigue, satisfaction, burnout	Attachment not significantly associated with compassion fatigue as central construct. Anxiety and avoidance predicted higher burnout, and anxiety predicted lower compassion satisfaction.	Compassion fatigue: not significant. Burnout: anxiety $B = .39$, $p < .01$; avoidance $B = .27$, $p < .05$. Compassion satisfaction: anxiety $B = -.39$, $p < .01$.	Regression analyses in two country samples; country association not significant.	Higher anxiety and avoidance → higher burnout. Higher anxiety → lower compassion satisfaction. No associations: compassion fatigue.	0.63 (Medium)
Tosone et al. (2010)	Compassion fatigue	Avoidance and anxiety/ambivalence significantly predicted higher compassion fatigue. Avoidance showed stronger association, but effect sizes for both were modest.	Avoidance: $B = .185$, $p < .001$; ambivalence: $B = .094$, $p = .005$; final model $R^2 = .161$.	Hierarchical regression. Controlled for trauma related variables.	Higher avoidance and anxiety/ ambivalence → higher compassion fatigue.	0.86 (High)
Tosone et al. (2011)	SdTS	Avoidance and anxiety/ambivalence both significantly predicted higher SdTS. Effects primarily direct than indirect.	Avoidance = .20, $p < .05$; ambivalence = .19, $p < .05$. Final model: 25% of STS variance.	Path analysis. Controlled for trauma related variables.	Higher avoidance and anxiety/ ambivalence → higher SdTS.	0.86 (High)
Tosone et al. (2015)	SdTS	Avoidance and anxiety/ambivalence both significantly predicted higher SdTS. Effects primarily direct than indirect.	Avoidance: β = .21, $p < .05$; ambivalence: β = .29, $p < .05$.	Path analysis. Controlled for trauma related variables.	Higher avoidance and anxiety/ ambivalence → higher SdTS.	0.82 (High)
Marmaras et al. (2003)	Vicarious traumatisation	All categories of insecure attachment styles associated with greater vicarious traumatization. Fearful-avoidant attachment strongest predictor. Secure attachment not significant in regression models.	Cognitive: fearful-avoid β = .30; preoccupied β = .27; dismissive-avoid β = .13. Behavioural: fearful-avoid β = .21; dismissive-avoid β = .20; preoccupied β = .18.	Multiple regressions; no covariate-adjusted model.	Insecure attachment → greater vicarious traumatization; secure attachment not significant in adjusted models.	.59 (Medium)
Brugnera et al. (2021)	General wellbeing	Anxiety and avoidance significantly associated with lower wellbeing. In path model, both retained significant associations with wellbeing. Reflective functioning partially mediated this.	Anxiety $r = -.49$, $p \leq .01$; avoidance $r = -.40$, $p \leq .01$. Path model: anxiety β = −.25, $p \leq .001$; avoidance β = −.18, $p \leq .001$.	Path analysis controlling for age and gender; model explained 34% of wellbeing variance.	Higher anxiety and avoidance → lower wellbeing; partly explained by lower reflective functioning.	0.90 (High)
Nissen-Lie et al. (2021)	Personal burdens/emotional distress (PB)	Attachment anxiety, but not avoidance, predicted greater PB after controlling for demographic, early-life, personality-related, work satisfaction, current worry.	Anxiety–PB: r = .37, p < .001; avoidance–PB: r = .20, p < .001. Adjusted model: anxiety β = .22, p < .001; avoidance β = −.04, p = .246.	Sequential multiple regression; attachment added after other control variables.	Higher anxiety → higher personal burdens.	0.90 (High)
Heinonen et al. (2022)	Life quality	Attachment insecurity was associated with poorer life quality. Attachment anxiety showed clearest association with both lower life satisfaction and higher life stress.	Anxiety–satisfaction: $\rho = -.26$; anxiety–stress: $\rho = .25$. Avoidance–satisfaction: $\rho = -.18$; avoidance–stress: $\rho = .13$; all ps < .001.	Correlational; no adjusted attachment model. No standardised outcome measure.	Higher anxiety and avoidance → poorer life quality ratings.	0.68 (Medium)
Elsayes et al. (2023)	Psychological distress	Attachment style did not significantly predict psychological distress.	Attachment style: univariate $B = .059$, $p = .813$; multivariate $B = -.240$, $p = .386$.	Regression model, controlled demographic/clinical variables	Attachment not significant.	0.59 (Medium)

Association between Attachment and Burnout

Seven studies examined burnout outcomes, comprising three high-quality (Castellini et al., 2024; Hiebler-Ragger et al., 2021; Wong & Denson, 2025) and four medium-quality studies (Brugnera et al., 2023; Carr & Egan, 2017; Hartley et al., 2016; Racanelli, 2005). Overall, findings suggested that attachment insecurity was associated with higher burnout, although patterns differed across attachment dimensions and burnout subscales.

The most consistent evidence was for attachment anxiety. In two medium-quality studies, anxiety was associated with the EE component of burnout: Hartley et al. (2016) reported a significant correlation, $r = .30$, $p < .05$, while Carr and Egan (2017) found that anxiety predicted EE after controlling for demographic, professional, and support variables, $\beta = .22$, $p < .05$. Hartley et al. (2016) found anxiety was associated with DP, $r = .44$, $p < .01$, although this study used correlations only and did not control for covariates. Stronger evidence came from Hiebler-Ragger et al. (2021), a high-quality study, where anxiety was the clearest adjusted attachment predictor of total burnout, $\beta = .30$, $p < .01$. Brugnera et al. (2023), a medium-quality, small-sample follow-up study, similarly found baseline anxiety was associated with later burnout, $r = .54$, BF10 = 106.44, and was included in the best-supported Bayesian burnout model – however, different outcome measures were used between the baseline and follow-up study.

Evidence for attachment avoidance was less consistent. Carr and Egan (2017) found avoidance predicted DP, $\beta = .23$, $p < .05$, but not EE. Brugnera et al. (2023) and Hartley et al. (2016), however, found no significant associations between avoidance and any burnout subscale. Castellini et al. (2024), a high-quality study, found no significant direct associations between either attachment anxiety or avoidance and EE or DP, although avoidance predicted lower PA, $\beta = -.113$, $p = .011$. Hiebler-Ragger et al. (2021) found avoidance was correlated

with burnout, $r = .30$, $p < .01$, but its adjusted association was smaller than anxiety, $\beta = .12$, $p < .05$, and did not meet significance threshold.

Two studies using broader burnout measures also supported links between attachment insecurity and burnout, but with caveats. Racanelli (2005), rated medium-quality, found both anxiety, $B = .39$, $p < .01$, and avoidance, $B = .27$, $p < .05$, associated with burnout, though the small sample and limited control of confounding reduce confidence. Wong and Denson (2025), rated high-quality, found both anxiety and avoidance correlated with burnout, but direct paths were non-significant in the final path model. Instead, avoidance showed small indirect effects on burnout through caregiving representations and disrupted cognitive schemas, $\beta = .006–.009$, with confidence intervals excluding zero.

Overall, the burnout literature provides moderate evidence – from four medium-quality studies and one high-quality study – that attachment anxiety is associated with EE or total burnout. Evidence for avoidance was more mixed, with some indication of associations with DP, PA, or indirect burnout pathways from two medium-quality and two high-quality studies. Associations with professional group were unclear, due to highly mixed professional samples being studied.

Association between Attachment and Compassion Fatigue, Shared Traumatic Stress (SdTS), Secondary Traumatic Stress (STS), and Vicarious Trauma

Seven studies examined trauma-related occupational wellbeing outcomes. Overall, this evidence was relatively robust, with five high-quality (Tosone et al., 2010; Tosone et al., 2011; Tosone et al., 2015; Wong & Denson, 2025; Yilmaz & Bekaroglu, 2025) and two medium-quality studies (Marmaras et al., 2003; Racanelli, 2005). Across studies, attachment insecurity was generally associated with greater trauma-related outcomes, although the pattern varied by construct and attachment dimension.

The strongest evidence was for avoidant or anxious/ambivalent attachment in relation to compassion fatigue and SdTS. While Racanelli (2005), rated medium-quality, found no significant attachment association with compassion fatigue, Tosone et al. (2010), rated high-quality, found a significant association between attachment avoidance and anxiety/ambivalence with compassion fatigue, with avoidance showing the stronger association: avoidance $B = .185$, $p < .001$; anxiety/ambivalence $B = .094$, $p = .005$. Two further high-quality studies found similar patterns for SdTS, a construct including compassion fatigue and PTSD symptoms. Tosone et al. (2011) found that both avoidance and anxiety/ambivalence predicted higher SdTS, avoidance = .20, $p < .05$; ambivalence = .19, $p < .05$, with the model explaining 25% of the variance. Tosone et al. (2015) replicated this pattern, with avoidance, $\beta = .21$, $p < .05$, and anxiety/ambivalence, $\beta = .29$, $p < .05$, both predicting higher SdTS. These higher-quality studies therefore provide relatively consistent evidence that avoidant and anxious/ambivalent attachment are associated with greater trauma-related occupational strain.

The evidence for STS was also generally supportive, although associations were more indirect. Yilmaz and Bekaroglu (2025), rated high-quality, found that both attachment anxiety and avoidance correlated with higher STS, anxiety–STS $r = .39$, $p < .01$; avoidance–STS $r = .29$, $p < .01$. Mediation analyses suggested these associations operated through coping strategies, with self-confident coping protective and helpless coping increasing STS risk. Wong and Denson (2025), also high-quality, found both anxiety and avoidance correlated with STS, but in the final path model only avoidance showed significant indirect effects on STS through caregiving representations and disrupted cognitive schemas, with small standardised indirect effects, $\beta = .006–.009$, and confidence intervals excluding zero.

Finally, Marmaras et al. (2003), the lowest-rated medium-quality study in this domain, found that insecure attachment styles were all associated with greater vicarious

traumatisation. Dismissive-avoidant, preoccupied, and fearful-avoidant attachment predicted disrupted cognitive schemas, βs = .13–.30, and intrusion, avoidance and hyperarousal symptoms, βs = .18–.21, while secure attachment was not significant.

Overall, the trauma outcomes-related literature provides comparatively consistent findings that attachment insecurity is associated with greater secondary trauma-related outcomes. The strongest evidence showed similar associations for both avoidance and anxiety/ambivalence, particularly in higher-quality studies of compassion fatigue and SdTS.

Association between Attachment and Psychological Distress, Personal Burdens, Quality of Life, and General Wellbeing

Six studies examined broader wellbeing outcomes. Two studies were rated high quality (Brugnera et al., 2021; Nissen-Lie et al., 2021), while four were rated medium quality (Brugnera et al., 2023; Carr & Egan, 2017; Elsayes et al., 2023; Heinonen et al., 2022). Overall, the clearest evidence in this domain was for attachment anxiety, which was more consistently associated with poorer wellbeing than was attachment avoidance.

The strongest evidence came from the two high-quality studies. Brugnera et al. (2021) found that both attachment anxiety and avoidance were associated with lower general wellbeing in psychotherapists, anxiety $r = -.49$, $p \leq .01$; avoidance $r = -.40$, $p \leq .01$. In the path model, both dimensions retained significant direct associations with stronger associations for anxiety $\beta = -.25$, $p \leq .001$; avoidance $\beta = -.18$, $p \leq .001$, with reflective functioning partially mediating these relationships. Nissen-Lie et al. (2021) similarly found that both anxiety and avoidance correlated with personal burdens, anxiety $r = .37$, $p < .001$; avoidance $r = .20$, $p < .001$, but after controlling for several variables, only anxiety remained significant, $\beta = .22$, $p < .001$.

Medium-quality studies broadly supported this anxiety-focused pattern, though with greater methodological limitations. Carr and Egan (2017) found that attachment anxiety was

associated with higher general stress, β = .35, $p < .001$, whereas avoidance was not significant. Brugnera et al. (2023), in a small one-year follow-up sample, found baseline anxiety predicted later psychological distress, $r = .62$, BF10 = 1098.71, and was included in the best-supported distress model; avoidance was not a predictor. Heinonen et al. (2022) found that both dimensions were associated with lower life quality, although anxiety showed stronger associations with lower life satisfaction, $\rho = -.26$, and higher life stress, $\rho = .25$, than avoidance, $\rho = -.18$ and $\rho = .13$ respectively; all ps < .001. This finding should be interpreted cautiously, as life quality was assessed using two single-item questions rather than a standardised measure. In contrast, Elsayes et al. (2023), the lowest-rated medium-quality study in this domain, found that attachment style did not significantly predict psychological distress in either univariate, $B = .059$, $p = .813$, or multivariate models, $B = -.240$, $p = .386$.

Overall, the evidence provides moderate-to-strong support for an association between attachment anxiety and poorer broader wellbeing outcomes. Evidence for avoidance was weaker and appeared less consistent once covariates were included.

Discussion

Overview of Results

This review synthesised published evidence examining the associations between adult attachment in mental health professionals and their wellbeing outcomes. Overall, attachment insecurity was generally associated with poorer clinician wellbeing across all three outcome domains. For burnout, the clearest evidence was for attachment anxiety, particularly in relation to EE and total burnout, while avoidance showed less consistent associations with indirect burnout pathways. For trauma-related outcomes, particularly compassion fatigue and SdTS, findings were comparatively consistent and higher-quality studies particularly implicated both avoidance and anxiety/ambivalence. For broader wellbeing outcomes, the

most reliable pattern was again for anxiety with weaker associations for avoidance. Overall, broadly anxiety showed the most consistent associations across domains, while avoidance was also implicated particularly in trauma-related outcomes and some burnout subcomponents, but less consistently across broader wellbeing outcomes. Findings across domains were not uniform, and variation in study quality, measures used, sample sizes and professions, and analytic approaches limited direct comparison.

The findings are broadly consistent with attachment theory which proposes that attachment shapes emotional regulation, interpersonal expectations, and responses to stress (Bowlby, 1988; Hazan & Shaver, 1987); and previous literature linking insecure attachment with poorer psychological wellbeing and distress (Karreman & Vingerhoets, 2012; Mikulincer & Shaver, 2016; West, 2015). Attachment anxiety is typically associated with heightened sensitivity to threat, fear of rejection, and hyperactivating emotion-regulation strategies (Brennan et al., 1998; Mikulincer & Shaver, 2016). This may help explain its more consistent association with EE, distress, personal burdens, and lower general wellbeing. These outcomes involve heightened emotional strain and difficulty regulating distress, which appears conceptually compatible with anxious attachment processes. This pattern also extends previous reviews suggesting that attachment anxiety may be particularly relevant to negative personal outcomes in helping professionals (Keith, 2018; West, 2015).

By contrast, avoidance showed a less uniform pattern, but was particularly implicated in trauma-related outcomes and some burnout subcomponents. Avoidant attachment is associated with emotional distancing, discomfort with dependence, and reduced support-seeking (Mikulincer & Shaver, 2016). These strategies may be adaptive in the short-term when managing emotionally intense clinical material, but may become problematic if they impact emotional processing, reflection, or use of support. This interpretation is consistent with the trauma-related studies, where higher-quality evidence suggested both avoidance and

anxiety/ambivalence were associated with compassion fatigue and SdTS. Similarly, findings from Wong and Denson (2025) and Castellini et al. (2024), suggest that avoidance may not always operate through simple direct effects but through cognitive, interpersonal, or mentalising mechanisms.

The findings also highlight the importance of disaggregating wellbeing constructs. Burnout, compassion fatigue, STS, SdTS and vicarious trauma are overlapping but theoretically distinct constructs (Elwood et al., 2011; Figley, 1995; Maslach et al., 1996; McCann & Pearlman, 1990; Newell et al., 2016). In this review, EE and general distress appeared more consistently associated with attachment anxiety, whereas DP, PA, STS, and shared or vicarious trauma outcomes showed associations with avoidant or mixed insecure attachment patterns. This may reflect differences in what each outcome captures: emotional depletion and general distress may be more closely related to hyperactivation, while trauma-related cognitive disruption or interpersonal distancing may be more relevant to avoidant strategies. However, these interpretations should remain tentative because studies varied in both their conceptualisation and measurement of outcomes.

There was limited evidence that findings differed by professional group. Studies of psychotherapists and psychologists more often examined broader wellbeing and burnout, while social worker studies more often focused on collective trauma and SdTS. Therefore, apparent professional differences may reflect differences in context, trauma exposure, outcome domain, and measurement rather than profession itself. Few studies directly compared professional groups or tested profession as a moderator.

Study Quality and Limitations

The overall quality of the included studies was moderate-to-high, with nine rated high-quality and seven medium-quality. This increases confidence that the review captured a meaningful pattern of association between attachment insecurity and poorer wellbeing.

Several higher-quality studies used validated measures, appropriate regression or path models, and some control of relevant covariates. In particular, higher-quality evidence supported associations between attachment anxiety and broader wellbeing outcomes, and between both avoidance and anxiety/ambivalence and trauma-related outcomes.

However, important limitations reduce the certainty of interpretations. Most studies were cross-sectional, meaning causality cannot be inferred. It is not established whether attachment insecurity contributes to poorer wellbeing, whether distress activates or amplifies insecure attachment strategies, or whether both are influenced by wider personal, organisational, or contextual factors. Although Brugnera et al. (2023) provided some temporal evidence of attachment effects on wellbeing, the small sample and different outcome measures used at baseline and follow-up means findings should be interpreted cautiously.

All studies relied on self-report measures, increasing the possibility of common method and response bias. Recruitment was often convenience-based or self-selecting, which may have overrepresented clinicians with particular interest in attachment or wellbeing. Samples were predominantly female and largely Western, with ethnicity poorly reported, limiting interpretation and conclusions about wider contextual factors, such as possible workplace discrimination, which may contribute to poorer wellbeing outcomes for different demographic populations and cultural contexts.

Measurement and analysis heterogeneity also limited synthesis. Confounding variables were often not accounted for, and wellbeing outcomes were varied, including MBI subscales, ProQOL compassion fatigue, STS scores, researcher-derived SdTS composites, single-item life-quality indicators, and general wellbeing measures. Consequently, some findings should be weighted cautiously, including but not exclusive to Hartley et al. (2016)

due to low MBI subscale reliability, Heinonen et al. (2022) due to non-standardised life-quality items, and Marmaras et al. (2003) due to lack of covariate adjustment.

Overall, while the evidence suggests an association between attachment insecurity and poorer clinician wellbeing, the heterogeneity of constructs, measures, samples, and analytic approaches prevented meta-analysis and limits definitive conclusions about specific attachment dimensions or professional subgroups.

Strengths and Limitations of the Review

This review had several strengths. The protocol was pre-registered on PROSPERO and the review was conducted in accordance with PRISMA guidance (Page et al., 2021), supporting transparency and methodological rigour. The search strategy was developed with librarian input and applied across five databases, with additional citation searching, increasing the likelihood relevant studies were identified. Clear inclusion and exclusion criteria were used, and screening reliability was strengthened through independent second-reviewer screening of a proportion of studies, with excellent inter-rater agreement. Data extraction and quality assessment were also partially checked by a second reviewer, and the use of a structured quality assessment tool allowed quality to inform the synthesis rather than treating all findings equally. The review also extends previous work by focusing specifically on mental health professionals and by including a broader range of wellbeing outcomes published since earlier reviews, as well as following narrative synthesis guidelines.

However, limitations include that only English-language, peer-reviewed studies were included, which may have introduced language and publication bias and excluded potentially relevant grey literature. The review included quantitative studies only, meaning qualitative accounts of attachment processes shaping clinician wellbeing were not captured. Although this focus supported comparison of statistical associations, it limited exploration of clinicians' lived experiences. Meta-analysis was not possible due to substantial heterogeneity in

professional groups, attachment measures, outcome measures, and analytic approaches. As a result, conclusions were based on narrative synthesis and remain partly interpretative. Furthermore, broader constructs such as personal-life stress and general wellbeing were included as secondary outcomes to capture aspects of clinician wellbeing beyond work-specific impacts and provide a more comprehensive synthesis. However, they are not specific to occupational experience and may reflect broader associations between attachment and distress. Grouping these constructs also increased heterogeneity and limited direct comparison across studies. Finally, the review's broad inclusion of different professional groups and settings increased coverage of the evidence base, but limited the extent to which conclusions could be drawn about specific professions, clinical contexts, or types of mental health work.

Clinical Implications

Findings suggest that attachment-informed approaches may be useful in supporting clinician wellbeing, particularly within supervision, training, and workforce support. However, these findings should not be interpreted as locating responsibility for distress within individual clinicians. Clinician wellbeing is shaped by organisational factors including workload, staffing, supervision quality, service culture, and exposure to client trauma (Van Hoy & Rzeszutek, 2022). Therefore, attachment-informed practice should be used to develop reflective and compassionate systems, rather than to imply that insecure attachment represents professional vulnerability in a fixed or deterministic way.

At an individual and supervisory level, the findings suggest value in reflective spaces that help clinicians notice how attachment-related strategies may be activated under occupational stress. For clinicians high in attachment anxiety, supervision may support emotional regulation, self-compassion, and the use of appropriate support when feelings of threat, rejection, or over-responsibility arise. For clinicians high in avoidance, supervision

may support safe emotional processing, help-seeking, and reflection on distancing strategies that may otherwise reduce support-seeking. This is consistent with evidence that the supervisory relationship is associated with burnout and sense of coherence in health professionals (Hiebler-Ragger et al., 2021).

Training programmes and services may also benefit from promoting skills linked to potential mechanisms identified in the review, including coping strategies and awareness of caregiving representations (Brugnera et al., 2021; Wong & Denson, 2025; Yilmaz & Bekaroglu, 2025). Such approaches could include reflective practice groups, supervision training, trauma-informed staff support, and psychoeducation around occupational stress and secondary trauma. Given evidence that therapist burnout may be associated with poorer client outcomes, supporting clinician wellbeing is also relevant for service quality and therapeutic effectiveness (Delgadillo et al., 2018).

Directions for Future Research

Future research should prioritise longitudinal and prospective designs to clarify the direction of associations between attachment and clinician wellbeing. The current evidence is predominantly cross-sectional, meaning it remains unclear whether attachment insecurity contributes to poorer wellbeing, whether occupational distress activates attachment-related strategies, or whether both are influenced by wider organisational and contextual factors. Larger, adequately powered studies are needed, with stronger control of confounders such as workload, caseload complexity, trauma exposure, supervision, organisational culture, personal trauma history, and wider wellbeing resources. This is particularly important given wider evidence that individual and work-related factors contribute to burnout and wellbeing among mental health professionals (O'Connor et al., 2018; Van Hoy & Rzeszutek, 2022).

Greater consistency in measurement is also needed. Studies should use validated and clearly defined measures of both attachment and wellbeing outcomes, while distinguishing

between burnout subcomponents, STS, compassion fatigue, SdTS, vicarious trauma, and broader distress. This would allow future reviews to compare findings more robustly and potentially conduct meta-analysis.

Further research should examine whether associations differ across professional groups, therapeutic settings, and types of clinical work, particularly trauma-focused or high-intensity roles. Studies should also test potential mechanisms briefly identified in this review, including coping strategies, caregiving representations, and cognitive schemas.

Finally, future studies should improve demographic reporting and consider social GRACES, including ethnicity, gender, culture, class, and disability. Current evidence was largely Western, predominantly female, and often poorly reported ethnicity. More inclusive sampling and intersectional analyses would improve generalisability and reduce the risk of assuming that attachment and wellbeing processes operate similarly across all clinicians.

Conclusion

This review synthesised evidence on associations between adult attachment and wellbeing outcomes in mental health professionals. Overall, findings suggest that attachment insecurity is associated with poorer clinician wellbeing, with attachment anxiety showing the most consistent associations across burnout, psychological distress, and general wellbeing. Attachment avoidance was also implicated, particularly in trauma-related outcomes and some burnout subcomponents. These results support the relevance of attachment theory for understanding how clinicians may experience, regulate, and seek support for occupational stress. However, conclusions are limited by cross-sectional designs, self-report measures, heterogeneous outcome constructs, and limited control of contextual factors. Attachment-informed approaches may be useful within supervision, training, and reflective practice, but should be embedded within wider systemic efforts to support clinician wellbeing. Future longitudinal and more diverse research is needed to clarify directionality and mechanisms.

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Service Improvement Project

Barriers and Facilitators to Accessing Psychological Trauma Support for Refugees and Asylum Seekers: Perspectives from Clients and Referrers

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Proposed Journal: The Cognitive Behaviour Therapist has been selected based on the project's relevance to CBT practitioners as the service is an evidence-based CBT trauma service. Additionally, the journal focuses on contributing to increased access and inclusivity for minoritised identities, while the project focuses on increased access to CBT treatment for a minoritised demographic.

Abstract

Background: Asylum-seeker and refugee (ASR) individuals receive reduced referral and access to mental health services, despite elevated need. The focus for this project was a specialist NHS traumatic stress service providing evidence-based treatment for complex post-traumatic stress disorder. The service receives few referrals for ASR individuals relative to total referrals. This project aimed to understand barriers to referral and access, and to make recommendations from findings based on referrer and client perspectives.

Method: Semi-structured interviews were conducted with six common referrers, and four ASR clients accessing the service. These were analysed using reflexive thematic analysis.

Results: Data for referrer and ASR interviewees were analysed separately and themes generated separately. 5 key themes were identified from referrers: i) Perceived Inaccessibility of the Service, ii) Confusion about Eligibility, iii) Stability as a Prerequisite for Referral, iiii) Interpreters as Necessary but Challenging, v) Cross-Service Collaboration as a Facilitator. 4 key themes were identified from ASR clients: i) Fears of Judgement and Stigma, ii) Uncertainty Around Entitlement, iii) Importance of Establishing Safety and Trust, iiii) Value of Flexibility and Empathy. Recommendations were drawn from the themes including increased internal and external collaboration, clarification of ASR eligibility and entitlement criteria, person-centred care accounting for individual client needs, and increased visibility of the service.

Conclusion: This project highlights the barriers to referral and access to a specialist traumatic stress service for ASR clients. Findings may be of interest and utility to mental health services. Recommendations made may improve access for this minoritised group.

Keywords: *asylum seekers, refugees, posttraumatic stress disorder, access, inclusivity*

Key Learning Objectives for Readers

- To increase understanding of barriers and facilitators affecting referral and access to a specialist NHS traumatic stress service for ASR.
- To identify how clinician perceptions of eligibility, service accessibility, and client "stability" may influence referral decision-making for ASR.
- To understand how fears of judgement, uncertainty about entitlement, and the need to establish safety and trust may influence early engagement with mental health services.
- To consider how flexibility, empathy, culturally aware practice, and cross-service collaboration may improve access to trauma-focused care for ASR.

Introduction

Terminology regarding forced migration is complex, contested, and evolving alongside legal and geopolitical contexts. ‘Asylum seeker’ and ‘refugee’ have specific legal and administrative functions, but these labels are not neutral: they can homogenise diverse experiences and may be accepted or resisted by those to whom they are applied, for example to resist a permanent identity of displacement (Crawley & Skleparis, 2018; Zetter, 2007). This project therefore uses ‘asylum seekers and refugees’ pragmatically, reflecting individuals’ recorded legal or service categories, while recognising that these terms may not represent every individual’s preferred identity or changing circumstances.

Individuals who are asylum seekers or refugees (ASR) can face repeated and prolonged exposure to traumatic and stressor events over their lifetime, spanning the pre-migration phase (such as facing war, persecution, and torture), during the migration journey, and even post-migration once they are in their resettled environment (Mesa-Vieira et al., 2022; Priebe et al., 2016). Research shows that due to these cumulative stressors, there may be higher rates of mental health difficulties in ASR populations compared to general populations (Blackmore et al., 2020; Henkelmann et al., 2020; Patanè et al., 2022). In particular, prevalence estimates of post-traumatic stress disorder (PTSD) in refugee groups are around 29%, with similarly elevated rates of depression (Henkelmann et al., 2020). These rates are higher than those observed in the general population; in England, 20.2% of adults had a common mental health condition in 2023/24, and 3.8% met criteria for a depressive episode (Morris et al., 2025).

It should be noted that although concepts such as PTSD can be clinically useful, they can derive from Western psychiatric frameworks and may not fully capture culturally situated understandings of distress (Hinton & Lewis-Fernández, 2011). Jabr and Helbich (2022) argue that PTSD can also decontextualise suffering under ongoing political violence: there may be

no clear ‘post’ when threat remains current. Such experiences should therefore be understood within their cultural and sociopolitical contexts, including through continuous traumatic stress frameworks (Eagle & Kaminer, 2013).

Considering this heightened vulnerability and that high levels of mental health difficulties including PTSD can persist for many years after displacement and resettlement (Blackmore et al., 2020), access to mental health services and support for ASR individuals is a critical need. However, ASR appear to find mental health services inaccessible, and referral rates remain low (Byrow et al., 2020; DeSa et al., 2022; Satinsky et al., 2019). Despite the clear elevated rate of difficulties, many ASR individuals do not receive care proportionate to their needs. One UK service evaluation found that asylum seekers were not over-represented in a mental health crisis team despite high levels of severe mental illness in this population, suggesting that systemic barriers may be limiting access rather than need being low. All asylum seekers on the caseload had experienced trauma and over half required an interpreter, highlighting clinical complexity and communication needs services may need to address. The authors identified barriers including poor awareness of services, stigma, cultural differences in help-seeking, trust concerns, and lack of culturally and linguistically appropriate information (Lashwood et al., 2025). In summary, ASR populations do not receive appropriate mental health care due to multiple limitations in referral and access (WHO, 2023).

A range of factors may help explain low referral and service utilisation rates for ASR. On the provider side, clinicians may remain unaware of trauma histories if they do not inquire directly about them, and some may feel under-equipped to manage refugee mental health needs in routine care (Eisenman et al., 2000; Jensen et al., 2013). Clinicians may also perceive that trauma-focused treatment is not feasible while ASR are living in unstable circumstances, despite UK National Health Service (NHS) guidance stating that unresolved

asylum claims or temporary accommodation should not preclude access to trauma-focused therapy, and broader review evidence suggesting psychological interventions during ongoing threat can still be beneficial (NHS England, 2024; Yim et al., 2024). This highlights the importance of improving clinicians' knowledge, confidence, and cultural competence regarding ASR-specific challenges. Better training has been recommended to support clinicians' identification of ASR trauma, to make appropriate referrals, and to provide culturally appropriate care for refugee populations (Jensen et al., 2013; Satinsky et al., 2019; Shannon et al., 2012). Service provision must also be situated within the wider current political context. In the UK, hostile-environment immigration policies and racialised narratives may create barriers to healthcare – whose needs are recognised and whose distress is legitimised, may reflect political and structural forces alongside clinical need (Holmes & Castaneda, 2016; Shahvisi, 2019).

From the perspectives of ASR themselves, there are numerous documented barriers to help-seeking. These encompass practical, cultural, and systemic obstacles that can discourage ASR from accessing support, and include limited knowledge of available services and how to access them, as many ASR individuals may be unfamiliar with the host country's healthcare system and uncertain about how to navigate referral pathways (Byrow et al., 2020). Additionally, language and communication difficulties may act as a barrier, as limited proficiency in the local language can make it harder to explain symptoms and engage with clinicians; where interpreters are needed, issues of trust and understanding may add further complexity (Lashwood et al., 2025). A perceived lack of cultural understanding may also discourage engagement, particularly where healthcare providers are seen as not understanding an individual's cultural background, and where Western models of mental health do not align with personal understandings of distress (DeSa et al., 2022). Finally,

stigma and shame surrounding mental health may be a significant barrier, with some individuals avoiding help for fear of being judged or ostracised (Byrow et al., 2020).

Although existing literature has identified a range of structural and interpersonal barriers to mental health access for ASR populations, there remains a need to understand how these barriers are experienced within specific service contexts, particularly within UK NHS trauma services. As above, existing literature identifies broad challenges such as stigma, language barriers, limited knowledge of services, and clinician uncertainty, but there is a need for further insight into how these difficulties shape referral decision-making, eligibility perceptions, and early engagement with specialist trauma services in practice. Qualitative research is well placed to contribute to this evidence base, as it can capture the perspectives of both referrers and ASR clients themselves, and explore how barriers and facilitators are understood, experienced, and potentially reproduced within everyday service pathways. A more detailed understanding of these processes may help inform service development and improve equitable access for ASR individuals.

The project was informed by Levesque et al.'s (2013) healthcare-access framework, which understands access as an interaction between individual, interpersonal, organisational, and systemic factors. Trauma-informed principles of safety, trust, and collaboration also informed exploration of how service processes may facilitate or hinder ASR clients' engagement (Sweeney et al., 2018).

Service Context

The service evaluated in this project is a specialist UK NHS traumatic stress service offering a range of trauma-focused treatment modalities, including cognitive-behavioural therapy and compassion-focused therapy, for adults with post-traumatic stress disorder (PTSD) or Complex PTSD (C-PTSD). This project was commissioned due to recognition from the service that access barriers for ASR have not been comprehensively understood and

that there is a lack of guidelines in place for working with these individuals. There are very few ASR individuals (approximately 5 per year) referred to and treated in this service relative to total referrals and as such, there is a recognised need to investigate and address potential barriers leading to possible low referral rates. This is consistent with NHS commitments to equal access to mental health services (NHS England and NHS Improvement, 2020). Given the high rates of psychopathology among this group (Henkelmann et al., 2020), the low ASR referral rates to the service, and NHS commitment to equal access policies, the need for understanding this potentially unequal access to the service for ASR is clear. While some Trust-wide changes – namely, changes to cross-service referral discussion platforms – coincided with the data collection for the project, the findings and recommendations remain relevant and applicable.

Based on the above, this project aimed to understand:

1. From the perspectives of common referrers to the service, what are the perceived barriers and facilitators to referring ASR to the service?
2. From the perspectives of ASR clients who are accessing the service, what are the perceived barriers and facilitators to access to the service?
3. What actionable recommendations can be drawn from these findings in order to improve referral and access to the service for ASR individuals?

Method

The project received approval from the Berkshire Healthcare NHS Foundation Trust Audit Department (ID: 10831; approval evidenced in Appendix R).

Participants

Referrer participants

The referrals made to the service during 2024 were analysed and proportions of referrals from key services were established. This identified the most common referrers as being other NHS services, namely the Common Point of Entry, Talking Therapies, local Mental Health Integrated Community Services (MHICS), and local Community Mental Health Teams (CMHTs). These and other organisations such as General Practitioners (GPs) and charities, as well key contacts within each service, were emailed and invited to participate. All six individuals who agreed to participate were interviewed, and none were excluded. A further six NHS services, nine GPs, and three charities were invited to participate, but did not respond. The distribution of participants across services can be seen in Table 1 below.

Table 1

Participating Referrer Services

Service	*N= 6*
NHS: Talking Therapies	3
NHS: Community Mental Health Team and Mental Health Integrated Community Service	1
NHS: Intensive Management of Personality Disorders and Clinical Therapies Team (IMPACTT)	1
Third Sector: Reading Refugee Support Group	1

Asylum seeker or refugee participants

Reviewing clinicians' caseloads and the clinical records of the service, clients were identified as having asylum seeker or refugee status. Analysis of records identified that approximately 5 ASR individuals are referred to the service each year. Of these, identified clients were contacted by the key clinician delivering their intervention to explain the study

and ask whether they would be interested in participating; five clients were contacted and four consented to participate. An interpreter was used with one participant who was not fluent in English. Inclusion criteria were: 1) identifying as holding ASR status; 2) being a client in the service either actively receiving or waiting for treatment; 3) being above the age of 18. Full demographic data can be seen in Table 2 below.

Table 2

ASR Participant Demographics

Demographic Variable	*N= 4*
Age	
30-40	4
Region of Country of Origin	
South Asia	1
West Africa	1
Southeast Europe	2
Gender	
Male	1
Female	3
In Treatment at Time of Interview	
Yes	2
No	2

Materials

For the two participant groups, two semi-structured interview schedules (Appendix H) were developed by the main researcher based on the aims of the project and refined with feedback from project supervisors and patient and public involvement. These included questions on barriers, facilitators, and suggestions for improvements to referral or access to

the service. The questions were broad to allow for flexibility in participant response, but prompts were included to be used flexibly as needed, based on each individuals' elaboration in responses.

Patient and Public Involvement

Two individuals with past ASR status who had accessed NHS mental health services used their lived experience to contribute to the development of participant information and consent sheets, and the interview schedule. This input mainly shaped the wording of the interview schedules and the addition of prompts, based on the individuals' experiences with services.

Procedure

After ASR clients had given consent to participate, they were contacted via telephone call by the primary researcher to explain full details of the study (Appendix I), gain their informed consent and signature (Appendix J), and arrange a video interview. For referrers, this process was carried out via email.

Interviews took place from January 2024 to September 2024 using Microsoft Teams. Interviews lasted between 40 to 60 minutes, and were conducted by the primary researcher using the interview schedules. With participants' consent, they were recorded using an encrypted Trust device and in accordance with the Trust's Information Governance guidelines, then transcribed and anonymised. At the end of each interview, participants were given a verbal debrief, and given the primary researcher's contact details or invited to speak to their clinician regarding questions or issues.

Data Analysis

Interviews were transcribed then analysed using the Braun and Clarke (2006, 2021) reflexive thematic analysis approach, combining inductive and deductive analysis. This involved moving iteratively between the two: inductively, coding remained open to

unanticipated meanings within participants' accounts, while deductively, the project aims and existing literature sensitised the analysis to barriers and facilitators. This permitted both addressing the aims of the project, while also allowing participants' perspectives to extend existing understanding. However, existing ideas may have drawn attention towards expected patterns, while the researcher's own perspective may have influenced the inductive analysis (author positionality in Appendix L).

Transcripts were read several times to support familiarisation, and initial codes were generated directly within the transcripts using highlighting and comments, then related codes were grouped into preliminary themes. Themes were subsequently reviewed and refined iteratively by returning to the dataset and checking coherence between and within themes to develop the final definitions. Emerging codes and themes were discussed with a second reviewer to support reflexive engagement with the data and consideration of alternative interpretations. Once results were finalised and recommendations drawn, a feedback session with service clinicians was held to present these and gain ideas on the recommendations' feasibility, which further informed the recommendations.

Results

A range of experiences were gathered in interviews with referrers and ASR clients. Resulting themes are summarised in Table 3 below.

Table 3

Summary of Themes

Referrer Themes	Client Themes
1. Perceived Inaccessibility of the Service	1. Fears of Judgement and Stigma
2. Confusion about Eligibility	2. Uncertainty around Entitlement

3. Stability as a Prerequisite for Referral	3. Importance of Establishing Safety and Trust
4. Interpreters as Necessary but Challenging	4. Value of Flexibility and Empathy
5. Cross-Service Collaboration as a Facilitator	

Referrer Themes

Five themes were found in the data gathered from referrer participants (RP).

Theme 1: Perceived Inaccessibility of the Service

All referrers described the service as a difficult service to refer into, due to a range of factors. Some referrers cited the lack of perceived clarity and consistency in referral criteria and acceptance: "*It's so difficult because between what I think their criteria should accept and what they do accept, sometimes there is a real disparity. It's not consistent about when they accept certain referrals and when they don't*" (RP1).

For some referrers, the administrative load of completing lengthy referral forms with this lack of clarity appeared to impact this perception of inaccessibility of the service: "*It's hard to gather all the information they need about whether a client has complex PTSD or not. It's not really our role to do that diagnosis, they need to change that expectation of a perfect referral*" (RP2).

After completing the forms, a lack of feedback when referrals were rejected was cited by some referrers as a deterrent to referring again in future, and as a contributing factor to clinicians feeling undermined and deskilled by high rejection rates and lack of feedback: "*Psychologists and therapists are referring then maybe being declined and people feel undermined because they are psychologists in their own right. The client has complex PTSD and requires this treatment so why is another colleague saying otherwise?*" (RP3) and "*Nobody even gets back to us about why the referral was not accepted*" (RP5).

Long waiting times for clients to receive treatment led to referrals being made to third-sector services with shorter waiting times: "*I'm also conscious that there are specific charities that are funded which might enable them to get access to that treatment sooner*" (RP4). For referrers working in Talking Therapies, this issue of waiting times in addition to the perceived "grey area" of complexity between what primary services could treat and what the service would accept, led to clients being treated within primary care: "*They might as well work with clinicians within Talking Therapies who are trained, rather than putting lots of work in just to be told no*" (RP1).

Ultimately, referrers expressed frustration at the opacity of the acceptance process and a recurring sentiment was that high rejection rates led to a sense of futility, with one stating: "*You kind of think, what's the point*? *It's a real struggle to get people in there and they won't be accepted anyway*" (RP1).

Theme 2: Confusion About Eligibility

Referrers described confusion around whether the service would accept individuals with asylum-seeker status for referral. While some reported knowing that asylum status alone was not a disqualifier for receiving treatment in secondary services due to recent training, other referrers reported remaining uncertainty. Perceptions of policies that asylum-seekers were not eligible for secondary care were reported to be common among referrers' colleagues, which they reported could impact likelihood of referral: "*we had an assumption that if people were waiting for the outcome of their claim, we couldn't refer them and they couldn't have treatment*" (RP6).

However, some referrers described that training delivered by the service around this perception had been helpful in providing clarity that asylum-seekers are in fact eligible: "*It was them telling other services that ASR clients can have access to secondary care when*

everyone else was adamant that they couldn't, that nothing had changed. They were pioneering in that respect" (RP2).

Theme 3: Stability as a Prerequisite for Referral

Clients' overall stability was considered by referrers as a prerequisite for referral to the service. Referrers described ASR clients as often not meeting this due to unstable housing, uncertainty around asylum status, ongoing traumatic stressors, or limited social support: "*I would say that if they do not have good social support to support them through treatment, the isolation might mean that they do not stay engaged*" (RP1) and "*With the hierarchy of needs, when some of those basic areas aren't met it's not possible then to work on the psychological aspects*" (RP4).

While some referrers acknowledged that these same adversities were trauma-related and might therefore increase clients' need for the service, the view reported by most referrers and reportedly among colleagues was that without sufficient stability, trauma-focused work was unlikely to be effective so they would be unlikely to refer: "*Just this morning I was gonna refer someone but that's because this client is at a place where most social barriers are resolved so they can engage with trauma therapy more successfully. So are there high levels of risk, social issues that need resolving like instability in accommodation, good social network… that work needs to be done first before being referred because the service is clearly for trauma-focused work*" (RP3) and "*I'd be thinking about, are they in a stable enough place to do that work at the minute? Prior to that kind of help maybe stabilise what's going on for them… those kinds of thoughts would block me from referring*" (RP6).

Theme 4: Interpreters as Necessary but Challenging

Referrers were generally comfortable with the idea of working through interpreters, and all were aware that the service did not see interpreter use as a barrier. However, referrers reported that their clients had concerns about trust, community links, and confidentiality

related to interpreters: "*Interpreting has always been a challenge in that it's hard to get a consistent interpreter. They may have left the country and because of the people they know they might worry that the interpreter is affiliated so some levels of mistrust could be present*" (RP3) and "*It sometimes can be a bit of a difficulty of getting the same consistent interpreter which adds an extra barrier for the client in terms of trust*" (RP4).

Some clients were thought to withhold information due to fear that interpreters might relay sensitive details to their community. Using interpreters was also seen as potentially slowing down therapeutic progress for clients, which could lead to dropouts from treatment: "*The concerns about interpreters and having a small pool and not feeling safe saying too much but they're stuck because they require an interpreter… I find it a lot slower to make progress when you need to use an interpreter. If they're not seeing a quick improvement they may be less likely to continue with therapy*" (RP2).

Theme 5: Cross-Service Collaboration as a Facilitator

Referrers valued when collaboration between their own and the evaluated service occurred, especially informal discussions, case consultations, and cross-team meetings. These were seen as opportunities to reduce misconceptions and foster a sense of mutual respect. However, such opportunities were described as inconsistent, or removed in recent system changes such as "OneTeam" replacing referral discussion platforms: "*We send a document into the abyss so there is no room for discussion and bouncing ideas off each other*" (RP4).

There was a desire among all referrers for more regular, low-barrier communication and a cultural shift to joint-working: "*Reaching out and building relationships between teams where case discussions can happen and there is more visibility so we can put a face to the team. It's hard to have a culture shift but we need interaction between the services*" (RP3). Alongside this, referrers also proposed other suggestions to facilitate collaboration, such as "*more visibility and outreach*" (RP5) from the service including to third-sector organisations

to improve interagency links, feedback on rejected referrals, and service-led training and information-sharing: "*We need better relationships between the charity and health sector, more information-sharing and interagency collaboration and partnership working*" (RP5).

Client Themes

Four themes were found in the data gathered from client participants (CP).

Theme 1: Fears of Judgement and Stigma

ASR clients described fears about being judged or stigmatised, both by professionals and their own communities, for seeking mental health support. Many entered therapy with internalised stigma, influenced by cultural narratives equating psychological help with weakness or madness. All clients reported concerns around being labelled as crazy and misunderstood by therapists: "*When I first started, it did enter my mind: 'am I a crazy person, is there something wrong with me*?'" (CP2), or judged by individuals in their community for accessing mental health care: "*Nobody in my community knows I am doing therapy, if they did they may say 'she's crazy like her dad'*" (CP4).

Additionally, some feared they would be judged or treated differently because of their ASR status due to past negative experiences of being discriminated against in other NHS services: "*I had a terrible experience in hospital and I wondered, is it because they're looking at my file thinking 'well she's an asylum-seeker, she doesn't deserve to be treated equally*" (CP1), or that aspects of their cultural background would be negatively interpreted by clinicians.

However, these concerns eased once they were engaged in treatment, and they reported feeling safe, understood, and reassured by therapists. Most clients reported that cultural matching with a therapist was not necessary, as long as sufficient trust and empathy was established for them to feel reassured that they would not be judged for cultural differences: "*As long as I have a connection with you and you understand the pain I am*

suffering… it's not possible for someone to know every culture, you just need to empathise with me" (CP3).

Theme 2: Uncertainty Around Entitlement

ASR clients expressed confusion or anxiety about whether they were eligible to access the service, especially while their asylum claims were unresolved: "*My worry was because of my status and obviously I'm not a resident, what if I do not receive the care that I need*" (CP1). Clients felt that there was a general lack of clear information about entitlement, pathways, and waiting times from services they were already accessing, which contributed to their worries. Yet when participants received more information from clinicians, this significantly improved their willingness to engage: "*If I don't understand I'm not going to come. If you explain it to me with simple words, I'm going to understand the problem and accept it and come to you again and again for help*" (CP3). This theme highlights how system-level ambiguity and ASR status insecurity intersect to shape access.

Theme 3: Importance of Establishing Safety and Trust

ASR reported that therapeutic engagement was not immediate, and that they needed time to feel emotionally safe. For some, being asked personal trauma questions too early felt invasive or retraumatising, especially when trust had not yet been established. Some feared misinterpretation or surveillance, such as worries that a therapist or interpreter "*could be a spy, so I need to have trust with you first*" (CP3).

Regarding interpreters specifically, some clients already felt hesitance in sharing information with a therapist and the inclusion of a third person increased this hesitance further: "*You can't explain everything and you don't want to share personal things when there are three people*" (CP2). However, when trust was successfully built, through acknowledging the need for additional time and sessions, clear communication, and continuity of interpreters, clients described relational safety and willingness to open up. This

engagement was further facilitated by having therapist consistency, and avoiding abrupt or impersonal assessments. Additionally, although long waiting times were highlighted as a barrier, clients found that reassuring communication from the service during this time further helped to establish trust.

Theme 4: Value of Flexibility and Empathy

A consistent facilitator of engagement was the service's tailored, person-centred approach. Participants valued flexibility, such as online appointments, accessible clinic locations, or therapists adjusting agendas to their needs. This adaptability helped them to overcome practical barriers like childcare arrangement issues, and difficulties with transport from their accommodation. Several noted that service therapists were more responsive and attuned to their specific difficulties and new issues that they would bring to a session than in other services they had experienced: "*The service has changed me, they helped me reduce my worries… better than any other service*" (CP4). Clients also reported positive reframing of therapy itself: they shifted from scepticism, such as "*just talking to someone won't be helpful*" (CP1), to finding that therapy was highly helpful, especially when delivered with cultural considerations, empathy, and clarity.

Discussion

Summary of Findings

This study aimed to explore the barriers and facilitators to accessing treatment in the service for individuals of ASR status, using perspectives from both referrers and ASR. The resulting themes highlight misalignments between the needs of ASR clients and the systems designed to support them, while also identifying opportunities for service improvement. Both participant groups reflected uncertainty around service criteria, ASR-related eligibility, readiness, navigation of referral pathways, and the use of interpreters. Importantly, referrers

often assumed that ASR clients would not be ready or eligible for the service, particularly in circumstances of social instability or legal uncertainty. Meanwhile, ASR clients described initial fear particularly in first assessments, mistrust and needing time to establish trust, and worry about being judged or discriminated against, but also described positive experiences once engaged with the service. These were aided by the service's provision of flexibility, empathy, and culturally considerate interactions. The results suggest that while engagement is positive once clients are receiving treatment, improving communication to clients at the outset, outreach to third-sector organisations, and interagency collaboration could enhance access.

The study's findings align closely with existing literature on the structural and interpersonal barriers to mental health access for ASR communities. Previous research has identified that ASR face multiple, layered barriers to accessing care (Byrow et al., 2020; DeSa et al., 2022; Lashwood et al., 2025). The present study is consistent with these broader trends and extends this literature by capturing how such barriers are understood and experienced by both referrers and ASR clients within an NHS specialist trauma service. One of the most prominent findings was that referral into the service was often perceived as inaccessible or unclear by clinicians. Referrers also reported uncertainty about eligibility linked to asylum status, despite recent training and guidance clarifying that the service accepts ASR clients irrespective of claim status. The persistence of these knowledge gaps reinforces recommendations from the literature for clearer, repeated messaging and system-wide clinician training (Jensen et al., 2013; NHS England, 2024; WHO, 2023).

Among the ASR client group, fears of being judged, institutional mistrust, and concerns about entitlement were barriers to help-seeking. These findings align with studies showing how stigma, cultural perceptions of mental health, and mistrust of services can discourage ASR clients from engaging in psychological support (Byrow et al., 2020). The

present study contributes additional nuance by showing that these barriers may begin to shift once clients are inside the service and encounter empathic, culturally safe clinicians. This highlights the dual importance of firstly improving communication and first contacts, and secondly ensuring that internal service environments remain trauma-informed, flexible, and responsive.

Interpreter-related issues were evident for both clinicians and ASR clients. Referrers noted client reluctance to share sensitive information when an interpreter was present, while ASR clients described a desire for consistent interpreters and concerns about breaches of confidentiality. Similar concerns have been reported elsewhere (Krystallidou et al., 2024); this study adds that perceived consistency and trustworthiness of interpreters may be central to successful therapeutic engagement.

From a clinical standpoint, the findings suggest that therapeutic engagement for ASR clients is contingent on early trust-building interactions. Clinicians working in trauma services must be mindful of the layers of mistrust and fear that many ASR clients may carry, and actively counter these through warmth, flexibility, and transparency. Several participants reported that initial fears around judgment, being misunderstood, or rejection due to asylum status were reduced by empathic clinicians. Others described disengagement when trust was not sufficiently established or when assessments felt abrupt or intrusive. These experiences suggest that trauma-informed care in the ASR context should place particular emphasis on pacing, consent, and client-led disclosure. Additionally, where interpreters are needed, services should aim for continuity, allow clients to express discomfort without fear of judgement, and consider matching by preference where possible.

Recommendations

Drawing from the findings above, a range of actionable recommendations were developed by the researcher and refined through consultation with project supervisors who

were clinicians in the service. Consultation chiefly involved confirmation of some suggested recommendations, such as confirmation that the service would be able to aim for continuity of interpreters. Final recommendations were then proposed to the service in a short presentation to clinicians, in order to improve referral and access to the service. These are summarised in Table 4.

Table 4

Summary of Recommendations

Area	Recommendation
Referral Criteria	1. Provide clear, widely available leaflets detailing referral guidance including thresholds and eligibility criteria with specific reference to eligibility for asylum seekers. Disseminate these to services across the NHS and third-sector organisations. 2. Provide case study examples of presentations and difficulties which are eligible for treatment, including case examples of ASR which clarify that asylum claim status and stability in circumstances are not prerequisites for referral.
Feedback to Referrers	3. Offer brief but specific feedback on rejected referrals in order to reduce ambiguity and uncertainty for referrers, and to reduce future generalisations about ineligibility and hesitance to refer.
Referral Process	4. Improve joint-working opportunities by creating informal spaces and consultation slots for discussion of potential referrals. This may be achieved through various means, such as monthly drop-ins held by the service, or attendance at other service's team meetings by an identified interagency link individual. 5. Continue with providing useful training to services on working with clients with asylum-seeker status, seeking

	particularly to clarify misconceptions that they are not eligible for treatment due to their asylum claim status or instability in circumstances.
External Partnerships	6. Address broader cross-sector systemic disconnects between services by increasing visibility and outreach to community and third-sector organisations who may not be aware of the service, in order to increase likelihood of ASR referrals. This could be through assigning of an interagency link individual as point of liaison, and the service sending periodic reminders regarding their offerings and suitability for ASR clients. 7. Build sustained, reciprocal interagency relationships and collaborations with these organisations which closely support ASR individuals, in order to use this as mutual opportunity for feedback loops, sharing experiences, learning, and improving services.
Communication with ASR Clients	8. For clarity and demystification, develop co-produced materials such as videos which include service clinicians, or leaflets in multiple languages explaining the service's offers and pathways, who is eligible, and what to expect. 9. Make explicit reference to ASR clients in these materials, for example by clearly stating on the service website that individuals with asylum-seeker status are eligible for referral. 10. Send generic service welcome letters which include the above information to ASR in their native language, removing the need for them to have these translated. 11. Communicate directly with ASR communities and collect feedback from ASR clients who have completed treatment in order to explore further barriers and facilitators to access.
Interpreter Use	12. Ensure interpreter consistency where possible. Establish at the outset whether the client and interpreter may already

	know one another. Provide options for clients to request alternative interpreters. Assure clients that interpreters are bound by the same rules of confidentiality. Allow additional time and sessions for clients to build trust with interpreter.
Service Flexibility	13. Continue to offer flexibility with hybrid appointments and satellite bases; use these options to make accommodations for housing, childcare, and transportation difficulties.
Therapeutic Continuity	14. Aim for continuity of clinician from assessment to intervention, where possible.
Trauma-Informed, Culturally Aware Practice	15. Clinicians take slow, trust-building approaches in assessment and at start of intervention, considering the unique experiences of multiple traumas which ASR may have experienced. 16. Avoid rapid and detailed questioning in early sessions where trust may not yet be established, while considering potential need for additional time and sessions. 17. Take a curious stance in relation to individuals' cultural background and practices, holding in mind the fear of stigma, judgement, and shame they may experience. 18. The service should work towards examining how Western assumptions and psychiatric frameworks may shape referral and treatment. Outcomes could include co-producing pathways with ASR communities, exploring individuals' own cultural understandings of distress and healing, addressing structural barriers, and adapting referral, assessment, and intervention processes rather than assuming that Western models are universally applicable.

Limitations

A strength of this project is the inclusion of both referrer and client perspectives, allowing for a richer and more comprehensive understanding of where and how barriers emerge in the referral and care pathway.

However, several limitations are acknowledged. First, ASR participants were all individuals who had either engaged with the service or were awaiting treatment. Therefore, the perspectives of those who had not accessed the service are missing, and so those who may have had more negative or disengaged experiences or met unsurmountable barriers were not represented here.

Second, the sample size was modest (n = 10); although this is common for qualitative service evaluations, the modest sample limited the breadth of perspectives represented. Regarding referrer participants, the services from which they were interviewed were limited, and it is possible that these services already had relatively positive collaboration with the service. Due to recruitment challenges, the perspectives of other NHS secondary care services, primary care services including GPs, and wider third-sector organisations were not captured and represented. Additionally, most of the ASR clients interviewed had fluent proficiency in English and this may risk a sampling bias. It is possible that clients with lower English proficiency may not have been thought to be suitable for referral to the service, or may not have been able to advocate for their needs; therefore, it is important to consider the need for future research which can capture disengaged experiences. Regarding interview schedules, these were framed somewhat differently: questions for ASR clients placed greater emphasis on barriers and difficulties, whereas referrer questions more consistently explored both barriers and facilitators, and this may have shaped different responses between groups. Although flexible follow-up allowed both positive and negative experiences to be discussed,

future evaluations may consider more consistent balancing and open-style questions when designing interview schedules.

Finally, although the findings are salient for the service itself, they may not be directly applicable to other services. However, based on the literature it is likely that many of these challenges are shared more widely.

Conclusions

This project underscores the systemic, interpersonal, and perceptual barriers that can affect the accessibility of this specialist NHS traumatic stress service, and potentially other trauma services, for individuals with ASR status. Despite recent improvements in training and policy, gaps remain in referrer confidence, clarity of referral processes, and service-user trust in the system. Yet, the findings also suggest that relatively modest changes, such as clearer communication, collaborative referral discussions, and culturally responsive, empathic care, are commonly viewed as effective and impactful in improving referral and access.

For services like the service evaluated in this project, the next step is to consolidate existing good practices and address points for improvement in the referral and treatment journey. This can move toward a more equitable, inclusive, and responsive service for a minoritised and vulnerable demographic.

Key Practice Points

- Clinicians should not assume that ASR status, unresolved asylum claims, or interpreter use make a client unsuitable or ineligible for specialist trauma treatment.
- Provide clear and consistent information about eligibility, referral pathways, and what clients can expect from the service to reduce mistrust and disengagement at the outset.
- Prioritise safety, pacing, and trust-building particularly during assessment and early sessions with ASR clients.

- When interpreters are needed, address confidentiality concerns explicitly, offer continuity and choice where possible, and allow additional time for trust-building and engagement.
- Strengthen collaboration between trauma services, referrers, and third-sector organisations to reduce referral hesitancy and improve equitable access.

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Theoretically Driven Research Project

Maladaptive Religious Schemata, Negative Religious Trauma Appraisals, and PTSD Symptom Severity in Muslim Individuals Who Have Experienced Trauma

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Abstract

Religious schemata may shape how traumatic experiences are interpreted, but little research has examined religious trauma appraisals in Muslim populations. This cross-sectional study examined associations between maladaptive religious schemata, negative post-traumatic religious appraisals, and PTSD symptom severity in 157 Muslim adults living in the UK who had experienced trauma. Participants completed online measures of trauma exposure, PTSD symptoms, religious schemata, negative religious trauma appraisals, general non-religious trauma-related appraisals, depression, and anxiety. Sixty-eight participants scored above the PCL-5 threshold and reported higher negative religious trauma appraisals and maladaptive religious schemata than those below threshold. Across the full sample, negative religious trauma appraisals statistically mediated the association between maladaptive religious schemata and PTSD symptom severity. Maladaptive religious schemata explained additional variance in negative religious trauma appraisals beyond general non-religious trauma appraisals, distress, and trauma load. Findings suggest that culturally specific religious meanings may be clinically relevant in trauma formulation, although causal conclusions cannot be drawn.

Keywords: *PTSD, trauma, Muslim mental health, religious appraisals, religious schemata*

Introduction

Religious Schemata and Psychological Distress

Religion can provide a framework through which individuals understand themselves, others, the world, and adverse life events. McIntosh (1995) conceptualised religion as a cognitive schema: an organised meaning system that guides perception, interpretation, memory, and coping (Abu-Raiya & Pargament, 2015). Similarly, James and Wells (2003) proposed that religious beliefs may function as a generic mental model through which individuals interpret life events and regulate distress. This schema-based understanding is clinically useful because the psychological impact of religious belief may depend not only on whether a person is religious, but on the content, rigidity, and personal meaning of specific religious beliefs (Abu-Raiya & Pargament, 2015; Exline et al., 2014).

In this study, maladaptive religious schemata are understood as stable, negatively biased cognitive-emotional frameworks concerning God, the self, and religious practice that organise experience in ways that generate distress and unhelpful patterns of thinking, feeling, and behaviour (Shaban et al., under review). This definition distinguishes maladaptive religious schemata from religiosity itself. The concept does not imply that religious belief is inherently problematic; rather, it refers to personally distressing, rigid, or punitive religious meanings, such as beliefs that God sees the person as bad, or that adversity reflects divine punishment (Lucchetti et al., 2021).

Maladaptive religious schemata overlap conceptually with constructs such as negative religious coping, spiritual struggle, and punitive images of God, as these all involve negative religious interpretations (Bradshaw et al., 2010; Exline, 2013; Pargament et al., 2011). However, negative religious coping usually describes how individuals respond to stressors, whereas maladaptive religious schemata refer to deeper underlying belief structures that may

shape those responses. This distinction is important because many individuals are exposed to similar religious teachings, yet only some interpret suffering as evidence of divine rejection or punishment (Shaban et al., under review). A schema framework may therefore help explain why religious meanings are associated with distress for some people but are protective or neutral for others. The different religious constructs outlined above are further described in Table 1.

Table 1

Definitions and Examples of Key Constructs

Construct	Definition	Illustrative example
Religiosity	The degree to which a person identifies with, believes in, or practises a religion; it does not indicate whether religion is helpful or distressing.	Praying regularly, viewing Islam as central to identity.
Religious schema	An organised religious meaning system that guides how experiences are understood and interpreted (McIntosh, 1995).	Viewing suffering as a test through which spiritual growth may occur.
Maladaptive religious schemata	Broad, relatively stable and distressing beliefs about God, the self or religious practice that are not tied to one specific event (Shaban et al., under review).	"God sees me as bad"
Negative religious coping	Religious responses to stressors that involve conflict, disconnection or punitive interpretations (Pargament et al., 2011).	Feeling abandoned by God or interpreting adversity as divine punishment.
Spiritual struggle	Conflict or distress involving God, faith, morality or a religious community (Exline, 2013).	Experiencing religious doubt, or anger towards God.
Negative post-traumatic religious appraisal	A negative, event-specific religious interpretation of a traumatic experience (Berzengi et al., 2017).	"This trauma happened because God is punishing me."

General negative trauma appraisal	A negative interpretation of trauma that is not specifically religious (Ehlers & Clark, 2000).	"I am permanently damaged" or "The world is unsafe."

Research on religious coping and spiritual struggle has consistently shown that negative religious coping is associated with poorer psychological adjustment, including higher depression, anxiety, and distress (Ano & Vasconcelles, 2005; Exline et al., 2014; Pargament et al., 2011). Evidence also suggests that these associations are present in Muslim populations (Abu-Raiya et al., 2018). Nevertheless, much of this literature has relied on broad or generic measures of religious coping, often developed in predominantly Western and Christian contexts. Reviews of Islamic religiousness measures suggest that existing measures have focused mainly on religiosity, spirituality, and morality, with comparatively less attention to maladaptive religious schemata as a specific construct (Nabi et al., 2023; Shaban et al., under review).

Cognitive Models of PTSD and the Role of Appraisals

The rationale for examining religious schemata in relation to PTSD is grounded in cognitive models of PTSD, particularly Ehlers and Clark's (2000) model. According to this model, PTSD is maintained when individuals process the trauma and its consequences in a way that results in a persistent sense of current threat. This sense of threat arises from excessively negative appraisals of the trauma and its aftermath (e.g. "I am permanently damaged", "The world is unsafe"), and characteristics of the trauma memory and its retrieval (e.g. poorly elaborated memories, strong sensory re-experiencing). Maladaptive cognitive and behavioural strategies (e.g. avoidance, thought suppression, or safety behaviours) maintain this threat by preventing disconfirmation of these threat-based appraisals (Ehlers & Clark, 2000).

Negative appraisals have strong empirical support as correlates and maintaining factors in PTSD. A meta-analysis found robust associations between maladaptive appraisals

and PTSD symptoms, with particularly strong evidence for negative self-appraisals in adults (Gómez de La Cuesta et al., 2019). Although much of this work has focused on appraisals of the self, world, and the future, appraisals are also likely to be shaped by cultural, social, and religious meaning systems (Jobson & O'Kearney, 2009). For a religious individual, trauma may therefore be interpreted not only as evidence that the world is unsafe or the self is damaged, but also as evidence of being punished, abandoned, or rejected by God.

Religious schemata may be especially relevant to trauma because they can provide explanations for why suffering occurred and what it means (Grey et al., 2024). For example, if an individual holds a rigid schema that bad events happen because God is angry with morally bad people, a traumatic event may be appraised as evidence of sinfulness or divine rejection. Such appraisals may intensify shame, guilt, fear, or perceived ongoing threat, and may therefore fit within the appraisal component of cognitive models of PTSD. While many religious meanings may support coping, connection, hope, and meaning-making, this study queries whether particular religious interpretations are experienced as threatening, shame-inducing, or maintaining distress.

Religious Appraisals and PTSD in Muslim Populations

Muslim individuals draw on diverse interpretations of Islamic teachings to make sense of suffering, distress, and adversity. These interpretations can include adaptive meanings, such as viewing difficulties as tests that can bring spiritual growth, but also potentially maladaptive meanings, such as interpreting trauma as divine punishment, believing distress indicates weak faith, or fearing consequences in the afterlife. A small but growing literature has examined negative religious coping and trauma-related appraisals among Muslim trauma-exposed individuals.

Aflakseir and Coleman (2009) found that religious coping contributed to mental health indicators, including PTSD, among disabled Iranian war veterans. Grey and colleagues

(2024) reported that negative religious coping was associated with higher PTSD symptom severity following the Beirut port explosion. In a key study of Muslim trauma survivors, Berzengi and colleagues (2017) found that negative religious coping and negative Islamic appraisals were associated with PTSD symptoms. Moreover, trauma-related appraisals mediated the relationship between negative religious coping and PTSD symptoms, suggesting that religiously framed meanings may be linked to PTSD partly through broader trauma-related appraisals.

These studies indicate that negative religious meanings may constitute cognitive mechanisms linked to PTSD. However, this literature has important limitations. First, much work has used generic religious coping measures, such as the Brief RCOPE, which do not fully capture Islamic trauma-specific appraisals. Second, fewer studies have examined broader maladaptive religious schemata that may shape interpretations of trauma. Third, much existing evidence comes from non-UK or clinical samples, such as war veterans, and there is comparatively little literature examining these processes among UK Muslim individuals recruited outside clinical services.

Measurement of Religious Schemata and Trauma-Specific Religious Appraisals

Recent work has led to the development of measures designed specifically to assess Islamic religious appraisals and maladaptive religious schemata. The Islamic Appraisals Questionnaire (IAQ) assesses positive and negative Islamic appraisals of a specific traumatic event (Berzengi et al., 2017). It therefore indexes event-specific religious appraisals in light of Islamic-specific beliefs, In contrast, the Religious Schema Questionnaire (ReSQue) assesses broader maladaptive religious schemata. The measure was developed using a schema framework and includes domains such as theocentric core beliefs, theophobia, eschatological anxiety, religious obligations distress, forbidden love, and theocentric conditional beliefs.

These domains assess distressing and negatively biased religious beliefs that are not tied to one specific trauma, and may pre-date trauma (Shaban et al., under review).

This distinction is central to the present study. The IAQ measures religious appraisals of the index traumatic event, whereas the ReSQue measures more general religious schemata that may shape how events are interpreted. The Brief RCOPE negative subscale remains useful as an established measure of negative religious coping, but it is not specific to Islamic appraisals and does not directly assess underlying religious schemata (Pargament et al., 2011); however, including it allows comparison of findings using the newer measures of IAQ and ReSQue, with a validated and established measure if needed. Together, these constructs allow the present study to distinguish between general maladaptive religious schemata, event-specific negative religious trauma appraisals, and general religious coping.

Rationale and Objective for the Present Study

The present study examines whether maladaptive religious schemata and negative religious trauma appraisals are associated with PTSD symptom severity in Muslim adults living in the UK who have experienced trauma. This focus addresses a gap in the literature by applying a schema-based understanding of religious cognition to PTSD in a Muslim trauma-exposed sample. It also extends previous work by examining whether broader maladaptive religious schemata are associated with trauma-specific religious appraisals and PTSD symptoms, rather than focusing only on negative religious coping.

Drawing on Ehlers and Clark's model, the study proposes that negative religious trauma appraisals may form part of the appraisal system associated with PTSD symptom severity. It further proposes that broader maladaptive religious schemata may be associated with clinically significant PTSD symptoms partly through their association with trauma-specific religious appraisals. Because the study is cross-sectional, these proposed pathways are tested as associations rather than as evidence of causal or temporal direction.

Hypotheses

Hypothesis 1: Muslim individuals with clinically significant PTSD symptom severity (PCL-5 score 31 or above defined as cut-off, but this is not a diagnosis) will score significantly higher on negative post-traumatic religious appraisals (IAQ) than Muslim individuals with clinically non-significant PTSD symptom severity.

Hypothesis 2: Muslim individuals with clinically significant PTSD symptom severity will score significantly higher on maladaptive religious schemata (ReSQue) than Muslim individuals with clinically non-significant PTSD symptom severity.

Hypothesis 3: Negative post-traumatic religious appraisals (IAQ) will mediate the association between maladaptive religious schemata (ReSQue) and PTSD symptom severity (PCL-5), such that higher maladaptive schemata will be associated with higher PTSD symptoms via more negative post-traumatic religious appraisals.

Hypothesis 4: Higher maladaptive religious schemata (ReSQue) will be associated with higher negative post-traumatic religious appraisals (IAQ), over and above general negative non-religious trauma-related appraisals (PTCI-9).

Method

Participants

For eligibility, participants had to meet inclusion criteria of being self-identifying Muslim individuals, currently living in the UK, aged 18 or above, and identifying with having experienced an event in their life which they found to be traumatic. They were recruited from across the UK using social media, emails to organisations, snowball sampling, and a dedicated participant recruitment platform. An a priori power analysis using G*Power 3 (Faul et al., 2007) was calculated for sample size for an ANCOVA with two groups: a

minimum total sample of 128 (64 per group) would be sufficient to obtain 80% power, with an alpha level of 0.05, and based on previous research assuming a medium effect size of 0.25.

Patient and Public Involvement

Two individuals identifying with the Muslim faith were recruited from the researcher's network to consult on recruitment materials and design development.

Procedure

After seeing an advertisement for the study, participants clicked the link provided which directed them to the Qualtrics survey. They were presented with an information sheet detailing the background and purposes of the study and what participation would involve. They were presented with the option to consent to taking part, after which they could answer inclusion criteria questions and if eligible, complete demographic questions and eight questionnaires. Demographic questions included age, gender, ethnicity, educational attainment, and employment status.

Ethics Statement

The study received favourable opinion from the University of Oxford Medical Sciences Interdivisional Research Ethics Committee (reference number: 867138). Participants were informed about the sensitive nature of questions, withdrawal, anonymity, and informed consent was obtained. Participants were debriefed at the end; if they scored above clinical thresholds, they received signposting information to sources of support without implying diagnosis. The majority of participants received no financial remuneration due to this being the original recruitment method, but individuals later recruited through the participant recruitment platform were compensated a token amount of £2.50.

Measures

Measures are described in Table 2. Full details of measures are in Appendix Q.

Table 2

Measures Used in the Study

Measure	Construct	Scoring / use in this study	Source and psychometrics	Current α
Life Events Checklist (LEC-5)	Trauma exposure/load	16 trauma event types plus one other-event item. Trauma load was the number of trauma types endorsed; participants also selected the index traumatic event to answer subsequent questionnaires.	Weathers et al. (2013); Gray et al. (2004). Test-retest reliability r = .82.	—
PTSD Checklist for DSM-5 (PCL-5)	PTSD symptom severity	20 DSM-5 PTSD symptom items rated for the past month; total scores range from 0 to 80. A score of 31 or above was used as a clinical threshold, not a diagnosis.	Weathers et al. (2013); Blevins et al. (2015). Strong internal consistency and test-retest reliability.	.95
Islamic Appraisals Questionnaire (IAQ), negative subscale	Negative post-traumatic religious appraisals	Six negative Islamic appraisal items relating to the index trauma were summed; higher scores indicate more negative Islamic appraisals.	Berzengi et al. (2017). Original negative subscale α = .72.	.85
Religious Schema Questionnaire (ReSQue)	Maladaptive religious schemata	18 items assessing six domains of maladaptive religious schemata, including theocentric core beliefs and theophobia; higher scores indicate greater endorsement.	Shaban et al. (under review). Demonstrated strong internal consistency and convergent validity in a Gulf Muslim sample.	.92
Brief Religious Coping Scale (Brief RCOPE), negative subscale	Negative religious coping (not Islam-specific)	Seven-item negative subscale of the 14-item Brief RCOPE; higher scores indicate greater negative religious coping.	Pargament et al. (2011). Widely used and psychometrically supported measure.	.89
Posttraumatic Cognitions Inventory, brief version (PTCI-9)	General non-religious trauma-related appraisals	Nine-item brief version of the PTCI; higher scores indicate more negative non-religious trauma-related appraisals.	Foa et al. (1999); Wells et al. (2019). Strong reliability and validity.	.87
Patient Health Questionnaire (PHQ-8)	Depression symptoms	Eight current depression-symptom items; higher scores indicate more severe depressive symptoms.	Kroenke et al. (2009). Validated as a population-based depression severity measure.	.89
Generalised Anxiety Disorder Scale (GAD-7)	Anxiety symptoms	Seven generalized anxiety symptom items; higher scores indicate more severe anxiety symptoms.	Spitzer et al. (2006). Demonstrated excellent internal consistency and test-retest reliability.	.92

Data Analysis

For this cross-sectional study, analysis was conducted in IBM SPSS Statistics Version 29. Data screening included examination of missing data, scale scoring, outliers, distributional assumptions, and calculation of Cronbach's alpha internal consistency. Descriptive statistics including means and standard deviations were calculated. Demographic

differences between PTSD symptom groups were calculated using independent-samples t-tests, chi-square tests, or Fisher's exact tests. Pearson correlations examined bivariate associations between trauma load, PTSD symptom severity, negative post-traumatic religious appraisals, maladaptive religious schemata, negative non-Islamic religious coping, general negative non-religious trauma-related appraisals, depression, anxiety, and age. Covariates were selected to control for theoretically relevant sources of variance. General negative non-religious appraisals were included to examine whether religious schemata and religious appraisals explained variance beyond these non-religious trauma-related cognitions. Trauma load was included to account for cumulative trauma exposure. Depression and anxiety symptoms were highly correlated and therefore PHQ-8 and GAD-7 scores were standardised into z-scores and averaged to create a single composite distress score – this general distress score was used as a covariate.

Hypotheses 1 and 2: group comparisons. Welch's independent-samples t-tests examined unadjusted PTSD group differences in mean IAQ scores and ReSQue scores. ANCOVAs then compared PTSD groups on IAQ scores and ReSQue scores while controlling for covariates as above. Assumptions were assessed using Levene's test, variance inflation factors, diagnostic plots, and tests of homogeneity of regression slopes. Where homogeneity of regression slopes assumption was violated, the relevant interaction term was interpreted.

Hypothesis 3: mediation analysis. The Hayes PROCESS macro v4.2 (Hayes, 2022) analysis examined whether, across the full sample, negative post-traumatic religious appraisals mediated the relationship between maladaptive religious schemata and PTSD symptom severity. ReSQue score was entered as the predictor, IAQ score as the mediator, and PCL-5 score as the outcome. Above covariates were included. The indirect effect was tested using 5000 bootstrapped samples and 95% confidence intervals.

Hypothesis 4: regression analysis. The regression examined whether, across the full sample, maladaptive religious schemata explained additional variance in negative post-traumatic religious appraisals beyond general negative non-religious trauma-related appraisals. In Step 1, PTCI-9, trauma load, and general distress were entered. In Step 2, ReSQue score was added. The change in R^2 was used to assess whether ReSQue explained significant additional variance in IAQ negative scores. Assumptions of linear regression were checked.

Results

Sample Characteristics

A total of 157 participants were included in the final analysis, with 89 participants in the low PTSD symptoms group and 68 in the high PTSD symptoms group. The groups did not differ significantly by age, $t(137.41) = -1.08$, p = .283, gender, $\chi^2(1) = 0.02$, $p = .891$; ethnicity, Fisher's exact $p = .733$; or education, $\chi^2(1) = 1.45$, $p = .229$. Demographic characteristics are presented in Table 3.

Table 3

Participant demographic characteristics by PTSD symptom group

Characteristic	Total (N = 157)	Low PTSD (n = 89)	High PTSD (n = 68)	Test	p
Age (years), M (SD)	35.73 (11.05)	34.87 (10.87)	36.83 (11.26)	t(137.41) = -1.08	.283
Gender, n (%)				$\chi^2(1) = 0.02$	.891
Female	91 (58.0)	51 (57.3)	40 (58.8)		
Male	65 (41.4)	38 (42.7)	27 (39.7)		
Prefer not to say	1 (0.6)	0 (0.0)	1 (1.5)		
Ethnicity, n (%)				Fisher's exact	.733
White	9 (5.7)	6 (6.7)	3 (4.4)		
Asian/Asian British	100 (63.7)	62 (69.7)	38 (55.9)		
Black/African/Caribbean/Black British	17 (10.8)	8 (9.0)	9 (13.2)		
Arab	15 (9.6)	5 (5.6)	10 (14.7)		
Mixed/multiple ethnic groups	9 (5.7)	5 (5.6)	4 (5.9)		
Other ethnic group	1 (0.6)	1 (1.1)	0 (0.0)		
Prefer not to say	6 (3.8)	2 (2.2)	4 (5.9)		
Education, n (%)				$\chi^2(1) = 1.45$	.229
No formal qualifications	2 (1.3)	0 (0.0)	2 (2.9)		
GCSEs or equivalent	7 (4.5)	5 (5.6)	2 (2.9)		

A-levels or equivalent	20 (12.7)	10 (11.2)	10 (14.7)		
Further education qualification	9 (5.7)	4 (4.5)	5 (7.4)		
Undergraduate degree	62 (39.5)	40 (44.9)	22 (32.4)		
Postgraduate degree	53 (33.8)	29 (32.6)	24 (35.3)		
Prefer not to say	4 (2.5)	1 (1.1)	3 (4.4)		
Employment status, n (%)				—	—
Employed full time	94 (59.9)	53 (59.6)	41 (60.3)		
Employed part time	24 (15.3)	13 (14.6)	11 (16.2)		
Student	8 (5.1)	6 (6.7)	2 (2.9)		
Unemployed	19 (12.1)	9 (10.1)	10 (14.7)		
Retired	1 (0.6)	1 (1.1)	0 (0.0)		
Other	9 (5.7)	6 (6.7)	3 (4.4)		
Prefer not to say	2 (1.3)	1 (1.1)	1 (1.5)		
Received psychological treatment for index trauma, n (%)				—	—
No	129 (82.2)	75 (84.3)	54 (79.4)		
Yes	24 (15.3)	12 (13.5)	12 (17.6)		
Prefer not to say	1 (0.6)	1 (1.1)	0 (0.0)		
Not applicable	3 (1.9)	1 (1.1)	2 (2.9)		

Note. Values are n (%) unless otherwise stated. Age data was available for 150 participants. Gender comparison used male/female categories as other categories were not selected.

Descriptive Statistics and Reliability

Descriptive statistics and internal consistency values for the study measures are presented in Table 4. Internal consistency was good to excellent across all measures.

Table 4

Descriptive Statistics and Internal Consistency for Study Measures

Measure	M	SD	Observed range	α
PCL-5 PTSD symptoms	26.81	17.04	0–58	.95
IAQ negative post-traumatic religious appraisals	18.15	8.66	6–38	.85
ReSQue maladaptive religious schemata	53.69	18.49	18–97	.92
Brief RCOPE negative non-Islamic religious coping	4.33	4.80	0–21	.89
PTCI-9 general negative non-religious trauma-related appraisals	30.06	11.23	9–60	.87
PHQ-8 depression symptoms	7.81	5.66	0–24	.89
GAD-7 anxiety symptoms	7.27	5.22	0–21	.92
LEC-5 trauma load	7.19	4.51	0–17	—

Note. N = 157 for all measures. M = mean; SD = standard deviation; α = Cronbach's alpha. Range shown is observed range in this sample. Cronbach's alpha not reported for LEC-5 trauma load.

Correlations between Main Study Variables

Pearson correlations between the main study variables are presented in Table 5. PTSD symptom severity was significantly positively associated with negative post-traumatic religious appraisals, maladaptive religious schemata, negative non-Islamic religious coping, general non-religious trauma-related appraisals, depression, anxiety, general distress, and trauma load. Age was not significantly associated with PTSD symptom severity.

Consistent with the proposed model, negative post-traumatic religious appraisals were significantly positively associated with maladaptive religious schemata and general negative non-religious trauma-related appraisals. Negative post-traumatic religious appraisals were also strongly associated with negative non-Islamic religious coping. Trauma load was weakly associated with PTSD symptom severity and general distress, but was not significantly associated with negative post-traumatic religious appraisals or maladaptive religious schemata.

Table 5

Pearson Correlations Between Main Study Variables

Variable	1	2	3	4	5	6	7	8	9	10
1. PCL-5	—									
2. IAQ	.54***	—								
3. ReSQue	.46***	.51***	—							
4. Brief RCOPE	.50***	.74***	.49***	—						
5. PTCI-9	.52***	.51***	.42***	.50***	—					
6. PHQ-8	.54***	.32***	.33***	.37***	.52***	—				
7. GAD-7	.58***	.39***	.36***	.36***	.56***	.81***	—			
8. General distress	.59***	.37***	.36***	.38***	.57***	.95***	.95***	—		
9. Trauma load	.23**	-.06	.05	.02	.03	.20*	.13	.18*	—	
10. Age	.11	.12	-.03	.00	.04	.04	.02	.03	.03	—

Note. N = 157. Values are Pearson correlation coefficients. *$p < .05$. **$p < .01$. ***$p < .001$.

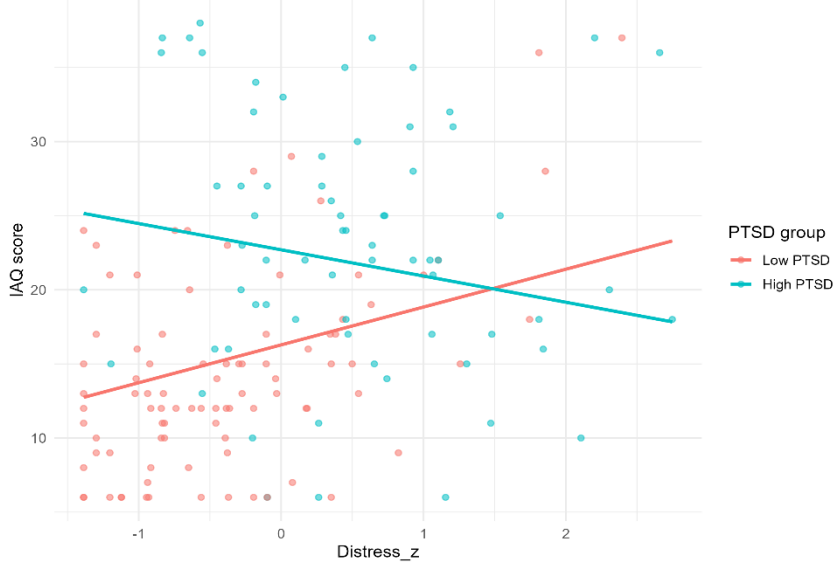
Hypothesis 1

Hypothesis 1 predicted that participants in the high PTSD symptom group would report higher negative post-traumatic religious appraisals than those in the low PTSD symptom group. As shown in Table 5, the high PTSD symptom group reported significantly higher IAQ negative scores in both unadjusted Welch's *t*-test and adjusted ANCOVA controlling for PTCI-9, general distress, and trauma load. However, the homogeneity of regression slopes assumption was violated, with a significant PTSD symptom group x general distress interaction, $F(1, 151) = 11.26$, $p = .001$, indicating that the difference between PTSD symptom groups in IAQ negative score varied according to general distress as shown in Figure 1. A heteroscedasticity-consistent HC3 test also supported this interaction, $F(1, 151) = 7.47$, $p = .007$. Conditional group contrasts showed that the high PTSD group reported significantly higher IAQ score at low and mean levels of distress, but at high levels of distress the group difference was smaller and no longer statistically significant.

Hypothesis 1 was therefore partially supported. Participants in the high PTSD symptom group generally reported higher negative post-traumatic religious appraisals, but this group difference was moderated by general distress.

Figure 1

Interaction Between PTSD Symptom Group and General Distress Predicting IAQ



Hypothesis 2

Hypothesis 2 predicted that participants in the high PTSD symptom group would report higher maladaptive religious schemata than those in the low PTSD symptom group. As shown in Table 6, the high PTSD symptom group reported significantly higher ReSQue scores in both the unadjusted Welch's *t*-test and the adjusted ANCOVA with covariates included and assumptions met. The adjusted model showed a significant effect of PTSD symptom group on ReSQue scores, $F(1, 152) = 10.30$, $p = .002$, partial $\eta^2 = .06$. Adjusted mean ReSQue scores were 49.46 (*SE* = 1.85) in the low PTSD group and 59.24 (*SE* = 2.16) in the high PTSD group.

Hypothesis 2 was supported. Participants in the high PTSD group reported significantly greater maladaptive religious schemata than those in the low PTSD group.

Table 6

Unadjusted and Adjusted PTSD Symptom Group Comparisons for IAQ and ReSQue Scores

Statistic	IAQ negative	ReSQue
N	89 Low / 68 High	89 Low / 68 High
Unadjusted comparison		
Low PTSD, M (SD)	14.36 (6.67)	46.97 (15.31)
High PTSD, M (SD)	23.12 (8.48)	62.50 (18.68)
Welch's t(df)	-7.02 (124.27)	-5.57 (127.79)
p	< .001	< .001
Adjusted ANCOVA		
Low PTSD, adjusted M (SE)	15.57 (0.79)	49.46 (1.85)
High PTSD, adjusted M (SE)	21.54 (0.92)	59.24 (2.16)
ANCOVA F(1, 152)	20.97	10.30
p	< .001	.002
Partial eta squared	.12	.06

Hypothesis 3

Hypothesis 3 predicted that negative post-traumatic religious appraisals would mediate the relationship between maladaptive religious schemata and PTSD symptom severity. A bootstrapped mediation analysis was conducted with ReSQue score as the

predictor, IAQ score as the mediator, and PCL-5 score as the outcome, with covariates included as above. As shown in Table 7 and Figure 2, higher ReSQue scores were significantly associated with higher IAQ scores, and higher IAQ scores were significantly associated with higher PCL-5 scores when ReSQue and covariates were included in the model. The indirect effect of ReSQue on PCL-5 through IAQ was significant, B = .095, 95% bootstrap CI [.030, .176], p = .013. The unstandardised direct effect of ReSQue on PCL-5 after IAQ was included was not statistically significant at the conventional .05 level, B = .125, SE = .064, p = .053.

Hypothesis 3 was supported, consistent with the proposed pathway whereby maladaptive religious schemata are associated with PTSD symptom severity partly through more negative post-traumatic religious appraisals. Given the cross-sectional design, this finding should be interpreted as consistent with the proposed cognitive pathway rather than evidence of causal direction.

Table 7

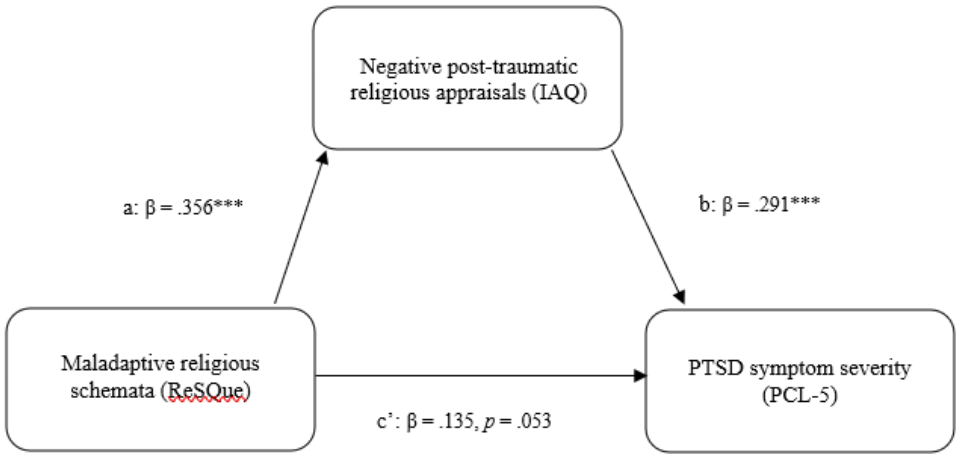
Mediation Model Coefficients for IAQ Negative Appraisals as Mediator Between ReSQue and PTSD Symptom Severity

Path	Association	B	SE	β	p	95% CI
a path	ReSQue → IAQ	.167	.042	.356	< .001	[.083, .245]
b path	IAQ → PCL-5	.573	.159	.291	< .001	[.254, .881]
c path (total effect)	ReSQue → PCL-5	.220	.067	.239	< .001	[.083, .345]
c′ path (direct effect)	ReSQue → PCL-5	.125	.064	.135	= .053	[-.006, .248]
Indirect effect	ReSQue → IAQ → PCL-5	.095	.038	.104	= .013	[.030, .176]

Note. N = 157. B = unstandardised coefficient; β = standardised coefficient; CI = confidence interval.

Figure 2

Mediation Model of the Association Between ReSQue and PTSD Symptom Severity Through IAQ Negative Appraisals



Note. Standardised coefficients are shown. Model controlled for PTCI-9, general distress, and trauma load. $p < .01$. $p < .001$.

Hypothesis 4

Hypothesis 4 used a hierarchical multiple regression, seen in Table 8, to investigate whether maladaptive religious schemata (ReSQue) would be associated with higher negative post-traumatic religious appraisals (IAQ) over and above general negative non-religious trauma-related appraisals (PTCI-9).

Model 1, including PTCI-9, general distress, and trauma load, was significant, R^2 = .283, adjusted R^2 = .269, $F(3, 153) = 20.13$, $p < .001$, explaining 28.3% of variance in IAQ. Adding ReSQue in Model 2 significantly improved model fit, ΔR^2 = .102, $F(1, 152) = 25.14$, $p < .001$. The final model was significant and explained 38.5% of the variance in IAQ, R^2 = .385, adjusted R^2 = .369, $F(4, 152) = 23.76$, $p < .001$. In the final model, ReSQue was significantly associated with IAQ, as was PTCI-9; general distress and trauma load were not significant. Variance inflation factors were all below 2, suggesting no problematic multicollinearity.

Hypothesis 4 was supported. Maladaptive religious schemata explained significant additional variance in negative post-traumatic religious appraisals beyond general negative non-religious trauma-related appraisals, general distress, and trauma load.

Table 8

Hierarchical Multiple Regression Predicting IAQ Negative Post-Traumatic Religious Appraisals

Variable	B	SE	t	p	95% CI
Model 1					
Constant	9.46	2.31	4.09	< .001	[4.89, 14.02]
PTCI-9	0.34	0.06	5.22	< .001	[0.21, 0.46]
General distress	1.30	0.77	1.68	.094	[-0.23, 2.83]
Trauma load	-0.19	0.13	-1.45	.150	[-0.46, 0.07]
Model 2					
Constant	3.17	2.49	1.28	.204	[-1.74, 8.09]
PTCI-9	0.25	0.06	4.00	< .001	[0.13, 0.37]
General distress	0.73	0.73	1.00	.320	[-0.71, 2.16]
Trauma load	-0.20	0.12	-1.62	.107	[-0.45, 0.04]
ReSQue	0.17	0.03	5.01	< .001	[0.10, 0.23]

Discussion

This study examined whether maladaptive religious schemata and negative post-traumatic religious appraisals were associated with PTSD symptom severity in Muslim adults who had experienced trauma. Overall, the findings provide support for the proposed model. Participants above PCL-5 threshold reported higher negative post-traumatic religious appraisals and maladaptive religious schemata than those below the threshold. Across the full sample, maladaptive religious schemata were associated with PTSD symptom severity partly through negative post-traumatic religious appraisals, and also explained additional variance in negative post-traumatic religious appraisals beyond general non-religious trauma-related appraisals, general distress, and trauma load.

These findings are consistent with cognitive models of PTSD, particularly Ehlers and Clark's (2000) model, which emphasises the role of trauma-related appraisals in maintaining a sense of current threat. The present findings suggest that, for some Muslim trauma

survivors, this appraisal system may include religiously specific meanings. For example, appraising trauma as divine punishment, rejection by God, or evidence of spiritual failure may intensify shame, guilt, fear, or perceived ongoing threat. It suggests that the psychological impact of religious beliefs depends partly on the content and meaning of specific appraisals. In this way, religious trauma appraisals may function similarly to other maladaptive trauma-related meanings, such as self-blame or beliefs about the world being unsafe.

The findings also extend previous work on religious coping and trauma in Muslim populations. Berzengi et al. (2017) found that negative Islamic appraisals, trauma-related appraisals, and religious coping were associated with PTSD symptoms among Muslim trauma survivors. Similarly, Grey et al. (2024) found that negative religious coping was associated with higher PTSD symptomatology after the Beirut explosion, and argued that the negative Brief RCOPE may partly capture religious appraisals of events rather than only coping behaviour. In the current study, negative religious trauma appraisals were strongly associated with negative Brief RCOPE scores, supporting the conceptual overlap between them. However, the IAQ is more specific as it assesses Islamic appraisals of a particular traumatic event, and, the ReSQue assesses broader maladaptive religious schemata that are not tied to one trauma.

The mediation result supported the proposed cognitive pathway: maladaptive religious schemata were associated with more negative religious trauma appraisals, which were associated with PTSD symptom severity. This provides support for distinguishing between religious schemata and event-specific religious appraisals, and possibly that maladaptive religious schemata may be linked to PTSD symptoms because they are associated with more negative religious interpretations of the trauma. However, the cross-sectional design means that the direction of this association cannot be established. It is

possible that religious schemata shaped subsequent religious appraisals, but it is also possible that trauma and PTSD symptoms intensified religious appraisals or altered religious schemata over time. The findings should therefore be interpreted as evidence for an indirect pathway, rather than that maladaptive religious schemata cause PTSD symptoms.

The finding that ReSQue explained additional variance in IAQ beyond general non-religious trauma appraisals is also theoretically important as it suggests that maladaptive religious schemata are not simply interchangeable with general non-religious negative trauma cognitions. Instead, they may capture a religiously specific dimension of meaning-making. At the same time, both ReSQue and PTCI-9 remained associated with IAQ in the final model, suggesting that religious and non-religious trauma-related appraisals may operate alongside each other rather than as separate processes. Overall, this supports the applicability of moving beyond general appraisals of self, world, and the future, and incorporating religious meanings into understanding of trauma for some individuals, and into cognitive formulations where these are important to the client.

One complex finding was that the group difference in negative religious trauma appraisals varied according to general distress. The difference between high and low PTSD symptom groups was clearest at low and mean levels of distress, but was smaller and not statistically significant at high distress. This should be interpreted cautiously. One possible explanation is that, at high levels of depression/anxiety distress, negative religious appraisals may be elevated regardless of PTSD symptoms, reducing the distinction between groups. Another possibility is that general distress shares variance with both PTSD symptoms and religious struggle. Clinically, this highlights the importance of assessing religious appraisals alongside broader emotional distress, rather than assuming that they are specific to PTSD.

These findings also raise questions about the possible development of maladaptive religious schemata. The ReSQue was developed from a schema framework and includes

domains such as theocentric core beliefs, theophobia, and religious obligations distress (Shaban et al., under review). These might develop through multiple routes, such as early religious socialisation, family or community messaging, and later experiences that reinforce shame or threat-based religious meanings. However, the current study did not measure any childhood religious or developmental experiences, so cannot determine whether these schemata pre-dated trauma, emerged after, or were strengthened by post-traumatic distress. Future research should therefore examine the developmental origins and pathways of these schemata more directly.

Clinically, the findings suggest that clinicians working with Muslim trauma survivors may benefit from assessing religious meanings of trauma in a sensitive and non-pathologising way. Culturally adapted therapies for Muslim clients emphasise the importance of understanding clients' religious worldviews and supporting clients to draw on positive religious coping where appropriate (Mir et al., 2019). One example is Behavioral Activation for Muslims (BA-M), which retains the principles of behavioral activation while incorporating Islamic teachings, values, and positive religious coping where desired by the client. The intervention was acceptable and feasible in UK services (Mir et al., 2015), and demonstrates how faith-sensitive adaptations can preserve evidence-based therapeutic mechanisms while increasing cultural relevance and engagement. Similarly, guidance on religion-adapted CBT suggests that religious and spiritual material can be incorporated into formulation and intervention when it is meaningful to the client (Rosmarin, 2018). In trauma-focused therapy, this may involve collaboratively exploring appraisals such as "God is punishing me", while avoiding invalidating faith. Where client-led, consultation with trusted faith leaders may also help clients integrate psychological and religious perspectives.

Limitations

Several limitations should be considered. First, the cross-sectional design prevents conclusions about causality or direction of effects. Second, all measures were self-report, which may increase shared-method variance and may be influenced by current mood, social desirability, or willingness to disclose religious struggle. Third, although the PCL-5 is a well-validated measure of PTSD symptom severity, the cut-off used in this study only indicates probable clinically significant symptoms rather than diagnosis. Research also notes against treating PCL-5 cut-offs as equivalent to structured diagnostic interviews, with evidence that PCL-5 scores may inflate severity and prevalence estimates compared to the CAPS-5 interview (Bovin & Marx, 2023). Fourth, the sample was voluntarily self-selecting and recruited online, meaning participants may have had greater interest in the topic, been more comfortable disclosing religious and traumatic experiences, or may have had higher levels of distress than the wider population of Muslim trauma survivors – this limits the sample's representativeness and generalisability of findings. Additionally, self-identification as Muslim and having had a traumatic experience introduced heterogeneity in religious identification and the nature and severity of trauma exposure. The sample was highly educated, with 73.3% holding an undergraduate or postgraduate degree. This may have increased participants' familiarity with psychological language and confidence completing complex self-report measures. Consequently, the findings may not generalise to Muslim adults with lower educational attainment, and whose understandings of religious and trauma-related experiences may potentially differ.

There were also measurement limitations. Trauma load was calculated by summing trauma types endorsed, which does not capture trauma frequency, severity, chronicity, or interpersonal nature. Treatment history, time since trauma, and trauma type were not included in analysis, and the study did not include a detailed measure of religiosity, sect, practice, or religious support. These factors might influence how religious beliefs are interpreted and

should be examined in future research. In addition, the ReSQue is relatively new and has primarily been validated in Muslim populations in the Gulf region, so further validation is needed in UK, community, and clinical samples.

Future Directions

Future research should use longitudinal designs to examine whether maladaptive religious schemata precede negative religious trauma appraisals and PTSD symptoms over time. It would also be valuable to examine potential moderators, such as religiosity, perceived religious support, spiritual struggle, shame, and experiences of Islamophobia or discrimination. Qualitative studies could explore how Muslim trauma survivors make religious meaning of trauma, and how they distinguish between helpful and distressing religious interpretations. Future research should also test whether incorporating religious appraisal work into culturally adapted trauma-focused interventions improves engagement or outcomes.

Conclusion

In conclusion, this study provides preliminary evidence that maladaptive religious schemata and negative post-traumatic religious appraisals are meaningfully associated with PTSD symptom severity in Muslim trauma survivors. The findings support cognitive models of PTSD while highlighting the importance of culturally and religiously specific appraisals. Clinically, the results suggest that religious meanings of trauma may be important to assess and formulate sensitively, particularly where they contribute to shame, fear, or perceived spiritual threat.

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Executive Summary

This project explored whether religious beliefs and meanings may be relevant to post-traumatic stress symptoms in Muslim adults who have experienced trauma. Many people use religion as a source of comfort, meaning, connection, and coping after difficult life events. However, for some people, traumatic experiences may also become linked with distressing religious meanings, such as feeling punished by God, abandoned by God, spiritually defective, or personally to blame. These kinds of meanings may be particularly important to understand in psychological formulation and trauma-focused therapy, especially when religion is central to a person's identity and worldview.

The study focused on two related but distinct ideas. The first was maladaptive religious schemata, meaning broader patterns of distressing religious beliefs about God, the self, and religious practice. These are not necessarily tied to one specific traumatic event. The second was negative religious trauma appraisals, meaning religious interpretations of a specific traumatic event, such as interpreting the event as punishment or rejection by God. The project aimed to understand whether these religious meanings were associated with post-traumatic stress disorder (PTSD) symptom severity in Muslim adults living in the UK.

A total of 157 Muslim adults who had experienced a traumatic event completed an anonymous online survey. They answered questions about trauma exposure, PTSD symptoms, religious schemata, religious appraisals of trauma, general trauma-related beliefs, depression, and anxiety. Sixty-eight participants scored above the clinical threshold on a self-report PTSD symptom measure, although this was not treated as a formal PTSD diagnosis. The findings suggested that religious meanings were relevant to PTSD symptom severity in this sample. Participants with higher PTSD symptoms reported more negative religious trauma appraisals and higher levels of maladaptive religious schemata than participants

below the PTSD symptom threshold. Across the full sample, maladaptive religious schemata were associated with PTSD symptom severity partly through negative religious trauma appraisals. In other words, broader distressing religious belief patterns were linked with more negative religious interpretations of trauma, which were in turn linked with higher PTSD symptoms. Maladaptive religious schemata also explained additional differences in negative religious trauma appraisals even after accounting for general non-religious trauma-related beliefs, depression/anxiety symptoms, and trauma load.

These findings are consistent with cognitive models of PTSD, which suggest that how a person interprets a traumatic event can influence whether a sense of current threat is maintained. This project extends that idea by suggesting that, for some Muslim trauma survivors, religious meanings may form part of this appraisal process. Importantly, the findings do not suggest that religion itself is harmful. Rather, they highlight that some specific religious interpretations, particularly those involving punishment, shame, abandonment, or spiritual threat, may be associated with distress.

The study has clinical relevance for NHS and wider mental health settings. Clinicians working with Muslim trauma survivors may benefit from sensitively asking about religious meanings of trauma where this is relevant to the client. This should be done in a non-pathologising way, recognising that religion may be a source of strength as well as, for some people, a source of distressing meanings. Formulation may therefore need to consider both general trauma-related beliefs and religiously specific appraisals. Where appropriate and client-led, clinicians may also consider how positive religious coping, trusted community support, or faith-informed perspectives can be incorporated into therapy.

There are important limitations. The study was cross-sectional, so it cannot show whether maladaptive religious schemata cause PTSD symptoms, or whether trauma and distress shape religious beliefs over time. All measures were self-report, and the PTSD

threshold indicated probable clinically significant symptoms rather than diagnosis. The sample was also recruited online and may not represent all Muslim trauma survivors in the UK.

Overall, the project provides preliminary evidence that religiously specific beliefs and appraisals may be important to consider when understanding trauma responses in Muslim adults. Future research should use longitudinal and qualitative methods to explore how these meanings develop over time, and how culturally and religiously informed approaches might improve trauma-focused assessment, formulation, and intervention.

Connecting Narrative

Across the three projects in this thesis, I have become increasingly conscious that psychological distress cannot be understood in isolation from the relational, cultural, spiritual, and organisational contexts in which people live and work. Although my SRL, SIP, and TDRP focused on different populations and used different methods, they became connected by a shared concern with trauma, meaning-making, access, and the wellbeing of both clients and clinicians. Together, they have helped me reflect on how I am developing my thinking as a psychologist and researcher: aiming to be evidence-based but also curious about context, identity, power, and the things that might be unspoken or overlooked.

My SRL examined the relationship between attachment style and wellbeing outcomes in mental health professionals. At the start, I had expected this project to feel more removed from clinical practice than my empirical projects due to the nature of the research approach. However, engaging with the literature on clinician wellbeing made the clinical relevance feel clear. The review reminded me that clinicians do not enter therapeutic work as neutral. We bring our own relational histories, emotion regulation strategies, vulnerabilities, and resources into emotionally demanding work. This felt especially important during training, where reflective practice is important, but there can also be pressure to appear resilient and unaffected by the stories we encounter.

The review also taught me about the discipline required in research. The literature was more varied than I had expected, and I found the process of screening, extracting, and synthesising evidence to be demanding and novel, but it really helped me appreciate the value and robustness of systematic methods and now I feel so much more confident in a research approach I had never experienced before. I also noticed my own wish to find a clear story, and the process helped me practice resisting over-simplification. The findings suggested

broad links between attachment and clinician wellbeing, but not in a neat or uniform way. This was a useful lesson for me in tolerating complexity and presenting evidence carefully rather than pushing for a neat conclusion.

The SIP moved me from reviewing published evidence to listening directly to people's experiences of a service system. This project explored barriers and facilitators to accessing specialist psychological trauma support for asylum seekers and refugees. In contrast to the SRL, which involved making sense of studies, the SIP asked me to engage with accounts that were immediate, personal, and sometimes moving. The interviews brought to life how access to care is shaped not only by formal eligibility criteria, but also by perceptions, assumptions, communication, trust, stigma, and uncertainty.

This project was also the one in which my own identity felt most relevant. As a British-Afghan trainee clinical psychologist, a first-generation immigrant, and someone whose wider family has experience of forced migration and asylum-seeking, I felt a really strong personal connection to the topic. This connection was part of what drew me to the project and helped me stay attuned to potential structural disadvantage and mistrust. At the same time, I was aware that shared minority status is not the same as shared experience, and that my own assumptions could have shaped what I noticed or prioritised. This encouraged me to approach the interviews and analysis with curiosity, to consider different interpretations, and to remain mindful of the difference between empathic resonance and over-identification.

The SIP also deepened my understanding of service improvement as a clinical activity. The findings highlighted the importance of practices that might seem relatively ordinary but are powerful, such as empathy, flexibility, transparency, and trust-building. It reinforced for me that improving access is not only about changing referral forms and written criteria, but also about changing the relational experience of services.

My TDRP allowed me to return to theory and empirical testing, while continuing to explore trauma, culture, and meaning-making. The project examined whether religious beliefs and trauma appraisals were associated with PTSD symptom severity in Muslim individuals. It drew on cognitive models of PTSD, but extended these ideas into a culturally and religiously specific context. I was interested in the possibility that for some Muslim trauma survivors, distress might be shaped not only by general appraisals, but also by wider, possibly developmental factors, like religious meanings.

This project was important to me because it addressed an area that can be neglected in mainstream psychological research and practice. Religion and culture can be meaningful in people's lives, but clinicians – including myself – might feel uncertain about how to ask about it, particularly when it is connected with shame, fear, or trauma. I was keen that the project did not pathologise religion or imply that faith is harmful. Rather, it helped me think about culturally-informed care and formulation as central to understanding distress and the meanings people use to make sense of trauma, rather than as an optional add-on to standard practice.

Across the thesis, I have moved between three levels of inquiry: the wellbeing of clinicians, the accessibility of services, and the meanings through which trauma may be understood. These levels feel closely connected: clinicians need support and reflective capacity to provide effective care; services need to be accessible and trustworthy for minoritised communities; and psychological interventions need to attend to cultural, relational, and spiritual meanings that shape distress. The process of completing these projects has strengthened my commitment to research that is clinically relevant, reflexive, and attentive to power and context.

More personally, I'm aware of how much the thesis has shifted my relationship with research. I began training seeing research loosely as challenging and separate from clinical

practice. Through these projects, I have come to see it as a way of listening, questioning assumptions, and making visible experiences that might otherwise remain marginalised. I have also learned that research rarely provides complete answers. Each project left me aware of limitations, unanswered questions, and the partial nature of the knowledge produced. However, I now see this as less as a weakness and more a part of the value of research: it invites further curiosity and dialogue. As I move towards qualified practice, I hope to carry forward this stance as a clinician who remains attentive to evidence, but also to context, culture, identity, and the lived realities of the people and systems with whom I work.

Acknowledgements

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I am thankful to my wonderful friends on the course who have made every part of my experience so full of fun and laughter. To my friends outside of the course, I will forever appreciate your love, patience, and the listening ears you have offered me while I have navigated this journey.

To my beloved siblings, particularly my baby sister, who has brought immeasurable joy to my life.

Thank you to my husband – words cannot express the gratitude I feel for you and the gentle, quiet, compassionate ways you have supported me and taken on my challenges as your own.

Finally, to my parents, who have given everything to bring me to where I am now and to give me opportunities they were not afforded themselves. My successes are your successes, and it is my privilege to carry forward the hopes you had for me. I stand on your shoulders and would not be here without you.

Appendix A: SRL – Instructions to Author

Manuscript preparation

Research in Psychotherapy: Psychopathology, Process and Outcome publishes the following article types:

- Hypothesis and Theory Papers
- Original Articles
- Methods and Tools
- Case Studies
- Reviews
- Minireviews
- Perspectives
- Short communications
- New Researchers
- Book Reviews
- Letters to the Editor
- Editorials
- Commentaries

Overview

Manuscript will be carefully scrutinized for evidence of plagiarism, duplication and data manipulation; in particular, images will be carefully examined for any indication of intentional improper modification.

Any suspected misconduct ends up with a quick rejection and is then reported to the US Office of Research Integrity.

Ensure that your work is written in **correct English before submission**. **Professional copyediting** can help authors improve the presentation of their work and increase its chances of being taken on by a publisher. In case you feel that your manuscript would benefit from a professional a professional English language copyediting checking language grammar and style, you can find a reliable revision service at:



The **Corresponding Author** must submit the manuscript online-only through our Manuscript Submission System.

Authors are kindly invited to suggest potential reviewers (names, affilitations and email addresses) for their manuscript, if they wish.

Preparing your manuscript

Ethical considerations

Articles that report on research involving either human or nonhuman animal participants should indicate whether approval was gained by an institutional board. Research involving nonhuman animal participants should also indicate whether guidelines for the care and use of animals were adhered.

Articles that report on research in healthcare settings should likewise indicate whether NHS approval or equivalent from an appropriate committee was gained. All research should meet the provisions of the **World Medical Association Declaration of Helsinki**.

The first page must contain:

I. running title (maximum of 5 words, only the first word should be capitalized);
II. title (title case, centered, and in 16 point bold Times New Roman font at the top of page), it should be without acronyms, concise, omitting terms that are implicit, and, where possible, be a statement of the main result or conclusion presented in the manuscript;
III. three to five key words;
IV. acknowledgments;
V. authors' contributions, e.g., information about the contributions of each person named as having participated in the study - in order to maintain anonymity of authors, required for the double-blind peer review process, only authors' initials or different symbol for each author should be used;
VI. disclosures about potential conflict of interests;
VII. further information (e.g., funding – including grant numbers if applicable, conference presentation ...).

The second page must contain:

I. Ethical approval and consent to participate;
II. Consent for publication;
III. Availability of data and material;

Tables and Figures
If **tables** are used, they should be double-spaced on separate pages of the manuscript, not embedded throughout the text. They should be numbered and cited in the text.
Tables should be provided as editable Word files, and authors should ensure that they are presented in a publication-ready format. Considering how a table fits on a page in a word-processing program can often provide insight into how it will appear on a journal page.
Larger or more complex tables will be made available online as supplementary material at the Editorial Office's sole discretion, including ensuring efficient readability of the paper publishing format.

Figures: Symbols and abbreviations used in figures can be defined in the figure caption or note or within the figure itself. Please avoid the use of boldface or greater size for the characters. Please remember that to promote good management of the space available images must take up the least possible space without compromising clarity. The number of figures should be reasonable and justified: no more than 20% of the article. They must be numbered with Arabic numerals and placed at the end of the manuscript.
Lettering of figures must be clearly labeled. Figures with different panels have to be grouped into a plate, and panels marked with letters. Micrographs contained in the same figure should be marked with letters.
There is no additional cost for publishing color figures.
A different caption for each figure must be provided at the end of the manuscript, not included in the figure file.
Figures should be designed using a well-known software package. Please note that the Production Office will not redraw or re-letter any images.

When requested by the Editors, **Figures** and graphs must be submitted as .**tif** or .**jpg** files, with the following digital resolution:

- Color (saved as CMYK): 300 dpi - maximum width 17 cm
- Black and white/grays: 600 dpi - maximum width 17 cm

If *abbreviations* are used in the text, authors are required to write full name+abbreviation in brackets [e.g. Multiple Myeloma (MM)] the first time they are used, then only abbreviations can be written (apart from titles; in this case authors have to write always the full name).
If *names of equipment or substances* are mentioned in the text, brand, company names and locations (city and state) for equipment and substances should be included in parentheses within the text.

Sections

The manuscript is organized by headings and subheadings. For all the articles (except for Editorials and Book Reviews) it is recommended to organize the manuscript in the following sections:

Introduction

A succinct literature review in respect with the construct(s) analyzed shoud be reported providing recent and complete references (following APA norms for references in the text). Subheadings might be avoided. Aim(s) and specific hypothese(s) might be reported at the very end of this section.

Methods

This section should report the specific procedure (even theoretical) the research followed, and it may be divided by subheadings (participants or single case description, measures, data analysis). This section should contain sufficient detail so that when read in conjunction with cited references, all procedures can be repeated. For experiments reporting results on human subject research, an ethics approval statement should be included in this section (Ethical Committee of Institution of Place, Protocol Number, year).

Results

This section may be divided by subheadings. Footnotes should not be used and must be incorporated into the main text.

Discussion

This section may be divided by subheadings. Discussions should cover the key findings of the study: discuss any prior results underlining the novelty and originality of the research, in the appropriate context; discuss the potential short-comings and limitations on their interpretations; discuss their integration into the current understanding of the problem and how this advances the current views; speculate on the future direction of the research and freely postulate theories that could be tested in the future.

Conclusions

This section must provide conclusive findings on the research.

References

References should be prepared strictly according to the APA style. To ensure the correct citation format, please check your references here: https://apastyle.apa.org/instructional-aids/reference-examples.pdf.

Manuscript style and content

Authors are advised that publication in *Research in Psychotherapy: Psychopathology, Process and Outcome* requires references, symbols and abbreviations to be in line with the manual of the American Psychological Association, 6th edition. To support the preparation of articles for submission in *Research in Psychotherapy: Psychopathology, Process and Outcome*, authors are encouraged to

review the American Psychological Association Guide for New Authors. Authors should pay particular attention to the readability of articles, in particular the Methods and Results sections of Research Articles and Short Communications.

Article types

Hypothesis and Theory Papers (unstructured abstract 250 words max; text 12,000 words max excluding abstract, references, figures and tables; max 6 tables and/or figures): Articles that analyze or debate established theories in health psychology, or presentations of theoretical innovations.
Original Articles (unstructured abstract 250 words max; text 12,000 words max excluding abstract, references, figures and tables; max 6 tables and/or figures): Articles that report original empirical investigations.
Methods and Tools (unstructured abstract 250 words max; text 12,000 words max excluding abstract, references, figures and tables; max 6 tables and/or figures): Articles that validate instruments used to study the outcome and process in psychotherapy.
Case Studies (unstructured abstract 250 words max; text 10,000 words max excluding abstract, references, figures and tables; max 6 tables and/or figures;): Reports describing observations on single psychological cases.
Reviews (unstructured abstract 250 words max; text 10,000 words max excluding abstract, references, figures and tables; max 6 tables and/or figures): Articles that provide systematic overviews, evaluations and interpretations of research in a given field of health psychology.
Minireviews (unstructured abstract 250 words max; text 3500 words max excluding references, figures and tables; max 4 tables and/or figures): Mini Reviews offer a succinct and clear summary of a specific topic, allowing readers to get up-to-date on new developments an/or emerging concept.
Perspectives (unstructured abstract 250 words max; text 3500 words max excluding references, figures and tables; max 4 tables and/or figures): Perspectives propose a viewpoint on a specific field or discipline, and discuss/describe current advances or future directions.
Short communications (unstructured abstract 250 words max; text 3000 words max excluding abstract, references, figures and tables; max 4 tables and/or figures): Articles that fall short of the criteria for full original articles. These may include, but are not limited to studies that have a limited sample size or duration.
New Researchers (unstructured abstract 250 words max; text 2000 words max excluding abstract, references, figures and tables; max 4 tables and/or figures): Articles authored typically by researchers within 3 years of PhD completion or 3 years of full time employment.
Book Reviews (no abstract required; text 2000 words max excluding references, figures and tables; max 1 table and/or figure): Reviews of published books.
Letters to the Editor (no abstract required; text 500 words max excluding references, figures and tables; max 2 tables and/or figures): Letters to the editor will be considered for publication. Typically, letters will contain information critical to health psychology research or in relation to recently published data.
Editorials (no abstract required; text 2500 words max excluding references, figures and tables; max 2 tables and/or figures;): Invited by the editor only.
Commentaries (about 2000 words, no abstract required, no figures and/or tables): These contributions provide a rapid forum for readers to comment about articles appeared for less than 1 year in the Journal.

Peer-review policy

All manuscripts submitted to our journal are critically assessed by external and/or in-house experts in accordance with the principles of peer review (**http://www.icmje.org/#peer**), which is fundamental to the scientific publication process and the dissemination of sound science. Each paper is first assigned by the Editors to an appropriate Associate Editor who has knowledge of the field discussed in the manuscript. The first step of manuscript selection takes place entirely in-house and has two major objectives: i) to establish the article appropriateness for our journals readership; ii) to define the manuscript priority ranking relative to other manuscripts under consideration, since the number of papers that the journal receives is much greater than it can publish. If a manuscript does not receive a sufficiently high priority score to warrant publication, the editors will proceed to a quick rejection. The remaining articles are reviewed by at least two different external referees (second step or classical

peer review). Manuscripts should be prepared according to the Uniform Requirements established by the International Committee of Medical Journal Editors (ICMJE) (**http://www.icmje.org/#prepare**).

Authorship and Contributorship
All persons designated as authors should qualify for authorship according to the ICMJE criteria. Each author should have participated sufficiently in the work to take public responsibility for the content. Authorship credit should only be based on substantial contributions to: i) conception and design, or analysis and interpretation of data, **and** to ii) drafting the article or revising it critically for important intellectual content; **and** on iii) final approval of the version to be published; **and** iv) agreement to be accountable for all aspects of the work. **Participation solely in the acquisition of funding or the collection of data does not justify authorship. General supervision of the research group is not sufficient for authorship.** Authors should provide a brief description of their individual contributions. Those who do not meet all four criteria should not be listed as authors, but they should be acknowledged. Those whose contributions do not justify authorship may be acknowledged individually or together as a group under a single heading. Authors can find detailed information on the Publisher's web site.

Obligation to Register Clinical Trials
The ICMJE believes that it is important to foster a comprehensive, publicly available database of clinical trials. The ICMJE defines a clinical trial as any research project that prospectively assigns human subjects to intervention or concurrent comparison or control groups to study the cause-and-effect relationship between a medical intervention and a health outcome. Medical interventions include drugs, surgical procedures, devices, behavioral treatments, process-of-care changes, etc. Our journals require, as a condition of consideration for publication, registration in a public trials registry. The journal considers a trial for publication only if it has been registered before the enrollment of the first patient. The journal does not advocate one particular registry, but requires authors to register their trial in a registry that meets several criteria. The registry must be accessible to the public at no charge. It must be open to all prospective registrants and managed by a non-profit organization. There must be a mechanism to ensure the validity of the registration data, and the registry should be electronically searchable. An acceptable registry must include a minimum of data elements (**http://www.icmje.org/about-icmje/faqs/clinical-trials-registration/**). For example, ClinicalTrials.gov (**http://www.clinicaltrials.gov**), sponsored by the United States National Library of Medicine, meets these requirements.

Appendix B: SRL – Search Strategy Developed with Librarians at University of Oxford and Oxford NHS Foundation Trust

therapist* OR psychotherapist* OR counsel?or* OR "clinical psychologist*" OR "counselling psychologist*" OR psychologist* OR "psychological therapist*" OR "mental health professional*" OR "mental health clinician*" OR clinician* OR practitioner* OR trainee* OR psychiatrist* OR "mental health nurse*" OR "psychiatric nurse*" OR "community psychiatric nurse*" OR "social worker*" OR "clinical social worker*" OR "case manager*" OR "care coordinator*" OR caseworker*

AND

attach* OR "adult attachment" OR "attachment anx*" OR "attachment avoid*" OR "attachment insecur*" OR "attachment style*" OR "attachment orientation" OR ECR OR "experiences in close relationships" OR AAI OR "adult attachment interview"

AND

burnout OR "emotional exhaustion" OR depersonalisation OR depersonalization OR "compassion fatigue" OR "secondary traumatic stress" OR "vicarious trauma" OR "vicarious traumatization" OR "professional quality of life" OR ProQOL OR wellbeing OR "well-being" OR distress OR "psychological distress" OR "work stress" OR "job stress" OR "occupational stress"

Appendix C: SRL – Search Strategy for Individual Databases

Database:
PsycINFO 1806 to present – 1104 results

#	Query	Results from 2 Mar 2026
1	(therapist* or psychotherapist* or counsel?or* or "clinical psychologist*" or "counselling psychologist*" or psychologist* or "psychological therapist*" or "mental health professional*" or "mental health clinician*" or clinician* or practitioner* or trainee* or psychiatrist* or "mental health nurse*" or "psychiatric nurse*" or "community psychiatric nurse*" or "social worker*" or "clinical social worker*" or "case manager*" or "care coordinator*" or caseworker*).ab,id,ti.	542,724
2	exp mental health personnel/ or clinicians/ or social workers/	168,717
3	1 or 2	573,689
4	(attach* or "adult attachment" or "attachment anx*" or "attachment avoid*" or "attachment insecur*" or "attachment style*" or "attachment orientation" or ECR or "experiences in close relationships" or AAI or "adult attachment interview").ab,id,ti.	67,987
5	attachment theory/ or attachment security/ or attachment style/	5,002
6	4 or 5	68,016
7	(burnout or "emotional exhaustion" or depersonalisation or depersonalization or "compassion fatigue" or "secondary traumatic stress" or "vicarious trauma" or "vicarious traumatization" or "professional quality of life" or ProQOL or wellbeing or "well-being" or distress or "psychological distress" or "work stress" or "job stress" or "occupational stress").ab,id,ti.	277,036
8	burnout/ or job burnout/ or compassion fatigue/ or emotional exhaustion/ or stress/ or vicarious trauma/	95,878
9	occupational stress/	27,522
10	well being/ or emotional well being/ or employee well being/ or social well being/ or spiritual well being/ or subjective well being/ or "quality of life"/ or work-life balance/	131,197
11	7 or 8 or 9 or 10	400,790
12	3 and 6 and 11	1,104

Database: Scopus 1960 to present – 1004 results

(TITLE-ABS-KEY (therapist* OR psychotherapist* OR counsel?or* OR "clinical psychologist*" OR "counselling psychologist*" OR psychologist* OR "psychological therapist*" OR "mental health professional*" OR "mental health clinician*" OR clinician* OR practitioner* OR trainee* OR psychiatrist* OR "mental health nurse*" OR "psychiatric nurse*" OR "community psychiatric nurse*" OR "social worker*" OR "clinical social worker*" OR "case manager*" OR "care coordinator*" OR caseworker*)

AND TITLE-ABS-KEY (attach* OR "adult attachment" OR "attachment anx*" OR "attachment avoid*" OR "attachment insecur*" OR "attachment style*" OR "attachment orientation" OR ECR OR "experiences in close relationships" OR AAI OR "adult attachment interview")

AND TITLE-ABS-KEY (burnout OR "emotional exhaustion" OR depersonalisation OR depersonalization OR "compassion fatigue" OR "secondary traumatic stress" OR "vicarious trauma" OR "vicarious traumatization" OR "professional quality of life" OR ProQOL OR wellbeing OR "well-being" OR distress OR "psychological distress" OR "work stress" OR "job stress" OR "occupational stress"))

Database: PubMed 1997 to present – 538 results

Search nu	Query	Sort By	Search Details	Results
10	#3 AND #6 AND #9		("therapist*"[Title/Abstract] OR "psychotherapist*"[Title/Abstract] OR "counse	538
9	#7 OR #8		"burnout"[Title/Abstract] OR "emotional exhaustion"[Title/Abstract] OR "deper	1,629,261
8	Burnout, Professional		"burnout, professional"[MeSH Terms] OR ("burnout"[All Fields] AND "professior	1,371,552
7	burnout[Title/Abstrac		"burnout"[Title/Abstract] OR "emotional exhaustion"[Title/Abstract] OR "deper	408,686
6	#4 OR #5		"adult attachment"[Title/Abstract] OR "attachment anx*"[Title/Abstract] OR "a	27,432
5	Attachment Behavior		("attach"[All Fields] OR "attachable"[All Fields] OR "attached"[All Fields] OR "at	18,559
4	adult attachment[Titl		"adult attachment"[Title/Abstract] OR "attachment anx*"[Title/Abstract] OR "a	11,050
3	#1 OR #2		"therapist*"[Title/Abstract] OR "psychotherapist*"[Title/Abstract] OR "counsel	824,744
2	Mental Health Person		(("mental health"[MeSH Terms] OR ("mental"[All Fields] AND "health"[All Fields	154,170
1	therapist*[Title/Abstr		"therapist*"[Title/Abstract] OR "psychotherapist*"[Title/Abstract] OR "counsel	743,334

Database: Web of Science 1900 to present – 866 results

Web of Science Search Strategy (v0.1)

Database: Web of Science Core Collection

Entitlements:

- WOS.IC: 1993 to 2026
- WOS.CCR: 1985 to 2026

- WOS.SCI: 1900 to 2026
- WOS.AHCI: 1975 to 2026
- WOS.BHCI: 2005 to 2026
- WOS.BSCI: 2005 to 2026
- WOS.ESCI: 2005 to 2026
- WOS.ISTP: 1990 to 2026
- WOS.SSCI: 1900 to 2026
- WOS.ISSHP: 1990 to 2026

Searches:

Search: (therapist* OR psychotherapist* OR counsel?or* OR "clinical psychologist*" OR "counselling psychologist*" OR psychologist* OR "psychological therapist*" OR "mental health professional*" OR "mental health clinician*" OR clinician* OR practitioner* OR trainee* OR psychiatrist* OR "mental health nurse*" OR "psychiatric nurse*" OR "community psychiatric nurse*" OR "social worker*" OR "clinical social worker*" OR "case manager*" OR "care coordinator*" OR caseworker*) (Topic) AND (attachment OR "adult attachment" OR "attachment anx*" OR "attachment avoid*" OR "attachment insecur*" OR "attachment style*" OR "attachment orientation" OR ECR OR "experiences in close relationships" OR AAI OR "adult attachment interview") (Topic) AND (burnout OR "emotional exhaustion" OR depersonalisation OR depersonalization OR "compassion fatigue" OR "secondary traumatic stress" OR "vicarious trauma" OR "vicarious traumatization" OR "professional quality of life" OR ProQOL OR wellbeing OR "well-being" OR distress OR "psychological distress" OR "work stress" OR "job stress" OR "occupational stress") (Topic)

Database: CINAHL 1961 to present – 385 results

S25
(S24) AND (S12) AND (S7)
((((((MH "Psychological Well-Being")) OR ((MH "Emotional Exhaustion")) OR ((MH "Quality of Life+")) OR ((MH "Stress, Occupational+")) OR ((MH "Compassion Fatigue")) OR ((MH "Burnout, Professional+")))) OR ((((AB (burnout OR "emotional exhaustion" OR depersonalisation OR depersonalization OR "compassion fatigue" OR "secondary traumatic stress" OR "vicarious trauma" OR "vicarious traumatization" OR "professional quality of life" OR ProQOL OR wellbeing OR "well-being" OR distress OR "psychological distress" OR "work stress" OR "job stress" OR "occupational stress"))) OR ((TI (burnout OR "emotional exhaustion" OR depersonalisation OR depersonalization OR "compassion fatigue" OR "secondary traumatic stress" OR "vicarious trauma" OR "vicarious traumatization" OR "professional quality of life" OR ProQOL OR wellbeing OR "well-being" OR distress OR "psychological distress" OR "work stress" OR "job stress" OR "occupational stress")))))) AND ((((MH "Attachment Behavior+")) OR ((((TI (attach* OR "adult attachment" OR "attachment anx*" OR "attachment avoid*" OR "attachment insecur*" OR "attachment style*" OR "attachment orientation" OR ECR OR "experiences in close relationships" OR AAI OR "adult attachment interview"))) OR ((AB (attach* OR "adult attachment" OR "attachment anx*" OR "attachment avoid*" OR "attachment insecur*" OR "attachment style*" OR

"attachment orientation" OR ECR OR "experiences in close relationships" OR AAI OR "adult attachment interview")))))) AND ((((((MH "Social Workers")) OR ((MH "Mental Health Personnel+")))) OR ((((AB (therapist* OR psychotherapist* OR counsel?or* OR "clinical psychologist*" OR "counselling psychologist*" OR psychologist* OR "psychological therapist*" OR "mental health professional*" OR "mental health clinician*" OR clinician* OR practitioner* OR trainee* OR psychiatrist* OR "mental health nurse*" OR "psychiatric nurse*" OR "community psychiatric nurse*" OR "social worker*" OR "clinical social worker*" OR "case manager*" OR "care coordinator*" OR caseworker*))) OR ((TI (therapist* OR psychotherapist* OR counsel?or* OR "clinical psychologist*" OR "counselling psychologist*" OR psychologist* OR "psychological therapist*" OR "mental health professional*" OR "mental health clinician*" OR clinician* OR practitioner* OR trainee* OR psychiatrist* OR "mental health nurse*" OR "psychiatric nurse*" OR "community psychiatric nurse*" OR "social worker*" OR "clinical social worker*" OR "case manager*" OR "care coordinator*" OR caseworker*)))))))

S24
(S23) OR (S15)
((((MH "Psychological Well-Being")) OR ((MH "Emotional Exhaustion")) OR ((MH "Quality of Life+")) OR ((MH "Stress, Occupational+")) OR ((MH "Compassion Fatigue")) OR ((MH "Burnout, Professional+")))) OR ((((AB (burnout OR "emotional exhaustion" OR depersonalisation OR depersonalization OR "compassion fatigue" OR "secondary traumatic stress" OR "vicarious trauma" OR "vicarious traumatization" OR "professional quality of life" OR ProQOL OR wellbeing OR "well-being" OR distress OR "psychological distress" OR "work stress" OR "job stress" OR "occupational stress"))) OR ((TI (burnout OR "emotional exhaustion" OR depersonalisation OR depersonalization OR "compassion fatigue" OR "secondary traumatic stress" OR "vicarious trauma" OR "vicarious traumatization" OR "professional quality of life" OR ProQOL OR wellbeing OR "well-being" OR distress OR "psychological distress" OR "work stress" OR "job stress" OR "occupational stress")))))

S23
(S21) OR (S20) OR (S19) OR (S18) OR (S17) OR (S16)
((MH "Psychological Well-Being")) OR ((MH "Emotional Exhaustion")) OR ((MH "Quality of Life+")) OR ((MH "Stress, Occupational+")) OR ((MH "Compassion Fatigue")) OR ((MH "Burnout, Professional+"))

S22
MH "Psychological Well-Being"
MH "Psychological Well-Being"

S21
MH "Psychological Well-Being"
MH "Psychological Well-Being"

S20
MH "Emotional Exhaustion"
MH "Emotional Exhaustion"

S19
MH "Quality of Life+"
MH "Quality of Life+"

S18
MH "Stress, Occupational+"
MH "Stress, Occupational+"

S17
MH "Compassion Fatigue"
MH "Compassion Fatigue"

S16
MH "Burnout, Professional+"
MH "Burnout, Professional+"

S15
(S14) OR (S13)
((AB (burnout OR "emotional exhaustion" OR depersonalisation OR depersonalization OR "compassion fatigue" OR "secondary traumatic stress" OR "vicarious trauma" OR "vicarious traumatization" OR "professional quality of life" OR ProQOL OR wellbeing OR "well-being" OR distress OR "psychological distress" OR "work stress" OR "job stress" OR "occupational stress"))) OR ((TI (burnout OR "emotional exhaustion" OR depersonalisation OR depersonalization OR "compassion fatigue" OR "secondary traumatic stress" OR "vicarious trauma" OR "vicarious traumatization" OR "professional quality of life" OR ProQOL OR wellbeing OR "well-being" OR distress OR "psychological distress" OR "work stress" OR "job stress" OR "occupational stress")))

S14
AB (burnout OR "emotional exhaustion" OR depersonalisation OR depersonalization OR "compassion fatigue" OR "secondary traumatic stress" OR "vicarious trauma" OR "vicarious traumatization" OR "professional quality of life" OR ProQOL OR wellbeing OR "well-being" OR distress OR "psychological distress" OR "work stress" OR "job stress" OR "occupational stress")
AB (burnout OR "emotional exhaustion" OR depersonalisation OR depersonalization OR "compassion fatigue" OR "secondary traumatic stress" OR "vicarious trauma" OR "vicarious traumatization" OR "professional quality of life" OR ProQOL OR wellbeing OR "well-being" OR distress OR "psychological distress" OR "work stress" OR "job stress" OR "occupational stress")

S13
TI (burnout OR "emotional exhaustion" OR depersonalisation OR depersonalization OR "compassion fatigue" OR "secondary traumatic stress" OR "vicarious trauma" OR "vicarious traumatization" OR "professional quality of life" OR ProQOL OR wellbeing OR "well-being" OR distress OR "psychological distress" OR "work stress" OR "job stress" OR "occupational stress")

TI (burnout OR "emotional exhaustion" OR depersonalisation OR depersonalization OR "compassion fatigue" OR "secondary traumatic stress" OR "vicarious trauma" OR "vicarious traumatization" OR "professional quality of life" OR ProQOL OR wellbeing OR "well-being" OR distress OR "psychological distress" OR "work stress" OR "job stress" OR "occupational stress")

S12
(S11) OR (S10)
((MH "Attachment Behavior+")) OR ((((TI (attach* OR "adult attachment" OR "attachment anx*" OR "attachment avoid*" OR "attachment insecur*" OR "attachment style*" OR "attachment orientation" OR ECR OR "experiences in close relationships" OR AAI OR "adult attachment interview"))) OR ((AB (attach* OR "adult attachment" OR "attachment anx*" OR "attachment avoid*" OR "attachment insecur*" OR "attachment style*" OR "attachment orientation" OR ECR OR "experiences in close relationships" OR AAI OR "adult attachment interview")))))

S11
MH "Attachment Behavior+"
MH "Attachment Behavior+"

S10
(S8) OR (S9)
((TI (attach* OR "adult attachment" OR "attachment anx*" OR "attachment avoid*" OR "attachment insecur*" OR "attachment style*" OR "attachment orientation" OR ECR OR "experiences in close relationships" OR AAI OR "adult attachment interview"))) OR ((AB (attach* OR "adult attachment" OR "attachment anx*" OR "attachment avoid*" OR "attachment insecur*" OR "attachment style*" OR "attachment orientation" OR ECR OR "experiences in close relationships" OR AAI OR "adult attachment interview")))

S9
AB (attach* OR "adult attachment" OR "attachment anx*" OR "attachment avoid*" OR "attachment insecur*" OR "attachment style*" OR "attachment orientation" OR ECR OR "experiences in close relationships" OR AAI OR "adult attachment interview")
AB (attach* OR "adult attachment" OR "attachment anx*" OR "attachment avoid*" OR "attachment insecur*" OR "attachment style*" OR "attachment orientation" OR ECR OR "experiences in close relationships" OR AAI OR "adult attachment interview")

S8
TI (attach* OR "adult attachment" OR "attachment anx*" OR "attachment avoid*" OR "attachment insecur*" OR "attachment style*" OR "attachment orientation" OR ECR OR "experiences in close relationships" OR AAI OR "adult attachment interview")
TI (attach* OR "adult attachment" OR "attachment anx*" OR "attachment avoid*" OR "attachment insecur*" OR "attachment style*" OR "attachment orientation" OR ECR OR "experiences in close relationships" OR AAI OR "adult attachment interview")

S7
(S6) OR (S3)

((((MH "Social Workers")) OR ((MH "Mental Health Personnel+")))) OR ((((AB (therapist* OR psychotherapist* OR counsel?or* OR "clinical psychologist*" OR "counselling psychologist*" OR psychologist* OR "psychological therapist*" OR "mental health professional*" OR "mental health clinician*" OR clinician* OR practitioner* OR trainee* OR psychiatrist* OR "mental health nurse*" OR "psychiatric nurse*" OR "community psychiatric nurse*" OR "social worker*" OR "clinical social worker*" OR "case manager*" OR "care coordinator*" OR caseworker*))) OR ((TI (therapist* OR psychotherapist* OR counsel?or* OR "clinical psychologist*" OR "counselling psychologist*" OR psychologist* OR "psychological therapist*" OR "mental health professional*" OR "mental health clinician*" OR clinician* OR practitioner* OR trainee* OR psychiatrist* OR "mental health nurse*" OR "psychiatric nurse*" OR "community psychiatric nurse*" OR "social worker*" OR "clinical social worker*" OR "case manager*" OR "care coordinator*" OR caseworker*)))))

S6
(S5) OR (S4)
((MH "Social Workers")) OR ((MH "Mental Health Personnel+"))

S5
MH "Social Workers"
MH "Social Workers"

S4
MH "Mental Health Personnel+"
MH "Mental Health Personnel+"

S3
(S2) OR (S1)
((AB (therapist* OR psychotherapist* OR counsel?or* OR "clinical psychologist*" OR "counselling psychologist*" OR psychologist* OR "psychological therapist*" OR "mental health professional*" OR "mental health clinician*" OR clinician* OR practitioner* OR trainee* OR psychiatrist* OR "mental health nurse*" OR "psychiatric nurse*" OR "community psychiatric nurse*" OR "social worker*" OR "clinical social worker*" OR "case manager*" OR "care coordinator*" OR caseworker*))) OR ((TI (therapist* OR psychotherapist* OR counsel?or* OR "clinical psychologist*" OR "counselling psychologist*" OR psychologist* OR "psychological therapist*" OR "mental health professional*" OR "mental health clinician*" OR clinician* OR practitioner* OR trainee* OR psychiatrist* OR "mental health nurse*" OR "psychiatric nurse*" OR "community psychiatric nurse*" OR "social worker*" OR "clinical social worker*" OR "case manager*" OR "care coordinator*" OR caseworker*)))

S2
AB (therapist* OR psychotherapist* OR counsel?or* OR "clinical psychologist*" OR "counselling psychologist*" OR psychologist* OR "psychological therapist*" OR "mental health professional*" OR "mental health clinician*" OR clinician* OR practitioner* OR trainee* OR psychiatrist* OR "mental health nurse*" OR "psychiatric nurse*" OR "community psychiatric nurse*" OR "social worker*" OR "clinical social worker*" OR "case manager*" OR "care coordinator*" OR caseworker*)

AB (therapist* OR psychotherapist* OR counsel?or* OR "clinical psychologist*" OR "counselling psychologist*" OR psychologist* OR "psychological therapist*" OR "mental health professional*" OR "mental health clinician*" OR clinician* OR practitioner* OR trainee* OR psychiatrist* OR "mental health nurse*" OR "psychiatric nurse*" OR "community psychiatric nurse*" OR "social worker*" OR "clinical social worker*" OR "case manager*" OR "care coordinator*" OR caseworker*)

S1
TI (therapist* OR psychotherapist* OR counsel?or* OR "clinical psychologist*" OR "counselling psychologist*" OR psychologist* OR "psychological therapist*" OR "mental health professional*" OR "mental health clinician*" OR clinician* OR practitioner* OR trainee* OR psychiatrist* OR "mental health nurse*" OR "psychiatric nurse*" OR "community psychiatric nurse*" OR "social worker*" OR "clinical social worker*" OR "case manager*" OR "care coordinator*" OR caseworker*)
TI (therapist* OR psychotherapist* OR counsel?or* OR "clinical psychologist*" OR "counselling psychologist*" OR psychologist* OR "psychological therapist*" OR "mental health professional*" OR "mental health clinician*" OR clinician* OR practitioner* OR trainee* OR psychiatrist* OR "mental health nurse*" OR "psychiatric nurse*" OR "community psychiatric nurse*" OR "social worker*" OR "clinical social worker*" OR "case manager*" OR "care coordinator*" OR caseworker*)

Appendix D: SRL – Data Extraction Templates

Study characteristics:

Study	Location and setting	Design	Sampling method	Sample profession	N	Gender	Age mean (SD)	Ethnicity	Attachment measure	Wellbeing outcome(s)
Hartley et al. (2016)	UK; three NHS adult psychosis inpatient mental health sites in North West England	Cross-sectional	Convenience sampling, self-selecting self-report survey	Inpatient mental health staff: mental health nurses (25%), support workers (20%), psychologists (18%), occupational therapists (16%), psychiatrists (10%)	50	17 male (34%), 33 female (66%)	37.5 (10.64)	N/R	The Attachment Measure	Burnout: MBI-HSS

Main findings:

Study	Wellbeing outcome measure	Main relevant finding	Statistical evidence reported	Analysis/covariate notes	Direction of association	Quality rating
Hartley et al. (2016)	Burnout: EE, DP, PA subscales	Anxiety significantly positively associated with EE and DP, but not PA. Avoidance not significantly associated with any burnout subscale.	Anxiety-EE $r = .30$, $p < .05$; anxiety-DP $r = .44$, $p < .01$; anxiety-PA $r = .21$, ns. Avoidance: significant associations.	Pearson's correlations, no adjusted model. Low reliability for MBI-HSS in this sample.	Higher anxiety → greater burnout, specifically EE and DP. Avoidance not significant.	0.68 (Medium)

Appendix E: SRL – Standard Quality Assessment Criteria Checklist (Kmet et al., 2004)

Criteria		Yes (2)	Partial (1)	No (0)	N/A
1	Question/objective sufficiently described?				
2	Study design evident and appropriate?				
3	Method of subject/comparison group selection *or* source of information/input variables described and appropriate?				
4	Subject (and comparison group, if applicable) characteristics sufficiently described?				
5	If interventional and random allocation was possible, was it described?				**N/A**
6	If interventional and blinding of investigators was possible, was it reported?				**N/A**
7	If interventional and blinding of subjects was possible, was it reported?				**N/A**
8	Outcome and (if applicable) exposure measure(s) well defined and robust to measurement / misclassification bias? Means of assessment reported?				
9	Sample size appropriate?				
10	Analytic methods described/justified and appropriate?				
11	Some estimate of variance is reported for the main results?				
12	Controlled for confounding?				
13	Results reported in sufficient detail?				
14	Conclusions supported by the results?				

Appendix F: SRL – Quality Assessment Results

Paper	Paper Name	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Total Score	Possible Score	Score	Categories
1	Hartley et al. (2016)	2	2	1	2	N/A	N/A	N/A	1	1	2	1	0	1	2	15	22	0.68	Medium
2	Marmaras et al. (2003)	2	2	0	1	N/A	N/A	N/A	2	1	1	1	0	1	2	13	22	0.59	Medium
3	Racanelli (2005)	2	2	1	1	N/A	N/A	N/A	2	0	1	2	0	1	2	14	22	0.63	Medium
4	Tosone et al. (2010)	2	2	1	2	N/A	N/A	N/A	2	1	2	2	1	2	1	19	22	0.86	High
5	Carr & Egan (2017)	2	2	1	1	N/A	N/A	N/A	1	1	2	2	1	1	2	16	22	0.72	Medium
6	Brugnera et al. (2021)	2	2	1	2	N/A	N/A	N/A	2	2	2	2	1	2	2	20	22	0.90	High
7	Nissen-Lie et al. (2021)	2	2	1	2	N/A	N/A	N/A	2	2	2	2	1	2	2	20	22	0.90	High
8	Heinonen et al. (2022)	2	2	1	2	N/A	N/A	N/A	0	2	1	2	0	1	2	15	22	0.68	Medium
9	Brugnera et al. (2023)	2	2	1	1	N/A	N/A	N/A	1	0	2	2	1	2	2	17	22	0.72	Medium
10	Wong & Denson (2025)	2	2	1	2	N/A	N/A	N/A	2	1	2	2	1	2	2	19	22	0.86	High
11	Castellini et al. (2024)	2	2	1	2	N/A	N/A	N/A	2	2	2	2	1	2	2	20	22	0.90	High
12	Hiebler-Ragger et al. (2021)	2	2	1	2	N/A	N/A	N/A	2	2	2	2	1	2	2	20	22	0.90	High
13	Elsayes et al. (2023)	2	2	1	1	N/A	N/A	N/A	0	1	1	2	1	1	1	13	22	0.59	Medium
14	Yilmaz & Bekaroglu (2025)	2	2	1	1	N/A	N/A	N/A	2	1	2	2	1	2	2	18	22	0.82	High
15	Tosone et al. (2011)	2	2	1	2	N/A	N/A	N/A	2	1	2	2	1	2	2	19	22	0.86	High
16	Tosone et al. (2015)	2	2	1	1	N/A	N/A	N/A	2	1	2	2	1	2	2	18	22	0.82	High

Note: Items 5–7 were treated as not applicable as interventional and random allocation were not possible for any of these studies due to their design and objectives, thereby giving a possible score of 22 for each study.

Appendix G: SRL – Narrative Synthesis Guidelines

Guidance from Popay and colleagues (2006) was followed to enable a robust and reproducible framework for the synthesis of study findings. This guidance requires the synthesis to develop a theoretical model of how the interventions work, why, and for whom (in this case, the associations between the variables of attachment and wellbeing, since no interventions were studied); to develop a preliminary synthesis of studies (where commons themes among studies were found); to explore relationships in the data (where conceptually similar findings were grouped together); and to assess the robustness of the synthesis product (where the quality assessment tool was used to evaluate the evidence in the synthesis, and this was critically reflected on).

SWiM reporting item	Item description
Methods	
1 Grouping studies for synthesis	1a) Provide a description of, and rationale for, the groups used in the synthesis (eg, groupings of populations, interventions, outcomes, study design)
	1b) Detail and provide rationale for any changes made subsequent to the protocol in the groups used in the synthesis
2 Describe the standardised metric and transformation methods used	Describe the standardised metric for each outcome. Explain why the metric(s) was chosen and describe any methods used to transform the intervention effects, as reported in the study, to the standardised metric, citing any methodological guidance consulted
3 Describe the synthesis methods	Describe and justify the methods used to synthesise the effects for each outcome when it was not possible to undertake a meta-analysis of effect estimates
4 Criteria used to prioritise results for summary and synthesis	Where applicable, provide the criteria used, with supporting justification, to select the particular studies, or a particular study, for the main synthesis or to draw conclusions from the synthesis (eg, based on study design, risk of bias assessments, directness in relation to the review question)
5 Investigation of heterogeneity in reported effects	State the method(s) used to examine heterogeneity in reported effects when it was not possible to undertake a meta-analysis of effect estimates and its extensions to investigate heterogeneity
6 Certainty of evidence	Describe the methods used to assess the certainty of the synthesis findings
7 Data presentation methods	Describe the graphical and tabular methods used to present the effects (eg, tables, forest plots, harvest plots)
	Specify key study characteristics (eg, study design, risk of bias) used to order the studies, in the text and any tables or graphs, clearly referencing the studies included
Results	
8 Reporting results	For each comparison and outcome, provide a description of the synthesised findings and the certainty of the findings. Describe the result in language that is consistent with the question the synthesis addresses, and indicate which studies contribute to the synthesis
Discussion	
9 Limitations of the synthesis	Report the limitations of the synthesis methods used and/or the groupings used in the synthesis and how these affect the conclusions that can be drawn in relation to the original review question

The image above details the Synthesis Without Meta-Analysis (SWiM) guidelines, which further provides a guiding framework for systematically conducing narrative synthesis when meta-analysis is not possible (Campbell et al., 2020).

Appendix H: SIP - Interview Schedule for Clients and for Referrers

Interviews for service users

1. Introduction (consent to recording would have been signed before:
    a. Introducing self, the study context, and contextualising the Berkshire Traumatic Stress Service (BTSS)
    b. Explaining the research purpose
    c. Establishing confidentiality and restating that participation will have no impact on the treatment received from BTSS
    d. Obtaining verbal informed consent

2. Demographics:
    a. Asking for background information: age, gender, country of origin, ASR status
    b. How did you first learn about BTSS?

3. Interview questions regarding access and engagement:
    a. What has been your overall experience of using and accessing BTSS?
    b. Did you have any concerns about accessing BTSS/a mental health service when you were referred?
    c. Did you encounter any barriers or difficulties in being referred to and accessing BTSS at the outset?
        i. What were these difficulties?
        ii. Were they overcome and how?
        iii. Optional prompts: perceptions of stigma, perceptions of cultural awareness, perceptions of language barriers, etc.
    d. Did you encounter any barriers or difficulties with engaging with BTSS and with the care that you received from them?
        i. What were these difficulties and at which stages did they occur?
        ii. Were they overcome and how?
        iii. Optional prompts: perceptions of stigma, perceptions of cultural awareness, perceptions of language barriers, etc.
    e. Overall, do you think that there are barriers or problems in accessing and receiving care from BTSS for yourself or for other individuals who identify as ASR?
        i. What do you think these problems might be?
        ii. How do you think they could be overcome?
        iii. Optional prompts: perceptions of stigma, perceptions of cultural awareness, perceptions of language barriers, etc.
    f. Did you have any positive experiences of being referred to and receiving care from BTSS which encouraged your engagement?
        i. What were these?

    g. Would you recommend using BTSS to those you know who are also from an ASR background? What about people you know who are not from an ASR background?

        i. Why/why not?
    h. Would you give any suggestions to BTSS that could improve the experience of accessibility and receiving care from them, for you and for other who are from an ASR background?
        i. What would these be?
        ii. Are these related to positive or negative experiences using any other similar services?

4. Ending:
    a. Debrief
    b. Restate confidentiality and withdrawal process
    c. Signposting and provide contact details

Interviews for referrers

1. Introduction (consent to recording would have been signed before):
    a. Introducing the study context and contextualising the Berkshire Traumatic Stress Service (BTSS)
    b. Explaining of the research aims, context, and purpose
    c. Establishing confidentiality and anonymity
    d. Obtaining verbal informed consent

2. Demographics (stating that this information will be anonymised and summarised in the writeup):
    a. Name/type of organisation (e.g. GP, NHS specialist service, community mental health service)
    b. Role of the respondent

3. Interview regarding access and engagement:
    a. What is your knowledge of what the BTSS is/does and what the referral criteria to them are?
    b. How frequently do you think that your organisation refers asylum seeker and refugee (ASR) individuals to BTSS?
    c. Have you identified any specific challenges for the ASR you come in contact with accessing mental health services as a whole?
        i. Optional prompts: enquire about perceptions of stigma in services, perceptions of cultural awareness in services, etc.
    b. Do you think that there are criteria that refugees need to fulfil to be referred to BTSS?
        i. Optional prompts: Criteria to refer ASR to secondary care services, MH support using an interpreter, etc.
    d. Have you encountered any barriers in referring ASR to BTSS? If so, what are these?
    e. Have you encountered any facilitators to referring ASR to BTSS? If so, what are these?

f. Have you identified any barriers to ASR accessing BTSS at the outset? If so, what are these?
g. Have you identified any facilitators to ASR accessing BTSS at the outset? If so, what are these?
h. Have you identified any barriers to ASR remaining engaged with BTSS once they have entered the service? If so, what are these?
i. Have you identified any facilitators to ASR remaining engaged with BTSS once they have entered the service? If so, what are these?
j. Are you aware of any policy recommendations related to service access for ASR which may have influenced yourself or colleagues in referring or not referring ASR to BTSS or other comparable services?

k. Are there any suggestions that you would make which might make it easier for you to refer ASR to BTSS?
l. Are there any suggestions that you would make for BTSS to improve access and engagement, and overall service provision, for ASR? These may be based on existing policies and guidelines or comparable services which enable access and engagement for ASR.

4. Ending:
    a. Debrief of aims of research
    b. Restate confidentiality and anonymity
    c. Provide contact details for further enquiry
    d. Enquire whether they may know of others who would like to participate

Appendix I: SIP - Participant Information Sheet for Clients and for Referrers

Information for patients

NHS
Berkshire Healthcare
NHS Foundation Trust

A Service-Evaluation of Berkshire Traumatic Stress Service: barriers and facilitators to accessing and engaging with the service for clients who are asylum seekers or refugees

Purpose

This project seeks to interview clients in the Berkshire Traumatic Stress Service (BTSS) who have asylum seeker or refugee status, to hear about their experiences of using the BTSS. We hope that this will build our understanding of the barriers and facilitators that clients may have experienced while receiving care from the service, in order to improve the service's provision for individuals from asylum seeker or refugee backgrounds.

We will carry out this service improvement project by holding interviews in April 2024 with clients who have accessed or are currently accessing BTSS. The interviews will involve asking a set of questions, and you will have the opportunity to describe what your experience in the service has been. The interviews will be video recorded for the service improvement project, but the recordings will be made anonymous and will only be accessible to the primary clinicians in the project. Once interviews are completed, the clinicians will produce a report to summarise the results and to make any recommendations to BTSS which have been identified.

Who are we going to share your data/recording with?

The interviews will be video recorded for the service improvement project, but the recordings will be made anonymous and will only be accessible to the primary clinicians in the project, and kept on a secure electronic system on a Berkshire Healthcare NHS Foundation Trust laptop. The clinicians work in BTSS, within the Berkshire Healthcare NHS Foundation Trust. Recordings will not be shared wider within the service or Trust outside of the primary clinicians involved in the project, nor be linked to your NHS health record.

How long will Berkshire Healthcare NHS Foundation Trust keep the data/recording?

The recordings will be kept for up to one year after the interviews have ended so that the service improvement project can be completed, and will be destroyed after this.

How do I exercise my right over the shared access data/recording?

If you wish, you can withdraw your consent and ask for recordings to be deleted up to a

week after your interview by contacting Anahita Shafai, the primary clinician involved in the project in the BTSS, at anahita.shafai@berkshire.nhs.uk

For more information:

For full information about how BHFT use your information to provide your care, please visit: https://www.berkshirehealthcare.nhs.uk/about-us/about-us/protecting-your-data-privacy-notice/

You may access the Information Commissioner's Office (ICO) website for further information on your data subject rights including your right to complain.

You may contact BTSS for further information and to get in touch with the service: traumaandveterans@berkshire.nhs.uk

You may contact Patient and Liaison Service (PALS) for informal, impartial, and confidential advice regarding any concerns you may have about the care you have received:
Telephone: 01189605027
Email: PALS@berkshire.nhs.uk

Berkshire Healthcare
NHS Foundation Trust

A Service-Evaluation of Berkshire Traumatic Stress Service: barriers and facilitators to referring clients to the service who are asylum seekers or refugees

Purpose

This project seeks to interview individuals who may refer clients to the Berkshire Traumatic Stress Service (BTSS). We are interviewing referrers to hear about their experiences of referring or not referring clients who have asylum seeker or refugee status to BTSS. We hope that this will build our understanding of the barriers and facilitators that asylum seeker and refugee clients may have experienced while seeking care from the service, in order to improve the service's provision for individuals from asylum seeker or refugee backgrounds.

We will carry out this service improvement project by holding interviews in April 2024 with referrers to the BTSS. The interviews will involve asking a set of questions, and you will have the opportunity to describe what your experience working with the service has been. The interviews will be video recorded for the project, but the recordings will be made anonymous and will only be accessible to the primary clinicians in the project. Once interviews are completed, the clinicians will produce a report to summarise the results and to make any recommendations to BTSS which have been identified.

Who are we going to share your data/recording with?

The interviews will be video recorded for the service improvement project, but the recordings will be made anonymous and will only be accessible to the primary clinicians in the project, and kept on a secure electronic system on a Berkshire Healthcare NHS Foundation Trust laptop. The clinicians work in BTSS, within the Berkshire Healthcare NHS Foundation Trust. Recordings will not be shared wider within the service or Trust outside of the primary clinicians involved in the project.

How long will Berkshire Healthcare NHS Foundation Trust keep the data/recording?

The recordings will be kept for up to one year after the interviews have ended so that the service improvement project can be completed, and will be destroyed after this.

How do I exercise my right over the shared access data/recording?

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For more information:

For full information about how BHFT use your information to provide your care, please visit: https://www.berkshirehealthcare.nhs.uk/about-us/about-us/protecting-your-data-privacy-notice/

You may access the Information Commissioner's Office (ICO) website for further information on your data subject rights including your right to complain.

You may contact BTSS for further information and to get in touch with the service: traumaandveterans@berkshire.nhs.uk

NHS
Berkshire Healthcare
NHS Foundation Trust

Recording Consent Form for Service-Evaluation

The purpose of this digital recording is to provide Berkshire Healthcare staff with an audio or audio-visual record of the session.
We cannot record you unless you give us explicit consent to do so.

If the feedback session is conducted via video call, the session will be audio and visually recorded due to MS Teams recording software only allowing simultaneous recording of both. However, if the feedback session is conducted face to face, the session will just be solely audio recorded via dataphone.

The recording will be kept confidential and stored securely and used only for the purpose(s) specified in the Participant Information Sheet.

By signing this form, I confirm that the project team have fully explained what they would like to record (see participant information sheet), the reasons for this and how the recordings will be used, therefore I understand that:

- As the recording is specifically for accurately transcribing the content of the feedback session (written out like a script of the conversation), I can withdraw my consent or ask for my recordings to be deleted up to a week after my feedback interview or before completing a focus group by contacting the primary project researcher in the Berkshire Traumatic Stress Service at anahita.shafai@berkshire.nhs.uk
- Recording of my focus group/interview will be accessible only by the clinical staff in the Berkshire Traumatic Stress Service who are conducting the project, and will be transcribed with names removed. The recording of the feedback session will be deleted one year from the date of submission of the project, which is provisionally May 2024.
- Although the recordings will not form part of my patient record, this consent form will.
- The recordings will not be made available to the worldwide web or other sharing medium. They will be held securely on Berkshire Healthcare NHS Foundation Trust systems.
- Verbal feedback I give in the feedback session, and any written comments I give on the end of group feedback forms may be quoted for the outcome report and in any presentations or publications that arise from this project. Anonymized quotes of my verbal feedback may be used. I understand that all reasonable efforts will be made to de-identify my data before such publication of the report. However, there is a chance I may be able to self-identify from reading such a publication.

I am signing this consent form as (please tick):

- o The Patient
- o A person with legal designation to consent on behalf of the patient

Full Name: _____Signature: _____ Date:_____

□ I give permission for you to contact me again to clarify information (please tick if you want us to do this)

Recording Consent Form for Service-Evaluation

The purpose of this digital recording is to provide Berkshire Healthcare staff with an audio or audio-visual record of the session.
We cannot record you unless you give us explicit consent to do so.

If the feedback session is conducted via video call, the session will be audio and visually recorded due to MS Teams recording software only allowing simultaneous recording of both. However, if the feedback session is conducted face to face, the session will just be solely audio recorded via dataphone.

The recording will be kept confidential and stored securely and used only for the purpose(s) specified in the Participant Information Sheet.

By signing this form, I confirm that the project team have fully explained what they would like to record (see participant information sheet), the reasons for this and how the recordings will be used, therefore I understand that:

- As the recording is specifically for accurately transcribing the content of the feedback session (written out like a script of the conversation), I can withdraw my consent or ask for my recordings to be deleted up to a week after my feedback interview or before completing a focus group by contacting the primary project researcher in the Berkshire Traumatic Stress Service at anahita.shafai@berkshire.nhs.uk
- Recording of my focus group/interview will be accessible only by the clinical staff in the Berkshire Traumatic Stress Service who are conducting the project, and will be transcribed with names removed. The recording of the feedback session will be deleted one year from the date of submission of the project, which is provisionally May 2024.
- The recordings will not be made available to the worldwide web or other sharing medium. They will be held securely on Berkshire Healthcare NHS Foundation Trust systems.
- Verbal feedback I give in the feedback session, and any written comments I give on the end of group feedback forms may be quoted for the outcome report and in any presentations or publications that arise from this project. Anonymized quotes of my verbal feedback may be used. I understand that all reasonable efforts will be made to de-identify my data before such publication of the report. However, there is a chance I may be able to self-identify from reading such a publication.

I am signing this consent form as (please tick):

o The Participant

Full Name: _____Signature: _____ Date:_____

□ I give permission for you to contact me again to clarify information (please tick if you want us to do this)

Appendix K: SIP – Instructions to Authors

All articles must include the following sections:

1. **Key Learning Aims** (3 – 5 bullet points)
   - Position – After the Abstract and Keywords
   - Intention – What will the reader learn through reading the paper?
2. **Key Practice Points** (3 – 5 bullet points)
   - Position – before the references
   - Intention – a summary of the papers with clear and practical implications for the day-to-day practice of CBT therapists
3. **Further Reading**
   - Position – before the references and after the Key Practice Points
   - Intention – to direct the reader to other relevant follow up literature

This stipulation is in keeping with the practitioner and professional development aims of the journal.

The main types of articles published are detailed below as a guide. Many of these will be therapy related but tCBT also welcomes papers related to subject areas such as CBT supervision and training.

Most papers will have a subject area (e.g. therapy, assessment, supervision, training, service development) and a paper type (e.g. Original Research, Case Study, Review) e.g. a single case study looking at the impact of supervision, an empirically grounded clinical guidance paper focussing on a training method.

Research Transparency

The Cognitive Behaviour Therapist believes in the importance of transparent and reproducible research. We therefore strongly encourage authors to make their evidence, data and other materials that underpin their findings openly available to readers which is outlined in our Research Transparency Policy(opens in a new tab). Authors will be asked on submission to include in their cover letter to the Editor whether they have made their data publicly available and confirm the inclusion of the Data Availability Statement. If the authors are not making their data publicly available, we ask them to state the reason why in their cover letter.

Types of Paper

Original Research*

Research evidence is at the heart of the practice of cognitive and behavioural psychotherapists. Original research will be published that directly relevant to the practice of CBT, such as the therapeutic relationship, therapeutic process and the evaluation of therapeutic strategies and techniques. It is expected that such reports meet both the necessary standards of scientific rigour and the journal's requirement of clear implications for the practice of CBT. Consequently, the description of the research and the presentation of results should be sufficiently brief to enable sufficient discussion of the practice implications. Consideration will be given to quantitative, qualitative and mixed approaches given appropriate fit between the question, methodology and research methods chosen.

For examples see:

Hutton, J., Ellett, L., & Berry, K. (2017). Adult attachment and paranoia: An experimental investigation. *The Cognitive Behaviour Therapist, 10*, E4. doi:10.1017/S1754470X17000058

Kobori, O., Salkovskis, P., Pagdin, R., Read, J., & Halldorsson, B. (2017). Carer's perception of and reaction to reassurance seeking in obsessive compulsive disorder. *The Cognitive Behaviour Therapist, 10*, E7. doi:10.1017/S1754470X17000095

McManus, F., Leung, C., Muse, K., & Williams, J. (2014). Understanding 'cyberchondria': An interpretive phenomenological analysis of the purpose, methods and impact of seeking health information online for those with health anxiety. *The Cognitive Behaviour Therapist, 7*, E21. doi:10.1017/S1754470X14000270

This category of paper type could also include single-case experimental design research or a case series.

For example see:

Thomson, C., Wilson, R., Collerton, D., Freeston, M., & Dudley, R. (2017). Cognitive behavioural therapy for visual hallucinations: An investigation using a single-case experimental design. *The Cognitive Behaviour Therapist, 10*, E10. doi:10.1017/S1754470X17000174

Style Guide

Title page

This should uploaded as a separate file the main text to ensure blind review.

The title should phrase concisely the major issues. Author(s) to be given with departmental affiliations and addresses, grouped appropriately. A running head of no more than 40 characters should be indicated.

The following statements should be included on the title page:

Acknowledgements

You may acknowledge individuals or organizations that provided advice, support (non-financial).

Conflicts of Interest

Authors should include a Conflicts of Interest declaration in their title page. This statement will be published in the final article. Conflicts of Interest are situations that could be perceived to exert an undue influence on an author's presentation of their work. They may include, but are not limited to, financial, professional, contractual or personal relationships or situations. Conflicts of Interest do not necessarily mean that an author's work has been compromised. Authors should declare any real or perceived Conflicts of Interest in order to be transparent about the context of their work. If the manuscript has multiple authors, the author submitting the title page must include Conflicts of Interest declarations relevant to all contributing authors. For further information about Conflicts of Interest please

see: https://www.icmje.org/recommendations/browse/roles-and-responsibilities/author-responsibilities--conflicts-of-interest.html(opens in a new tab).

Example wording for your Conflicts of Interest declaration is as follows: “Conflicts of Interest: Author A is employed at company B. Author C owns shares in company D, is on the Board of company E and is a member of organisation F. Author G has received grants from company H.” If no Conflicts of Interest exist, your declaration should state “Conflicts of Interest: None”.

If the study you are submitting focuses on a commercially available product (such as online CBT tools or APPS) or is funded by a commercial company, you should ensure that your Conflict of Interest statement covers the following:

- What the relationship is between the authors and the company. If authors had access to all study data and if they have entered into any agreement with the company that may limit their independence in analysis and interpretation of the data, preparation of the manuscript and choosing where to publish it.
- What the role of the sponsoring company has been in the following areas: design of the study; data collection, analysis and interpretation; writing the manuscript; approving the manuscript for publication and deciding where to publish.
- Authors should also state that they have not been encouraged or asked to repress, withhold, or modify any data, results, or conclusions by the sponsoring company.
- What influence the connection with the company could be perceived to have and how the authors have mitigated this.
- A statement may also be added by the Editorial Office to clarify what steps the Editors have taken to rule out any bias that may arise from any potential Conflict of Interest.
- Please note internal ethical approval by a commercial company would not be acceptable, it would need to be from an independent institution.
- Any authors with questions regarding this policy are welcome to contact the Editorial Office prior to submission to discuss further.

Data Availability Statement

This is a brief statement about whether the authors of an article have made the evidence supporting their findings available, and if so, where readers may access it. More information on Data Availability Statements and example statements can be found here(opens in a new tab). Please note that if you are not making your data publicly available, we ask you to state the reason why in your cover letter to the Editor. Also see information on Data Availability below in these instructions.

Financial support

Please provide details of the sources of financial support for all authors, Including grant numbers. For example, "This work was supported by the Medical research Council (grant number XXXXXXX)". Multiple grant numbers should be separated by a comma and space, and where research was funded by more than one agency the different agencies should be separated by a semi-colon, with "and" before the final funder. Grants held by different authors should be identified as belonging to individual authors by the authors’ initials. For example, "This work was supported by the Wellcome Trust (A.B., grant numbers XXXX, YYYY), (C.D., grant number ZZZZ); the Natural Environment Research Council (E.F., grant number FFFF); and the National Institutes of Health (A.B., grant number GGGG), (E.F., grant number HHHH)". Where no specific funding has been provided for research, please provide the following statement: "This research received no specific grant from any funding agency, commercial or not-for-profit sectors."

Main Text (anonymised with no author information)

This should be uploaded as a .doc file with the following running order (unless a Case study). The following format is based on APA style, which should be followed throughout: http://www.apastyle.org/(opens in a new tab)

Abstract

This should summarize the article in no more than 250 words, references should not be included in the abstract.

Keywords

Please include up to six key words that could be used to effectively search for the article.

Key Learning Aims

Body of paper

This should begin with an introduction, succinctly introducing the point of the paper to those interested in the general area of the journal. Attention should be paid to the Editorial Statement. The appropriate positions of tables and figures should be indicated in the text. Footnotes should be avoided where possible.

Ethical Statements

All papers should include a statement indicating that authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS. If preferred, authors based outside of the UK may state research has conformed to the Declaration of Helsinki. Authors should also confirm if ethical approval was needed, by which organisation, and provide the relevant reference number. If no ethical approval was obtained, the authors should state what governance arrangements were in place (e.g. audit committee approval). We also expect authors to respect human participants' right to privacy, and to gain any necessary informed consent to publish before submitting to us and include a statement in their manuscript that consent has been obtained. Where case reports are detailed in a submission, the author must state that the person described has seen the submission in full and agreed to it going forward for publication.

Key Practice Points

Further Reading

References

Please use APA style for the in-text citations and references. In the reference list there is an additional requirement that author names be listed in **bold** face. For example:

Grady, J. S., Her, M., Moreno, G., Perez, C., & Yelinek, J. (2019). Emotions in storybooks: A comparison of storybooks that represent ethnic and racial groups in the United States. *Psychology of Popular Media Culture, 8*(3), 207–217. https://doi.org/10.1037/ppm000...

Authors are encouraged to make use of referencing software packages (e.g. Endnote, Mendeley, Reference Manager etc.) to assist with formatting - extensions for APA formatting are easily accessible. Authors are also reminded to use bold face for author names in the reference list.

Tables and Figures

These should not be included in the body of the manuscript text, but uploaded as individual files.

Use text anchors to show their intended position within the manuscript.

Numbered figure captions should be provided.

Tables

Use APA style. Tables should be provided in editable Word format. They should be numbered and given explanatory titles.

Name your uploaded file to correspond with the caption in the manuscript.

Figures

Use APA style. All artwork should be submitted as separate TIFF format files.

The minimum resolution for submission of electronic artwork is:

Halftone Images (Black and White Photographs only): 300 dpi (dots per inch).

LineTone (Black and White Photographs plus Line Drawings in the same figure): 600 dpi (dots per inch).

Bitmap (Line Drawings only): 1200 dpi (dots per inch).

Please see this link(opens in a new tab) for full guidance on artwork

Seeking permission for copyrighted material

If your article contains any material in which you do not own copyright, including figures, charts, tables, photographs or excerpts of text, you must obtain permission from the copyright holder to reuse that material. As the author it is your responsibility to obtain this permission and pay any related fees, and you will need to send us a copy of each permission statement at acceptance.

Usually the publisher of the original work holds the copyright, unless explicitly stated otherwise. Most publishers have forms on their websites that can be completed electronically, or use automated electronic permissions services like Rightslink® to grant permissions automatically online. See here(opens in a new tab) for more information on when you need to seek permission and how to request this.

Supplementary Files

Where unpublished material e.g. behaviour rating scales or therapy manuals are referred to in an article, copies should be submitted as an additional document (where copyright allows) to facilitate review. Supplementary files can be used to convey supporting or extra information to your study, however, the main manuscript should be able to 'stand-alone'. Supporting documents are reviewed but not copyedited on acceptance of the article. They can therefore be submitted in PDF format, and include figures and tables within the text. There is no word limit for supporting online information.

Supplementary materials will be published with the same metadata as your parent article, and are considered a formal part of the academic record, so cannot be retracted or modified other than via our article correction processes. Supplementary materials will not be typeset or copyedited, so should be supplied exactly as they are to appear online. Please make sure you are familiar with our detailed guidance on supplementary materials(opens in a new tab) prior to submission.

Video Content

The journal also allows authors to upload video content as supplementary material to provide support or additional understanding. Video files created by authors should be provided in .mp4 format, and should not exceed 500mb in file size. Video files can be uploaded to the journal's ScholarOne system during the submission process using the file designation 'Video File'. As with other forms of supplementary material, these files will be available to reviewers but not edited on acceptance of the article, and will be hosted online alongside the article when published.

Reporting Standards

The Cognitive Behaviour Therapist supports standardised reporting practices, consult the following table to ensure your submission meets the reporting standards for your manuscript type. Please include the relevant supporting information (such as diagrams and checklists) with your submission files. See http://www.equator-network.org/reporting-guidelines/(opens in a new tab) for more information on manuscript types not described below.

The journal also encourages clarity in describing interventions sufficient to allow their replication through the use of the Template for Intervention Description and Replication Checklist(opens in a new tab) (TIDieR).

Randomised Controlled Trial	CONSORT	http://www.consort-statement.org/(opens in a new tab)
Systematic reviews and Meta-Analysis	PRISMA	http://www.prisma-statement.org/(opens in a new tab)
Study Protocols	SPIRIT	http://www.spirit-statement.org/(opens in a new tab)

Use of Inclusive Language

tCBT reminds authors to use inclusive language (see these C4DISC guideines(opens in a new tab) for further information) which are in line with the BABCP values of opposing discrimination of any kind and continually working to improve our recognition of, and take an active stance against discrimination and inequality(opens in a new tab).

Use of artificial intelligence (AI) tools

We recognise that the use of artificial intelligence (AI) in research publications is increasing. However, we do not consider artificial intelligence (AI) tools to meet the accountability requirements of authorship, and therefore generative AI tools such as ChatGPT and similar should not be used in any part of the writing of manuscripts, including editing and referencing. Nor should these tools be listed as an author on any submitted content.

We will permit the use of AI tools for spelling and grammar checking to improve the readability and language of a manuscript. This must be done with human oversight and authors should carefully review the output before submission. Any use of generative AI tools must be disclosed by the authors in the Acknowledgements section in the title page of their manuscript. This should include the tool used and its version, the date it was used and reason for its use along with a declaration that the author(s) are entirely responsible for the scientific content of the paper and that the paper adheres to the journal's authorship policy. Failure to acknowledge assistance from technical writers, language editors, AI tools and/or writing agencies in drafting manuscripts for publication in the Acknowledgements section may lead to disqualification of the paper.

Authorship and contributorship

All authors listed on any papers submitted to this journal must be in agreement that the authors listed would all be considered authors according to disciplinary norms, and that no authors who would reasonably be considered an author have been excluded. For further details on this journal's authorship policy, please see this journal's publishing ethics policies.

Author affiliations

Author affiliations should represent the institution(s) at which the research presented was conducted and/or supported and/or approved. For non-research content, any affiliations should represent the institution(s) with which each author is currently affiliated.

For more information, please see our author affiliation policy and author affiliation FAQs.

Competing Interests

All authors must include a competing interest declaration in their title page. This declaration will be subject to editorial review and may be published in the article.

Competing interests are situations that could be perceived to exert an undue influence on the content or publication of an author's work. They may include, but are not limited to, financial, professional, contractual or personal relationships or situations.

If the manuscript has multiple authors, the author submitting must include competing interest declarations relevant to all contributing authors.

Example wording for a declaration is as follows: "Competing interests: Author 1 is employed at organisation A, Author 2 is on the Board of company B and is a member of organisation C. Author 3 has received grants from company D." If no competing interests exist, the declaration should state "Competing interests: The author(s) declare none".

Policy on prior publication

When authors submit manuscripts to this journal, these manuscripts should not be under consideration, accepted for publication or in press within a different journal, book or similar entity, unless explicit permission or agreement has been sought from all entities involved. However, deposition of a preprint on the author's personal website, in an institutional repository, or in a preprint archive shall not be viewed as prior or duplicate publication. Authors should follow the Cambridge University Press Preprint Policy regarding preprint archives and maintaining the version of record.

Appendix L: SIP – Author Positionality

This study was informed by a critical realist position: assuming that barriers and facilitators to accessing services for ASR are shaped by real interpersonal and systemic factors, while also recognising that these realities are accessed through participants' accounts and interpreted by the researcher. In keeping with reflexive thematic analysis, I aimed to view myself not as a neutral observer, but as actively involved in the generation and interpretation of the data.

I am a female British-Afghan trainee clinical psychologist and am visibly from a global majority background. I am also a first-generation immigrant, and the majority of my wider family members, who identify as Afghan, have experience of asylum seeking and forced migration across a vast range of countries. My personal background, family context, and interest in equality, diversity, and inclusion contributed to my strong interest in the experiences of ASR and informed my decision to undertake this service improvement project.

These characteristics may have shaped the research process in several ways. In interviews with ASR participants, my visible ethnic minority identity and possible perceived cultural proximity may have facilitated trust and openness when discussing sensitive experiences such as discrimination, stigma, or fear of services. Equally, I remained mindful that participants may have made assumptions about my background or a shared understanding that were not accurate, and that shared minority status does not equate to equal experience. In interviews with referrers, I wondered whether my identity may also have influenced how comfortable participants felt expressing views about culture, asylum status, or perceived barriers, including the possibility that they may have framed their responses more cautiously.

My personal and family connection to issues of migration also meant that I may have undertaken the study with pre-existing assumptions, including an expectation that asylum seekers and refugees would face structural disadvantages. While this helped me remain attuned to these issues, it also raised the possibility that I might privilege interpretations centred on disadvantages, or be more receptive to data that aligned with my prior concerns. I therefore aimed to approach interviews and analysis with curiosity and awareness of alternative interpretations. To support reflexivity, I engaged in ongoing reflection, including considering how my assumptions and social position may have influenced interviewing and theme development. I aimed to ask open, non-leading questions during interviews and to avoid assuming shared meanings with participants. During analysis, I tried to consider alternative interpretations of the data, with the intention not to eliminate subjectivity, but to acknowledge and critically examine how my position shaped the process of analysis.

Appendix M: TDRP – Instructions to Authors

Instructions for authors

Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read and follow them as closely as possible, as doing so will ensure your paper matches the journal's requirements.

We offer a range of editing, manuscript preparation and post publication services to assist you in preparing your manuscript for submission, increase your chance of acceptance, or broaden the readership of your article. General guidance on every stage of the publication process is available at our Author Services website.

Before preparing your paper for submission we advise that you read the journal Aims and Scope to check if your article is suitable for the journal, and Journal Information for any publication charges. For editing support, including translation and language polishing, explore our Editing Services website.

Submission requirements for *Mental Health Religion & Culture* article types are shown below, and we advise that you structure your paper in the order presented in the table. **Please provide all the required information to ensure your paper is not delayed while we request the missing information.**

- Article requirements
- Image Descriptions
- Style requirements
- File requirements
- Check before you submit
    - Your paper
    - Figures and tables
    - Anonymisation
- Submit
- More information

Article requirements

Word limit
7500 words excluding tables / references / figure and table captions / footnotes / endnotes

- Exceptions can be made with editor approval.

Anonymisation
An anonymous version of your paper is required when submitting. See Anonymisation Checklist

- **Title**
- **Author information**
    - All author names, including first and last name
    - All up-to-date author email addresses

    - All author affiliations and countries
    - Corresponding author indicator
    - ORCiDs / social media handles (optional)
- **Abstract**
    - 150 words
- **3-7 Keywords**
- **Main text**
- **Declarations and ethics statements**
    - Ethical approval (if applicable)
    - Informed consent from participants (if applicable)
    - Data availability statement for Basic Data Sharing Policy
    - Clinical trial registration (if applicable)
    - Consent to publish statement / form (if applicable)
    - Competing interests
    - Funding
    - Author contributions (if applicable)
    - Acknowledgements (if applicable)
- **References** (no more than 40 references)
- **Appendices** (if applicable)

Registered Reports

- Should be written with the following elements in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgements; data availability statement; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).
- Should be no more than 3500 for Stage 1 reports and no more than 5000 words for Stage 2, inclusive of the abstract, tables, references, figure captions, footnotes, endnotes.
- Should contain an unstructured abstract of 250 words.
- Should contain no more than 6 keywords. Read making your article more discoverable, including information on choosing a title and search engine optimization.
- Registered reports – are a form of empirical article in which the methods and proposed analyses are pre-registered and reviewed prior to the research being conducted. High quality protocols are then provisionally accepted for publication before data collection commences. Acceptance in principle indicates that the article will be published pending successful completion of the study according to the pre-registered methods and analytic procedures, as well as inclusion of a defensible and evidence-based interpretation of the results. Full details on the registered reports workflow and policies can be found here.

Letters to the Editor
Letters to the Editor should be limited to 2,000 words and 20 references.

Image Descriptions

This journal now adds image descriptions (alternative text, alt text), to all images conveying information necessary for an understanding of your work. Image descriptions are typically used by systems such as pronouncing screen readers to make images accessible to people that cannot read or see the object due to a visual disability. Image descriptions can also provide

better image context/descriptions to search engines, helping them to index an image properly and improve the discoverability of your research.

Taylor & Francis uses advanced Artificial Intelligence (AI) technologies to produce image descriptions and include them in your published content. You will have the opportunity to review image descriptions during the proofing process.

Authors have the option to include image descriptions as part of your submitted manuscript. If you choose to provide image descriptions, please follow our guidelines.

Style requirements

This Journal allows Format-Free Submission. You don't need to format your manuscript to meet any special style requirements, but your submission should be easy to read and comment on. Your references can be in any scholarly citation format, so long as formatting is consistent throughout the article.

Upon revision or acceptance, you may be asked to format your manuscript according to the journal guidelines. We may need you to send us any extra items required for publication. Find out more about preparing a Format-Free submission.

- Reference guide (no more than 40 references)
- Spelling: American or British -ise
- Double quotation marks within single
- Numbered or unnumbered headings:
    -
        - **First-level headings (e.g. Introduction, Conclusion) should be in bold, with an initial capital letter for any proper nouns.**
        - ***Second-level headings should be in bold italics, with an initial capital letter for any proper nouns.***
        - *Third-level headings should be in italics, with an initial capital letter for any proper nouns.*
        - ***Fourth-level headings should be in bold italics, at the beginning of a paragraph.*** The text follows immediately after a full stop (full point) or other punctuation mark.
        - *Fifth-level headings should be in italics, at the beginning of a paragraph*. The text follows immediately after a full stop (full point) or other punctuation mark.
- Font: Times New Roman size 12 with double-line spacing
- Margins: At least 2.5cm (1 inch)

Advice is available on using special characters and mathematical scripts and equations.

File requirements

- Cover letter not required
- LaTeX is not allowed
- Separate file for figures and captions (if applicable)
- Separate file for tables and captions (if applicable)
- Supplemental online material (if applicable)

Check before you submit

Your paper

- Checked your paper meets the word limit
- Checked all essential elements of article present
- Checked that all citations in the text have a corresponding entry in the References
- Styled your paper according to the journal guidance
- If submitting a LaTeX file you will also need to provide a PDF version
- Not submitted the paper elsewhere
- Checked you are compliant with Taylor & Francis Editorial Policies

Figures and tables

- Must be cited in the main text and in chronological order
- Provided in a separate file to main paper
- Captions must include the matching number from the main text citation
- If the figure or table is not your own, you have obtained written permission to use it
- Captions must include copyright holder details and state that permission to reproduce has been obtained
- Acceptable file format
- Acceptable figure quality
- Tables must be editable

More information is available on Submitting electronic artwork and submitting tables.

Anonymisation

Check the requirements for your article type above and if an anonymous version is required to protect your identity during peer review, create a copy of your main file and then remove the following information:

- All author names
- All author affiliations
- All author email addresses
- All author ORCIDs and social media handles
- All author biographical notes
- Headers and footers that would reveal author identities
- Self-citation in the main text and references
- Acknowledgements
- Funding statement
- References to authors in figure and tables captions
- Clinical trial numbers and registration dates
- File identifiers that would reveal author identities

You also need to:

- Label the file as 'Without author details'

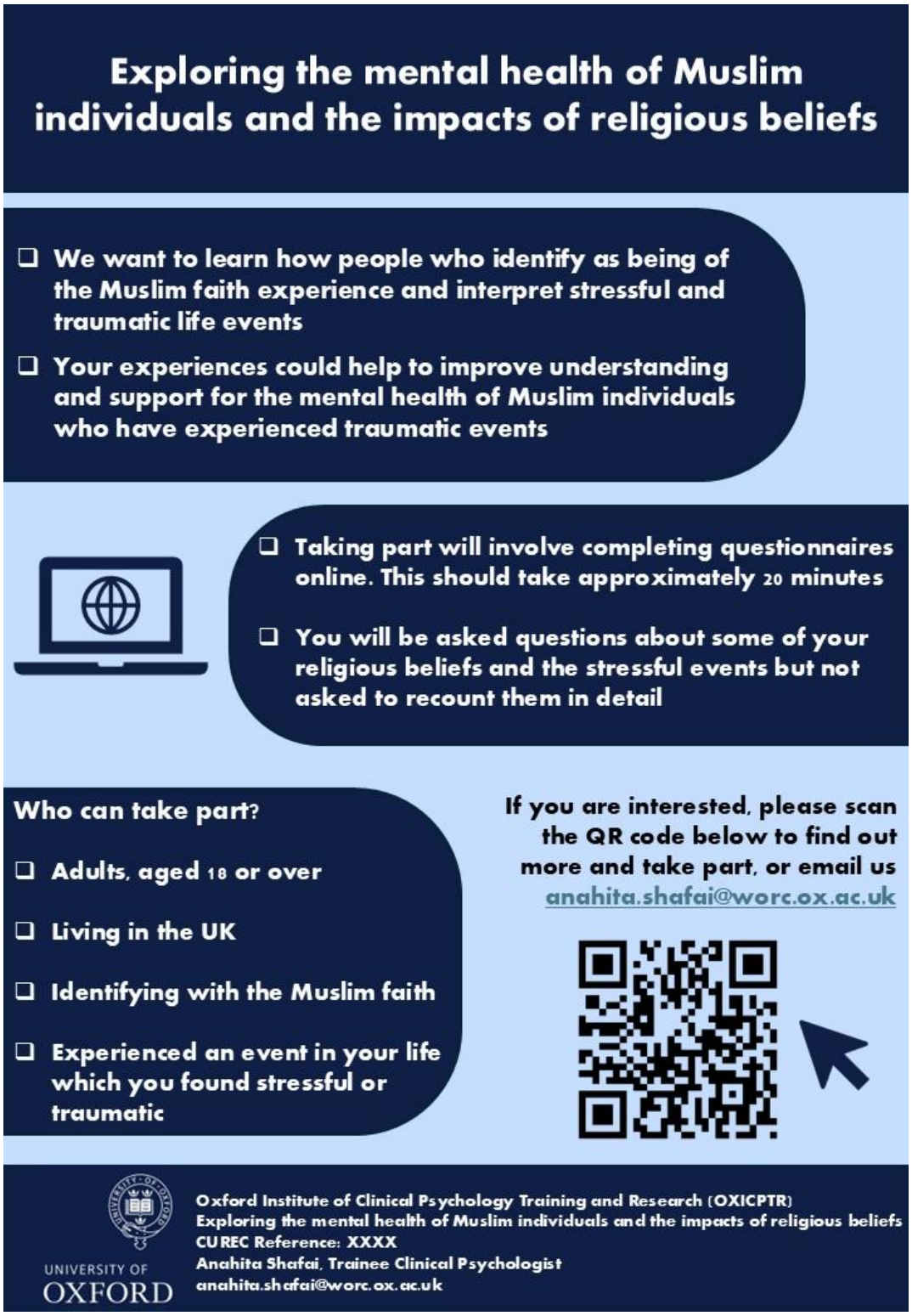
- If you are depositing data in a repository, make sure that it preserves anonymity.

More details on how to anonymise your file.

Submit

Please note that by submitting your paper you are agreeing to originality checks during the peer-review and production processes.

Appendix N: TDRP – Recruitment Poster



Appendix O: TDRP – Participant Information Sheet

The Mental Health of Muslim Individuals and the Impacts of Religious Beliefs

CUREC Reference: 867138

General Information

The aim of this research is to investigate the reactions to, and experiences of, traumatic life events, and whether these might be different based on various religious beliefs. We are interested in hearing from adults who identify as being from Muslim faith (and may or may not be practising), and who have experienced any events in their lifetime which they consider as being stressful, traumatic, negative, painful, or upsetting - this could be any type of event. We hope to develop an understanding of factors that might make people more or less susceptible to developing post-traumatic stress disorder (PTSD). We hope that this will help to guide therapists in their understanding of working with clients who identify as being from Muslim faith, and who may have experienced traumatic events.

We are happy to hear from a range of people, however to take part you must meet the following criteria:

- Be aged 18 years and over
- Live in the UK
- Read and understand English to a degree that allows independent completion of online questionnaires
- Identify as being of Muslim faith
- Have experienced an event in your lifetime which you found to be traumatic, stressful, negative, painful or upsetting at the time (this could be any type of event).

You are being invited to participate if you self-identified as meeting these criteria. If you take part in this online survey, you will be asked some questions about religious beliefs and about your experience of this traumatic event, both then and now. Please read through this information before agreeing to participate (if you wish to) by ticking the 'yes' box below.

Summary

- This project is investigating Muslim individuals' reactions to, and experiences of, traumatic life events, and whether these might be different based on their various religious beliefs
- We are recruiting individuals who identify as being of Muslim faith
- Anyone who is aged 18 years or older, and who has had something happen (at any time in their life) that was negative, traumatic, stressful or particularly upsetting can take part.
- This will involve completing a number of questionnaires, which will take approximately 20 minutes in total to complete.
- The questionnaires will ask about various religious beliefs, and the types of traumatic events you might have experienced and your thoughts and reactions to what happened. *You will not be asked at any point to recount in detail what happened.*

You may ask any questions before deciding to take part by contacting the researcher (details below).

The Principal Researcher is Anahita Shafai, a Trainee Clinical Psychologist who is attached to the Oxford Institute of Clinical Psychology Training and Research at the University of Oxford. This research is being completed under the supervision of Professor Craig Steel.

If you decide to take part, you will be invited to indicate your consent below. The first part of the survey will then determine whether you meet the eligibility criteria. If you meet the criteria, you will then be directed to an online set of questionnaires that can be completed at a time that is convenient to you. The questionnaires will include some general questions about you (e.g. age, gender, ethnicity), about religious beliefs, about exposure to stressful and traumatic life events, and about your interpretations of and reaction to these events. *You will not be asked at any point to recount in detail what happened.*

There are 8 different questionnaires in the study. We expect that these questionnaires will take approximately 20 minutes to complete, however it may take more or less time than this. You will be able to save your progress and take breaks during the questionnaires if you would like to. No background knowledge is required, and there are no right or wrong answers.

As part of the study, we will ask about mental health difficulties including anxiety, depression and posttraumatic stress disorder (PTSD). If your responses indicate that you may be experiencing such difficulties, we will provide signposting information about support organisations in a pop-up message. These are also available to everyone at the bottom of this information sheet.

Do I have to take part?

No. Please note that participation is voluntary. If you do decide to take part, you may withdraw at any point for any reason before submitting your answers by closing the browser. You do not have to give a reason for withdrawing. As the questionnaire data collected is anonymous (even to the researcher) you will be unable to withdraw your data once you complete the study as we will not be able to identify it.

All questions are optional.

How will my data be used?

We will not collect any data that can directly identify you. Your IP address will not be stored. It will not be possible to directly identify any data stored about you or your answers to the questionnaires. We will take all reasonable measures to ensure that data remains confidential.

Data will be stored in password-protected electronic files on the University of Oxford's secure servers. Research data will be stored for 3 years after publication or public release of the work of the research. This information will then be permanently deleted and destroyed.

Who will have access to my data?

The University of Oxford is the data controller with respect to your personal data and, as such, will determine how your personal data is used in the study. The University will process your personal data for the purpose of the research outlined above. Research is a task in the public interest. Further information about your rights with respect to your personal data is available from https://compliance.admin.ox.ac.uk/individual-rights.

The researchers involved in this study will have access to the research data.

We hope to report our findings in academic journals and present them to relevant organisations and on social media using the anonymised research data. The findings will also contribute to Anahita Shafai's Doctorate in Clinical Psychology thesis. You will not be identified in any reports or publications arising from the study.

Who has reviewed this research?

This research has received favourable opinion from a subcommittee of the University of Oxford Central University Research Ethics Committee [reference number 867138].

Who do I contact if I have a concern or I wish to complain?

Every care has been taken to ensure your safety during the course of the study. If you have a concern about any aspect of this study, please speak to Anahita Shafai (anahita.shafai@worc.ox.ac.uk)or their supervisor Professor Craig Steel (craig.steel@hmc.ox.ac.uk) and we will do our best to answer your query. We will acknowledge your concern within 10 working days and give you an indication of how it will be dealt with. If you remain unhappy or wish to make a formal complaint, please contact:

> The University of Oxford Research Governance, Ethics & Assurance (RGEA) team at rgea.complaints@admin.ox.ac.uk or on 01865 616480.

What do I do if I need support?

We understand that thinking about things that were traumatic may be distressing for some people. We encourage you to consider whether you feel able to complete the study at this time. If you do decide to take part, please note that you can stop and save your progress if you need a break. You can also withdraw at any time without needing to explain why.

If you are experiencing distress or difficulties with your mental health, the NHS can help. There are also many charities who can provide advice, and emotional and practical support. If you are concerned about your mental health, we encourage you to speak to your GP who can then refer you for further specialist help.

Sources of help and support:

- If you feel you are in immediate risk of harming yourself or someone else, we strongly recommend that you contact **999** or visit your **local A&E department.**
- **Your GP**
- **NHS 111** (please note that 111 is not available in Northern Ireland)
- **Muslim Council of Britain** - Provide a list of Muslim mental health charities and organisations. Website: Muslim Council of Britain
- **Samaritans-** Samaritans provides confidential emotional support, 24 hours a day, for people who are experiencing feelings of distress or despair. Samaritans are there if you're worried about something, feel upset or confused, or just want to talk to someone.

Telephone: 116123

E-mail: jo@samaritans.org

Website: http://www.samaritans.org

- **Mind-** Mind provides a national telephone helpline and email service which can provide information on mental health difficulties, where to get help and the types of treatments available.

Telephone (9am-6pm, Mon-Fri): 0300 123 3393

Text: 86463

Email: info@mind.org.uk

Website: http://www.mind.org.uk/

- **Papyrus-** Papyrus provide confidential support and advice to young people (under 35) struggling with thoughts of suicide through their helpline, HOPELINEUK.

Telephone: 0800 068 4141

Text: 07860039967

Website: https://www.papyrus-uk.org/papyrus-hopelineuk/

Email: pat@papyrus-uk.org

Thank you for your interest in this research and for reading this information sheet. If you would now like to take part, please click YES below to indicate your consent to take part.

If you do not wish to take part, you may exit the study by closing this page.

Please note that you may only participate in this survey if you are 18 years of age or over.

☐ I certify that I am 18 years of age or over

If you have read the information above and agree to participate with the understanding that the data you submit will be processed accordingly, please tick the box below to start.

☐ Yes, I agree to take part

Appendix P: TDRP – Ethics Approval Letter

Medical Sciences Interdivisional Research Ethics Committee (MS IDREC)
Research Governance, Ethics & Assurance, Research Services, University of Oxford, Boundary Brook House, Churchill Drive, Headington, Oxford, OX3 7GB

Applicant: Anahita Shafai
Principal Investigator: Professor Craig Steel
Department: Oxford Institute of Clinical Psychology Training and Research (OxICPTR)

Study title: Do maladaptive religious beliefs predict PTSD symptom severity in Muslim individuals who have experienced trauma?
(Version: 1.0)

Ethics reference: Medical Sciences Interdivisional Research Ethics Committee (MS IDREC) - 867138

Dear Professor Craig Steel,

On behalf of the Committee, I confirm that the above research study described in the application and other supporting documentation submitted to the committee has been carefully considered on behalf of the Medical Sciences Interdivisional Research Ethics Committee (MS IDREC) in accordance with the University's regulations and policy for ethics approval of research involving human participants, human tissue and/or personal data. The opinion is as follows:

Opinion of Research Ethics Committee: Favourable Opinion

Subject to the following conditions:

Decision Date: 19 Nov 2025, 10:37

Opinion End Date: 18 May 2027

If favourable, insurance-provided indemnity arrangements will be in place between the decision date and opinion end date and you may now commence your study activities. Should you plan to continue the research beyond the end date above, it is your responsibility to ensure that you request, and receive, an extension (via amendment) from the committee for indemnity to remain in place. You may be required to provide a justification.

Please note the following:

Amendments: Should there be any subsequent changes to the reviewed study, applications for amendments can be made via the Oxford Ethics Application System (Worktribe Ethics).

Reports: Studies considered by OxTREC are expected to submit an *annual progress report* on each anniversary of study approval, until the study is completed. An end of study report is also required.

Audit: This study may be selected for audit at the discretion of the Research Governance, Ethics and Assurance Team.

Data safety: It is the responsibility of the PI to ensure that all data collected during the course of the study is stored and transferred safely and securely in accordance with University requirements. Further guidance and advice are available from the Research Data Team. Additional information is available at https://researchsupport.web.ox.ac.uk/governance/ethics

Yours Sincerely

MS IDREC Ethics Officer

Appendix Q: TDRP – Measures Pack

Each individual questionnaire will be on an individual page on Qualtrics. The instructions for each questionnaire will be presented on its own page at first, and then will also be visible on the questionnaire page after the participant clicks 'next'.

LEC-5:

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event select one or more of the boxes to the right to indicate that:
(a) it happened to you personally
(b) you witnessed it happen to someone else
(c) you learned about it happening to a close family member or close friend
(d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder)
(e) you're not sure if it fits
(f) it doesn't apply to you

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Please read each event carefully and remember that there are no right or wrong answers. If you are uncertain, please select the option (or options) that fit your experience best.

Event	Happened to me	Witnessed it happen to someone else	Learned about it happening to a close family member or friend	Exposed to it as part of my job	Not sure	Doesn't apply
Natural disaster (for example, flood, hurricane, tornado, earthquake)						
Fire or explosion						

Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
Serious accident at work, home, or during recreational activity						
Exposure to toxic substance (for example, dangerous chemicals, radiation)						
Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						
Other unwanted or uncomfortable sexual experience						
Combat or exposure to a war-zone (in the military or as a civilian)						

Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)						
Life-threatening illness or injury						
Severe human suffering						
Sudden violent death (for example, homicide, suicide)						
Sudden accidental death						
Serious injury, harm, or death you caused to someone else						
Any other very stressful event or experience						

Most Stressful Event

Of the stressful events which you selected, which **<u>one</u>** of these events would you say was the worst overall and bothers you the most currently or has had the biggest impact on your life?

_____

_____

How long ago did this happen? (Please estimate if you are not sure e.g. 2 years ago)

_____

Did you receive any psychological treatment for the impacts this event may have had on you?

- Yes

- No
- Don't know
- Prefer not to say
- Not applicable

PCL-5:

The next questions will ask you to answer in regard to the one event which you chose as finding to be most stressful or traumatic.

Below is a list of problems that people sometimes have in response to a very stressful experience. Bearing in mind this worst event you chose on the last page, please read each problem carefully and then select one of the options to the right to indicate how much you have been bothered by that problem in the past month.

If you experienced more than one of the stressful events in the last questionnaire, please complete this questionnaire for the event that you indicated bothers you the most now.

Please read each question carefully, but do not spend too much time on each one. There are no right or wrong answers, so your best guess is fine. We are interested in your personal experience.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?					
2. Repeated, disturbing dreams of the stressful experience?					
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?					
4. Feeling very upset when something reminded you of the stressful experience?					
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?					
6. Avoiding memories, thoughts, or feelings related to the stressful experience?					
7. Avoiding external reminders of the stressful experience (for					

example, people, places, conversations, activities, objects, or situations)?					
8. Trouble remembering important parts of the stressful experience?					
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?					
10. Blaming yourself or someone else for the stressful experience or what happened after it?					
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?					
12. Loss of interest in activities that you used to enjoy?					
13. Feeling distant or cut off from other people?					
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?					
15. Irritable behaviour, angry outbursts, or acting aggressively?					
16. Taking too many risks or doing things that could cause you harm?					
17. Being “superalert” or watchful or on guard?					
18. Feeling jumpy or easily startled?					
19. Having difficulty concentrating?					
20. Trouble falling or staying asleep?					

RESQUE:

Listed below are statements that people might use to describe their **personal experiences with religious and spiritual beliefs in general, and are not related to a specific stressful/traumatic event**. Please read each statement and decide how well it describes you and your beliefs now, as an adult. Please base your answers on how you genuinely feel rather than what you think the answer should be.

Please note that this questionnaire asks about your personal (current) experience with religious and spiritual beliefs and is in no way questioning religion itself.

Statement	Completely untrue of me	Mostly untrue of me	Slightly more untrue than true	Slightly more true than untrue	Mostly true of me	Completely true of me
I believe God sees me as a bad person						
I believe God is disappointed in me						
I believe God sees me as a sinner						
I pray more out of fear than faith						
I avoid thoughts about praying because of the fear they induce in me						
I perform religious duties more to avoid the punishment of God than because of the pleasure I experience in them						
I worry about what will happen to me on the day of judgement						
I worry a lot about what will happen to me in the grave						

I worry a lot about what will happen to me in the hereafter						
I feel ashamed of myself for doing something religiously forbidden, even if no one knows about it						
I feel guilty when I don't pray on time						
I feel bad about myself when I don't pray on time						
I worry whenever I have romantic feelings (even if I don't act on them)						
I feel angry with myself for having romantic feelings towards someone						
I feel very ashamed when I have romantic feelings towards someone (even if I don't act on them)						
I believe that if you don't pray, you are a bad person, period						
I believe God is angry with those who don't follow Islam						
I believe that how good you are depends on whether you pray						

and read the Quran or not						

IAQ:

The next questions relate to the one most stressful/traumatic event you identified earlier in the survey.

Listed below are statements that people might use to describe their personal experiences with religious and spiritual beliefs, after a stressful/traumatic event. Please read each statement and decide how much you agree or disagree with it. Please base your answers on how you genuinely feel rather than what you think the answer should be.

Please note that this questionnaire asks about your personal experience with religious and spiritual beliefs and is in no way questioning religion itself.

Holding in mind the one most stressful/traumatic event you identified earlier in the survey, please answer the questions below.

Statement	Totally disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Totally agree
I sometimes feel angry with God for letting this happen to me							
God punished me for my lack of faith							
I sometimes wonder whether I deserved to experience the event							
What happened to me was unfair							
God punished me for my sins							
This event was a sign of God's anger at me							

BRCOPE:

The next questions relate to the one most stressful/traumatic event you identified earlier in the survey.

Listed below are statements that people might use to describe their personal experiences with religious and spiritual beliefs, after a stressful/traumatic event. Please read each statement and decide to what extent you did what the item says - how much or how frequently. Please base your answers on how you genuinely feel rather than what you think the answer should be.

Please note that this questionnaire asks about your personal experience with religious and spiritual beliefs and is in no way questioning religion itself.

Holding in mind the one most stressful/traumatic event you identified earlier in the survey, please answer the questions below.

Statement	Not at all	Somewhat	Quite a bit	A great deal
Wondered whether God had abandoned me				
Felt punished by God for my lack of devotion				
Wondered what I did for God to punish me				
Questioned God's love for me				
Wondered whether my religious community had abandoned me				
Decided the devil made this happen				
Questioned the power of God				

PTCI-9:
The next questions relate to the one most stressful/traumatic event you identified earlier in the survey.

We are interested in the kinds of thoughts which you may have had after the traumatic event. Below are a number of statements that may or may not be representative of your thinking. Please read each statement carefully and tell us how much you agree or disagree with each statement. People react to traumatic events in many different ways. There are no right or wrong answers to these statements. Choose the option that best corresponds to your answer.

Holding in mind the one most stressful/traumatic event you identified earlier in the survey, please answer the questions below.

Statement	Totally disagree	Disagree very much	Disagree slightly	Neutral	Agree slightly	Agree very much	Totally agree
The event happened because of the way I acted							
People can't be trusted							
Somebody else would not have gotten into this situation							
I can't rely on other people							
I have no future							
People are not what they seem							
There is something about me that made the event happen							
I feel like I don't know myself anymore							
Nothing good can happen to me anymore							

PHQ-8:

Below are some experiences that people may have. We are interested to what extent you had such experiences in the last two weeks. Please read each question carefully, but do not spend too much time on each one. There are no right or wrong answers, so your best guess is fine. We are interested in your personal experience.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				

GAD-7:

Below are some experiences that people may have. We are interested to what extent you had such experiences in the last two weeks. Please read each question carefully, but do not spend too much time on each one. There are no right or wrong answers, so your best guess is fine. We are interested in your personal experience.

Over the last two weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge				
2. Not being able to stop or control worrying				

3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it is hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid, as if something awful might happen				

Appendix R: SIP – Project Approval from Trust

Volunteer & Work Placement Dept.
Berkshire Healthcare NHS FT
London House
London Road
Bracknell
RG12 2UT

Ms Anahita Shafai

Email honorary.contracts@berkshire.nhs.uk

Dear Anahita,

HONORARY CONTRACT –

1 *Berkshire* Healthcare NHS Foundation Trust would like to offer you an honorary contract in the capacity of trainee clinical psychologist with Berkshire traumatic stress service, based at Erlegh House. Your start date will be as agreed with your line manager and end 1st October 2025. Your hours of work will be flexible-to be discussed. You will receive no payment for the hours worked under your honorary contract. Either party can terminate the contract giving one week's notice.

2 This post allows you to undertake the duties outlined in this contract with Berkshire Healthcare NHS Foundation Trust on premises and using facilities of Berkshire Healthcare NHS Foundation Trust. If your duties involve clinical or administrative duties connected with patient care you are granted access to the associated records.

3 If in the course of your duties you undertake any form of research, you agree to make yourself familiar with the UK Policy Framework for Health and Social Care Research (See link: http://www.hra.nhs.uk/resources/research-legislation-and-governance/research-governance-frameworks/) and agree to accept the responsibilities associated with your role that are outlined within it. Berkshire Healthcare NHS Foundation Trust manages all research in accordance with the requirements of the UK Policy Framework for Health and Social Care Research. As a contract holder of Berkshire Healthcare NHS Foundation Trust you agree to comply with all reporting requirements, systems and duties of action put in place by the trust to deliver research governance.

4 You and your employer recognise the Trust's right to benefit from intellectual property arising from work undertaken under this contract in accordance with the Health and Social Care Act 2001. In circumstances where there is potential intellectual property you are required to notify

the Trust. Specific intellectual property agreements will be negotiated on an individual case by case basis.

5 You are required to observe the policies and procedures of the Berkshire Healthcare NHS Foundation Trust in so far as they apply to this appointment and to observe all NHS policies and procedures in respect of clinical and research activities.

6 If your post is one that requires a disclosure, at whatever level, from the Disclosure and Barring Service the Trust retains the right to request that a further disclosure is sought on a five year basis.

You are required, by virtue of this agreement to inform the Trust of any conviction, charge, caution, or other relevant action including any investigation that has occurred prior to or during your engagement with the Trust. ***The Trust retains the right to terminate this appointment and your engagement if it is felt that this will have an impact or effect on the position you hold and/or duties that you carry out.*** Failure to disclose such information will constitute a breach of contract and will be treated as a disciplinary offence.

7 You must act at all times in accordance with the trust's policies, procedures and guidance, copies of which are available in the Human Resources Department. The Trust reserves the right to terminate this contract where your conduct is inconsistent with the high standards of work and behaviour expected in your continued honorary placement with the Trust. Disciplinary Procedure, copies of which are available in the human resources department are also on the Trust's Intranet. Failure to abide by the disciplinary rules will result in action being taken in accordance with the Disciplinary Procedure. If you are dissatisfied with any decision, you have a right to appeal against this decision to your line manager.

8 You will report, on a day to day basis, to Dr Dorothy King / Dr Hjordis Lorenz. If you wish to raise concerns or complaints about your commitments under this contract you should first raise the matter with your line manager – Dr Dorothy King / Dr Hjordis Lorenz. The agreed procedure for settling differences between you and the Berkshire Healthcare NHS Foundation Trust will be in accordance with the Trust's grievance procedure. Full details of the procedure are available on the Trust Intranet. This information will be fed back to your employing body.

9 The Trust accepts liability in respect of your acts and omissions to the degree that those acts and omissions were carried out whilst working on behalf of the Trust and in accordance with your appointment under this contract. You must however, observe the same standards of care and propriety in dealing with service users, staff, visitors, equipment, and premises as is expected of any other contract holder. You must also act appropriately and responsibly at all times.

10 Whilst undertaking officially sanctioned NHS duties, you are covered by the NHS indemnity against claims for negligence. In other circumstances (e.g when providing services for which you receive a separate fee or if undertaking research which has not received trust approval) you are not covered by the indemnity. If you intend to treat private service users on trust premises you must have a valid indemnity. Medical practitioners are advised to maintain membership of a medical defence organisation and submit copy of current membership to the recruitment department.

11 You are required to ensure the security and confidentiality of all information regarding service users or staff at all times. You should not release any such information to anyone other than an approved person in the course of your duties. If as a contract holder you handle service user or staff related information on computers, you must ensure that it is stored on a trust shared drive, or, where appropriate, your staff home drive. You must not store information on the C/: drive, desktop, or any other area of the computer. Information must remain on Trust drives and is not transferred to computers owned by other organisations including those of your substantive employer without appropriate authorisation. This authorisation might be in the form of a formal agreement between Berkshire Healthcare NHS Foundation Trust and your substantive employer with regard to specific types of information or a specific agreement between yourself and the trust with regard to storage of such information. You should be aware of your responsibilities under the GDPR (Data Protection) and only use such information for a registered purpose, not disclosing it to any unauthorised person. You should make yourself familiar with relevant Trust policies.

12 In the event of unavoidable absence due to sickness, injury or accident, you must notify Dr Dorothy King / Dr Hjordis Lorenz immediately**.** You must report any accident or injury, however trivial, arising out of or in the course of your activities in the Trust to Dr Dorothy King / Dr Hjordis Lorenz and make appropriate records and statements as required.

13 You are responsible for familiarising yourself with the Trust's mandatory training courses such as manual handling, health and safety, fire training etc. For further information and to book training, please contact your line manager. Health and Safety at Work Act requires you to take reasonable care for the health and safety of yourself and other persons who may be affected by your acts or omissions at work and to cooperate with the Trust to ensure that statutory regulations, Trust policies and codes of practice, and department safety rules are adhered to.

14 Please ensure that you wear your ID badge at all times or be able to prove your identity if challenged.

15 The dress code is that the Trust wishes to ensure a smart, professional image to be conveyed at all times to the service users and other visitors.

If you agree to accept this Honorary Contract on the terms specified above, please sign the form of acceptance at the foot of this page and return it to the Voluntary & Work Placement Dept. *Please save a signed copy for your reference.*

Yours sincerely,

Dr Dorothy King
Highly Specialised Clinical Psychologist

PLEASE DO NOT DETACH

I have read and agree to the above conditions.

Signed……..Date…….....……