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Abstracts

Systematic Review of the Literature (SRL): A systematic review of the psychometric properties of outcome measures used to assess vicarious trauma and secondary traumatic stress in healthcare professionals

Secondary trauma is common in healthcare professionals, with significant impacts to wellbeing. Whilst several measures of secondary trauma stress and vicarious trauma exist, to date there has been no synthesis of the evidence on which tool is most appropriate for this population. **Objective(s):** The review aimed to systematically assess the psychometric properties of outcome measures for measuring Vicarious Trauma and Secondary Trauma Stress in healthcare professionals. **Methods:** Reports evaluating the psychometric quality of Vicarious Trauma or Secondary Trauma Stress outcome measures (English versions) used with healthcare professionals were considered eligible. Six databases were searched from 1990 to January 2025. The Consensus based Standards for the selection of health Measurement Instruments (COSMIN) guideline for systematic reviews was used to evaluate eligible studies, synthesise, and descriptively summarise the overall evidence to determine whether these measures can be recommended for use. **Results**: Seven outcome measures assessing Vicarious Trauma or Secondary Trauma Stress in healthcare professionals were reviewed. By the standards of the COSMIN tool, only one measure (the Secondary Trauma Stress subscale of the ProQOL-5) could be recommended for use. **Discussion:** This systematic review showed that whilst several measures of secondary trauma exist, only one currently meets COSMIN's psychometric standards and can be recommended for use. Further studies could consider improving the psychometric quality of the measures available in this field to ensure high quality research in this vital area. Areas not considered by this review, including cross-cultural validity, are highlighted for future consideration.

Service Improvement Project (SIP): Understanding the experience of mental health self-disclosure within a Gender Identity Clinic

Minimal research exists on the experience of disclosing mental health difficulties to healthcare professionals working within Gender Identity Clinics (GICs). This study aimed to understand the barriers and facilitators of mental health disclosure experienced by service-users at a GIC in England. Six semi-structured interviews were completed between November 2022 and June 2023. The interviews were analysed using Interpretative Phenomenological Analysis (IPA). Four superordinate themes were interpreted from the data: *Facing and overcoming challenges in accessing gender care*; *The journey to the true self*: *Who have I been and who I am now?; The flow of power, and creating personal agency,* and *The true lived experience of the Gender Clinic*. The themes revealed multiple barriers in the pursuit of gender-affirming healthcare. They reflect participants' views on power, self-identity and the GIC's strengths/limitations. These findings are related to existing literature on disclosure and healthcare barriers. Recommendations were generated, including greater service-user involvement in the development of care-plans, clearer definition of terminology, and increased accessibility to the GIC through person-centred approaches.

Theory Driven Research Project (TDRP): The influence of stigma on PTSD symptom severity and help-seeking intentions in mental health staff experiencing workplace trauma

Abstract

Research suggests that negative appraisals predict post-traumatic stress symptoms and play a role in their maintenance. Some research also suggests an association between self-stigma and trauma symptoms exists. However, these relationships have not been explored amongst mental health professionals working in inpatient psychiatric services. Employees in this context are exposed to high levels of violence and are at greater risk of developing post-traumatic stress disorder (PTSD). Moreover, professionals have expressed that potentially stigmatising narratives exist in the workplace. Therefore, the main aim of this study was to investigate the relationship between negative appraisals, anticipatory stigma, self-stigma and post-traumatic stress symptom severity (PTSS) amongst mental health professionals over time. Stigma had also been identified as a barrier to help-seeking in research on correctional officers, and qualitatively in mental health professionals. As such, a secondary aim was to explore the possible relationship between stigma and help-seeking intentions. Thirty-three participants completed survey one, and thirteen completed survey two. The results indicated high levels of negative appraisals amongst participants, and PTSS was indicative of probable PTSD. Analyses suggested that negative appraisals predicted PTSS. However, stigma did not appear to predict PTSS or help-seeking intentions in this study. The findings indicate the importance of targeting negative appraisals in interventions for this group. Future studies are encouraged to further explore the possible role stigma plays in predicting PTSS and help-seeking in sufficiently powered studies.

Systematic Literature Review

Title: A systematic review of the psychometric properties of outcome measures used to assess vicarious trauma and secondary traumatic stress in healthcare professionals.

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External Supervisor: N/A

Word Count: 5997 words (excluding title, references & appendices)

Date of Submission: Hilary Term 2025

Proposed Journal: Trauma, Violence, & Abuse (Sage Journals)

This journal was selected due to its focus on systematic reviews and issues related to trauma. The journal's submission guidelines can be viewed in appendix 1.1.

Abstract

Secondary trauma is common in healthcare professionals, with significant impacts to wellbeing. Whilst several measures of secondary trauma stress and vicarious trauma exist, to date there has been no synthesis of the evidence on which tool is most appropriate for this population. **Objective(s):** The review aimed to systematically assess the psychometric properties of outcome measures for measuring Vicarious Trauma and Secondary Trauma Stress in healthcare professionals. **Methods:** Reports evaluating the psychometric quality of Vicarious Trauma or Secondary Trauma Stress outcome measures (English versions) used with healthcare professionals were considered eligible. Six databases were searched from 1990 to January 2025. The Consensus based Standards for the selection of health Measurement Instruments (COSMIN) guideline for systematic reviews was used to evaluate eligible studies, synthesise, and descriptively summarise the overall evidence to determine whether these measures can be recommended for use. **Results**: Seven outcome measures assessing Vicarious Trauma or Secondary Trauma Stress in healthcare professionals were reviewed. By the standards of the COSMIN tool, only one measure (the Secondary Trauma Stress subscale of the ProQOL-5) could be recommended for use. **Discussion:** This systematic review showed that whilst several measures of secondary trauma exist, only one currently meets COSMIN's psychometric standards and can be recommended for use. Further studies could consider improving the psychometric quality of the measures available in this field to ensure high quality research in this vital area. Areas not considered by this review, including cross-cultural validity, are highlighted for future consideration.

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Funding: No funding was received for this systematic review.

***Keywords*:** Vicarious Trauma, Secondary Traumatic Stress, Psychometric Properties, Outcome Measures, Systematic Review

Brief review of relevant Literature

Research indicates there is a cost to healthcare professionals caring and working with individuals exposed to traumatic events (TE). Several constructs have been coined to describe the potential costs to those caring for victims of traumatic experiences. These include, but are not limited to, Vicarious Trauma (VT) (McCann & Pearlman, 1990) and Secondary Trauma Stress (STS) (Bride, 2002; Figley, 1995a). Exposure to TE is reportedly common (Benjet et al., 2016), with a lifetime prevalence said to range between 16-90% in the general population (Breslau & Davis, 1992; Breslau et al., 1998; Creamer et al., 2001; Darves-Bornoz et al., 2008; de Vries & Olff, 2009; Norris, 1992; Resnick et al., 1993; Ullman, 1995; Williams et al., 2007). This suggests there is a high possibility that healthcare professionals will be working with those exposed to TE, and consequently could develop VT or STS. A recent systematic review found that 20% of professionals experienced trauma symptoms at a frequency significantly higher than the general population and consistent to those with a diagnosis of post-traumatic stress disorder (PTSD) (Velasco et al., 2023).

Vicarious Trauma

VT is a construct termed by McCann and Pearlman (1990) to describe the accumulative process of unique, often negative, changes that can occur for professionals who repeatedly engage empathically with trauma survivors in the context of a therapeutic relationship (Pearlman & Saakvitne, 1995; Sabin-Farrell & Turpin, 2003). Such therapists are often exposed to other's trauma by the nature of therapeutic intervention being aimed at understanding the TE from the client's perspective whilst working to reappraise and alter their existing narrative surrounding the TE (Ehlers & Clark, 2000). The concept has been understood from a constructivist self-developmental perspective (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). It is hypothesised that TE can disrupt individual's cognitive

schemas of key psychological needs (safety, trust, power, esteem, and intimacy), and as such working with trauma survivors can also disrupt the professionals' schemas altering their beliefs, expectations and assumptions about self, others, and the world (Padmanabhanunni & Gqomfa, 2022; Pearlman & Saakvitne, 1995). Thus, potentially shifting their beliefs from, for example, "others are trustworthy" to "others cannot be trusted".

VT is estimated to affect 40 – 85% of helping professionals (Mathieu, 2012). The consequences of VT for the clinician span both their professional and personal life and are said to mirror the trauma symptoms of their clients (Aparicio et al., 2013; McCann & Pearlman, 1990; Padmanabhanunni & Gqomfa, 2022). Professional consequences of VT include absenteeism, poor decision making, poor mental health, cynicism towards client's difficulties, self-imposed importance and boundary violations in the therapeutic relationship (Bartoskova, 2017; Iqbal, 2015; Newman et al., 2024). Overall, working therapeutically with others' trauma can increase both short and long-term levels of psychological distress in professionals, though the psychological impact can be managed through personal and organisational coping strategies (Cohen & Collens, 2013), such as supervision and caseload management (Sutton et al., 2022).

Secondary Trauma Stress

STS is a construct developed by (Figley, 1995a) to conceptualise the psychological consequences resulting from secondary exposure to TE amongst professionals and/or lay-persons. Since the COVID-19 Pandemic, STS has become more recognised, with a prevalence rate of 47.5% reported amongst frontline healthcare professionals (Orrù et al., 2021). STS symptoms are said to resemble those of post-traumatic stress disorder (PTSD) such as hyperarousal, flashbacks, and avoidance (Watts & Robertson, 2015), but symptoms

need not meet the full diagnostic criteria (Sprang et al., 2019). Other consequences include negative reactions to others distress such as frustration and exhaustion (Stamm, 2010a).

STS is argued to be conceptually distinct from VT (Branson, 2019; Gusler et al., 2023). The key differences between STS and VT are in symptom development; VT results from accumulative exposure over a long time period compared to acute onset in STS (Branson, 2019), and the cognitive changes are unique to VT (Baird & Kracen, 2006), which are of focus in its assessment (Jenkins & Baird, 2002).

Measures of VT and STS

Given the suggested incidence of VT and STS and their potential consequences personally and professionally to healthcare practitioners, alongside the challenge of the terms being conflated and used interchangeably within research, there is a real a need to consider how best each concept can be assessed. Furthermore, to evaluate the effectiveness of VT and STS interventions, valid and reliable outcome measures are needed.

Arguably, if an outcome measure's psychometric properties are unknown or poor, then the quality of data collected with it are uncertain and their use questionable (Ioannidis et al., 2014; Walton et al., 2015). Furthermore, the current field of research is heavily critiqued by inconsistences in the measurement of VT (Branson, 2019) and STS (Sprang et al., 2019).

Currently, measures developed to assess VT include; the Traumatic Stress Institute Belief Scale (Pearlman, 1996), the Trauma attachment and belief scale (TABS) (Pearlman, 2003) and the Vicarious Trauma Scale (Vrklevski & Franklin, 2008), though their validity have been questioned (Aparicio et al., 2013; Strange, 2021). Furthermore, VT research has utilised outcome measures designed for related, yet theoretically distinct, concepts such as PTSD (Pearlman, 2003), STS (Branson, 2019; Bride et al., 2004), and compassion fatigue (CF) (Figley, 1995a; Stamm, 2010a){Figley, 1995 #336}. Therefore, this mixed usage of

assessment measures, including the use of assessment measures designed for other constructs, likely limits the conclusions that can be drawn.

There are also measures designed to directly assess STS; the Secondary Trauma Stress Scale (Bride et al., 2004) and Professional Quality of Life (ProQOL)-5 (Stamm, 2010b). Nonetheless, research into STS has also used VT specific measures in its assessment (Sprang et al., 2019). This is problematic as research is potentially misrepresenting the concepts which are argued to be distinct from one another, thus limiting any study's conclusion on the concept. A recent systematic review concluded that the STS scale (Bride et al., 2004) was a valid measure and the tool of choice for assessing secondary exposure to trauma in nurses (Watts & Robertson, 2015). However, this does not ascertain whether the tool is the most appropriate for other healthcare professionals.

Several studies and reviews highlight the need for further research into the area of VT (Branson, 2019; Cohen & Collens, 2013; Sutton et al., 2022). However, without robust assessment of the outcome measures, the same methodological issues will arise adding to the inconsistencies in the research and lack of comparability across research. Consistent and robust outcome measures for healthcare professionals will allow for improved assessment of VT and STS specifically in the evaluation of interventions aimed at targeting VT and STS in the workplace. Thus, this systematic review aims to appraise the psychometric properties of outcome measures used in the assessment of VT and STS.

The aim of this systematic review is to evaluate the outcome measures available for VT and STS, specifically those used with healthcare professionals and interpreters working with survivors of trauma, or witnesses of traumatic events. The review aims to critically evaluate the psychometric properties of VT and STS outcome measures and establish whether there is

a measure most suitable for use in practice. The review aims to answer the following research questions:

- What are the psychometric properties of outcome measures used to assess Vicarious Trauma (VT) and Secondary Traumatic Stress (STS) measures?
- Are the measures used to assess VT and STS in healthcare professionals adequate for clinical and/or research use?

Methodology

The updated Consensus-based Standards for selection of health Measurement Instruments (COSMIN) methodology for systematic reviews of PROMs was used to guide this systematic review (Mokkink et al., 2024). The review was registered with PROSPERO in April 2023, registration code CRD42023355937.

Search Strategy

Online databases (MEDLINE, EMBASE, PsycINFO, CINAHL, ASSIA and EMCARE) were searched for relevant articles in July 2024 resulting in 20 articles (including dissertations and theses) meeting the inclusion criteria. The search was rerun in January 2025 to ensure the review was up to date for submission, no additional studies were included (appendix 1.2). Search terms were identified from previous literature, meeting with a librarian, the COSMIN manual, using synonyms and known acronyms. The search consisted of four elements: (1) construct(s) of interest (2) target population (3) measurement tool(s) (4) measurement properties, as identified by the filter developed by (Terwee et al., 2009). The terms for element (4) were altered dependent on the database searched, and the complete search strategy can be found in appendix 1.3.

Inclusion criteria

Articles including peer review and dissertations/theses in the review had to meet the following criteria:

- Studies reporting quantitative data only.
- Articles dated from 1990 (date of VT construct conception) to present.
- Articles evaluated the psychometric properties of outcome measures aimed at assessing VT or STS. The key psychometric properties of interest were reliability, and validity (excluding cross-cultural validity). *Papers without a main focus on the psychometric evaluation of VT and STS outcome measures were not included.*
- Articles had to be assessing the psychometric properties of the English version of the outcome measure.
- Study participants included healthcare professionals (i.e. counsellors, psychologists, nurses and social workers) and interpreters working with survivors of trauma, or witnesses of traumatic events.
- Articles published in the English language.

Selection and Data-Collection Process

The main author screened all titles and abstracts. A second reviewer (AJ) screened a random sample of 20% of the articles (540) at this stage with 98.52% observed agreement rate and kappa of .819 achieved. A second reviewer (RB) screened a random sample of at least 25% of articles at the full-text screening stage with an agreement level of 93.75% and a Kappa of .875 being achieved. Data-extraction was completed independently with RB duplicating 50% of the extraction. Extracted data included reference, participant demographics, sample, sample size, study setting, study location, and the characteristics and psychometric properties of the outcome measure. Risk of bias was completed using the COSMIN Risk of Bias

Checklist (Mokkink et al., 2018), whereby the worst score method was applied. The second reviewer (RB) assessed 30% of included articles with a Kappa of 0.85 achieved.

Assessment of psychometric properties

Outcome measures were rated by the main author based on the COSMIN criteria for good measurement properties (Mokkink et al., 2024). Thus, each measurement property's result was rated as sufficient (+), insufficient (–), or indeterminate (?), regardless of the quality of the study. To check rating the system was understood correctly the main author and EK rated 3 studies independently reaching agreement on the properties of structural validity and internal consistency. Therefore, the remainder of the studies were rated by the main author alone. Although, any concerns during the rating process were discussed with EK until a consensus was reached.

The results were summarised where more than one study was identified for each measurement property per tool. The GRADE approach (Guyatt et al., 2008) was adopted to rate the quality of evidence; it utilised a 4-point scale where the evidence was graded from *high* ("We are very confident that the true measurement property lies close to that of the estimate of the measurement property") to *very low* ("We have very little confidence in the measurement property evidence: the true measurement property is likely to be substantially different to the estimate of the measurement property" (Guyatt et al., 2011). A GRADE was not given if the summarised result was rated as indeterminate (?) or if the evidence was derived from only one study.

See table 1 below for the COSMIN psychometric definitions adopted in this review (Mokkink et al., 2024). In line with the COSMIN guidance, the main author and EK devised hypotheses relevant for the constructs of interest (STS and VT) to be used in the assessment of construct validity. These are highlighted in Table 1.2.

Table 1.

COSMIN *definitions of psychometric properties*

Domain	Psychometric Property	Definition
Reliability		The degree to which the measurement is free from measurement error.
	Internal Consistency	The degree of interrelatedness among the items.
	Reliability	The proportion of total variance in the measurements which is due to true differences between patients.
	Measurement Error	The systematic and random error of a patient's that is not attributed to true changes in the construct to be measured.
Validity		The degree to which an instrument measures the construct(s) it proports to measure.
	Content Validity	The degree to which the content of an instrument is an adequate reflection of the construct to be measured.
	Construct Validity	The degree to which the scores of an instrument are consistent with hypotheses (for instance with regard to internal relationships, relationships to scores of other instruments or differences between relevant groups) based on the assumption that the instrument validity measures the construct to be measured.
	Structural Validity	The degree to which the scores of an instrument are an adequate reflection of the dimensionality of the construct to be measured.
	Criterion Validity	The degree to which scores of an instrument are an adequate reflection of a 'gold standard'.

Table 1.2.

Hypotheses for Construct Validity and their Rationale.

Hypotheses for Construct Validity		Rationale
Hypothesis 1	Target instrument(s) (VT or STS) and comparator measuring the same construct should be highly correlated (i.e. measure assessing PTSD or Trauma symptomology): r≥0.7	These instruments should measure exactly the same construct and correlate highly
Hypothesis 2	Comparator instrument measures a largely related construct (e.g., VT & STS, Burnout, Compassion fatigue): r 0.4-0.7	These instruments measure largely related constructs and correlate quite highly
Hypothesis 3	Comparator instrument measures a moderately related construct (e.g., measures related to mood, stress and affect such as depression or anxiety or general wellbeing): r 0.3-0.6	These instruments measure moderately related construct and correlate moderately
Hypothesis 4	Relevant subgroups (healthcare professionals vs general population or those working with trauma vs those without) should differ at least 10% in scores or correlation ≥0.30 between relevant subgroups and scores.	There should be a marked difference in scores between relevant subgroups based on the constructs (VT and STS) theory that suggests HCPs develop these conditions due to working with or caring for traumatised individuals

Results

A total of 20 articles and 10 full outcome measures were initially identified in the assessment of VT and STS (PRISMA figure 1). However, based on the COSMIN guidance, the decision was made to exclude three of the identified outcome measures as it was not possible to access their measurement details. This resulted in three articles being removed from the review (Humphries-Wadsworth, 2002; Kadambi, 2004; Motta et al., 1999). Thus, a total of 17 articles were reviewed. Seven full scale measures were reviewed, and in line with the COSMIN tool sub-scales specifically assessing STS or VT were also counted as unique

measures and reviewed. Five of the full outcome measures were reported to assess the STS construct and two were designed to assess VT.

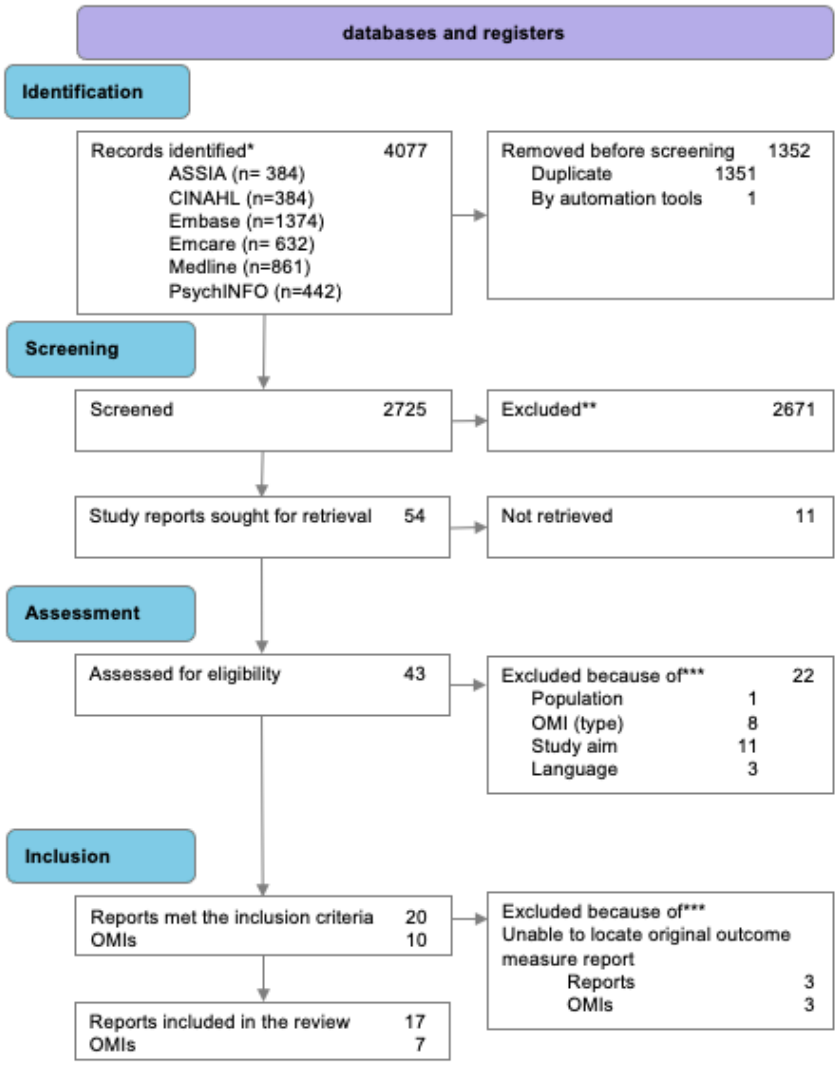

Figure 1. PRISMA flow diagram depicting the selection of reports and studies.

Outcome Measure Characteristics

Table 1.3 outlines the outcome measures identified in the assessment of VT and STS. The table displays the outcome measure characteristics including their structure. Some of this data was sought from the original reports of the identified outcome measures as not all required data on the measurement's characteristics were recorded in the reviewed articles. Data on

feasibility is provided in Table 1.4. Please note that all measures have been entered as full scales with details provided on their subscale structures. For the ProQOL-5, the authors recommend the subscales not be used in isolation (Stamm, 2010b). However, due to the nature of this review our main focus was on the STS subscale only where possible. Thus, evaluating the individual compassion satisfaction and burnout subscales was beyond the scope of this review.

Risk of Bias

Risk of bias is presented in Table 1.5 for each outcome measure per measurement property. A total of 54 studies were identified across the included articles. The majority of studies received either a very good or adequate risk of bias rating. A doubtful rating was given to studies on structural validity by Zivanovic and Vukcevic Markovic (2020) as the same sample was used for both the exploratory factor analysis (EFA) and confirmatory factor analysis (CFA). Most studies reporting on construct validity were downgraded as they did not provide the sample's mean or standard deviation data for both the construct of interest (VT/STS) or the comparator instrument.

Table 1.3.

Outcome Measure Characteristics

Reference	Outcome Measure	Language	PROM design								
			General design requirements				PROM Structure				
			Clear construct	Clear origin of construct	Clear target population for which the PROM was developed	Clear context of use	(Sub)scale names (number of items)	Response options	Possible range of scores (per (sub)scale)	Scoring algorithm	Recall Period
Bride (2002)	Secondary Traumatic Stress Scale (STSS)	English	R	R	R	R	Full Scale (17) Intrusion (5) Avoidance (7) Arousal (5)	1=Never, 2= Rarely, 3=Occasionally, 4= Often, 5= Very Often	Total Score = 17- 85 Intrusion = 5-25, Avoidance = 7-35, Arousal=5-25	Sum of scores	Last 7 days
Stamm (2010b)	Professional Quality of Life (ProQOL)-5	English	R	R	R	R	Full Scale (30) Compassion satisfaction (10) Burnout (10) Secondary Trauma Stress (10)	1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often	Compassion Satisfaction, Burnout and Secondary Trauma Stress= 10-50	Reverse code relevant items. Sum of scores.	Current Situation
Weitkamp et al. (2014)	Questionnaire for Secondary Traumatisation (FST)	English	R	R	R	R	Full Scale (31)	1= never to 5=very often	Total Score= 31-155	Sum of scores	Acute (past 7 days) or Lifetime
Figley (1995a)	Compassion Fatigue Self-Test (CFST) - Psychotherapists	English	R	R	R	R	Full Scale (40) Compassion fatigue (24) Burnout (16)	1=rarely/ never, 2= at times, 3= not sure, 4= often, 5= very often	Total Score=40-200 Compassion Fatigue= 23-115, Burnout = 17-85.	Sum of scores	Past 30 days
Gentry et al. (2002)	Compassion Fatigue Self-Test (CFST) – Caregivers	English	R	R	R	R	Full Scale (30) Secondary/post-trauma (22) Burnout (8)	1=Rarely/ Never to 10= Very Often	Total Scale= 30-300, Compassion Fatigue= 22-220 Burnout= 8-80	Sum of scores	Present
Vrklevski	Vicarious	English	R	R	R	R	Full Scale (8)	1=strongly	Total Scale =	Sum of scores	

Reference	Outcome Measure	Language	PROM design								
			General design requirements				PROM Structure				
			Clear construct	Clear origin of construct	Clear target population for which the PROM was developed	Clear context of use	(Sub)scale names (number of items)	Response options	Possible range of scores (per (sub)scale)	Scoring algorithm	Recall Period
and Franklin (2008)	Trauma Scale (VTS)							disagree to 7= strongly agree	8-56		
Van De Water (1996)	Trauma Work Impact Scale	English	R	R	R	R	Full Scale (65) Sensory Image disruptions (6) Personal identity (5) Personal Safety (5) Therapist feelings of burnout (5) Professional relationships with colleagues (5) Feelings of distrust and uncertainty (5) Others safety (4) Feelings towards trauma survivors (4) Ability to separate work from other activities (4) Negative impressions of others (4) Listening to trauma material (3) Coping strategies (3) Mood states	1=Never 2=Rarely 3=Sometimes 4=Often 5=Always	Total Score= 5-325, Sensory Image disruptions= 6-30 Personal identity, Personal Safety, Therapist feelings of burnout, Professional relationships with colleagues and Feelings of distrust and uncertainty= 5-25 Others safety, Feelings towards trauma survivors, Ability to separate work from other activities and Negative impressions of others= 4-20 Listening to trauma material, Coping strategies and	Sum of scores	Current Situation

Reference	Outcome Measure	Language	PROM design								
			General design requirements				PROM Structure				
			Clear construct	Clear origin of construct	Clear target population for which the PROM was developed	Clear context of use	(Sub)scale names (number of items)	Response options	Possible range of scores (per (sub)scale)	Scoring algorithm	Recall Period
							(3) Personal relationships with loved ones (2)		Mood states= 3-15 Personal relationships with loved ones= 2-10		

Table 1.4.

Feasibility of the Outcome Measures

		Burden for patients			Practical aspects to obtain the PROM			
Outcome Measure	**Version**	**Time to administer**	**Number of items**	**Full copy available**	**Licensing information**	**Costs**	**Administration form**	**Available translations (Yes/Unknown/No)**
STSS	Original	NR	17	Yes	Copyrighted	Free	Paper and Pencil	Yes
ProQOL-5	Revised Version 5	NR	30	Yes	Permission to use freely as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.	Free	Paper and pencil or computer option	Yes
FST	Original	5 minutes	31	Yes	Unknown	Free	Paper and pencil or computer option	Unknown
CFST-Psychotherapists	Original	NR	40	Yes	Copyrighted	NR	Paper and Pencil	Yes
CFST-Caregivers	Revised	NR	30	Yes	Unknown	NR	Paper and Pencil	Unknown
VTS	Original	NR	8	Yes	Unknown	NR	Paper and Pencil	Unknown

Trauma Work Impact Scale	Original	NR	65	Yes	Unknown	NR	Paper and Pencil	Unknown

NR= Not reported

Results of individual studies

Table 1.6 presents the extracted data on the assessed measurement properties, present for each study (for additional study details see appendix 1.4). It includes the reported result and the rating against the COSMIN criteria for good measurement properties (Mokkink et al., 2024).

Content validity was not formally assessed in the studies on psychometric properties. Therefore, only a reviewer rating was provided. Relevance, comprehensiveness and comprehensibility were rated as sufficient for the following measures: STSS, ProQOL-STS subscale, FST and Trauma Work Impact Scale. The CFST measures contained the same items for the CF subscale; their content validity was rated insufficient for comprehensibility because less than 75% of items were considered to be worded appropriately. Lastly the VTS scale was rated as insufficient on comprehensiveness as not all key concepts were covered by its eight items. The measure failed to incorporate questions related to cognitive shifts in individual's world and self-view (Aparicio et al., 2013).

For internal consistency it was not possible to rate results based on Omega or standard error of the theta (SE (θ) as COSMIN has not developed criteria for this data (Mokkink et al., 2024).

For STSS internal consistency individual scores were rated as indeterminate with both full-scale reliability and individual subscale reliability reported as >0.7 suggesting at least acceptable internal consistency. However, based on the structural validity results the criteria for at least low evidence of sufficient unidimensionality was not met.

When reviewing the FST the authors suggested that a single factor was a better fit, compared to the 6 factor structure identified through two EFA's, though it was not assessed

(Weitkamp et al., 2014). For the purpose of rating internal consistency at least low evidence of unidimensionality was assumed for the FST scale.

The CFST psychotherapists measure, both full scale and the CF subscale, was rated as indeterminate as the criteria for at least low evidence of sufficient unidimensionality was not met.

The Trauma Work Impact full scale was also rated as indeterminate because the criteria for at least low evidence of sufficient unidimensionality was not met. The subscale internal consistency data was provided as a range; therefore, not enough information was provided to rate each scale individually. An overall indeterminate score was therefore specified. However, the range given suggests that at least one subscale would have been rated as insufficient as alpha =0.38.

Results Syntheses

The summarised results, ratings and the quality of evidence ratings are presented in Table 1.7. Results were summarised where more than one study was reviewed per measurement property for the outcome measures, or multiple correlations were performed in the assessment of construct validity. Summarised results and recommendations for each outcome measure/subscale are discussed below.

Table 1.5.

Risk of Bias for each outcome measure and psychometric property

Outcome Measure	Reference	Structural validity	Internal consistency	Construct Validity
STSS 17-item				
3 Factors: Intrusion, Avoidance and Arousal	Bride (2002)	Very Good	Very Good	-
	Bride et al. (2004)	Very Good	Very Good	Adequate
	Zivanovic and Vukcevic Markovic (2020)	Doubtful	Very Good	-
	Ahmed et al. (2022)	Very Good	-	Adequate
1 Factor Structure	Bride (2002)	-	Very Good	-
	Bride et al. (2004)	-	Very Good	Adequate
	Ting et al. (2005)	Very Good	Very Good	-
	Zivanovic and Vukcevic Markovic (2020)	Doubtful	Very Good	Very Good
	Belletti (2023)		Very Good	Adequate
ProQOL-5				
3 Factor Structure: Compassion Satisfaction, Burnout and STS	Keesler and Fukui (2020)	Very Good	Very Good	-
	Singh et al. (2024)	Very Good	Very Good	-
1 Factor Structure: STS Subscale only	Hemsworth et al. (2018) – Palliative Care Workers	Very Good	Very Good	-
	Hemsworth et al. (2018) – Australian Nurses	Very Good	Very Good	Adequate
	Hemsworth et al. (2018) – Canadian Nurses	Very Good	Very Good	Adequate
	Heritage et al. (2018)	Very Good	Very Good	-
	Ang et al. (2020)	Very Good	Very Good	Adequate
	Deaton and Whitbeck (2024)	-	Very Good	-
FST				
	Weitkamp et al. (2014) Sample 1	Adequate	Very Good	-

Outcome Measure	Reference	Structural validity	Internal consistency	Construct Validity
	Weitkamp et al. (2014) Sample 2	Adequate	Very Good	-
	Weitkamp et al. (2014) Sample 3	-	Very Good	-
CFST Psychotherapists				
Full Scale	Jenkins and Baird (2002)	-	Very Good	Adequate
CF Subscale		-	Very Good	Adequate
CFST – Caregivers				
	Adams et al. (2006)	Doubtful	-	Adequate
VTS				
	Aparicio et al. (2013)	Doubtful	Very Good	-
	Belletti (2023)	-	Adequate	Adequate
Trauma Work Impact Scale				
	Van De Water (1996)	Inadequate	Very Good	-

Recommendations

STSS (Full Scale, Intrusion, Arousal and Avoidance subscales)

There is moderate quality of evidence for insufficient structural validity for both a three-factor model and one-factor model of the STSS measure. A moderate quality of evidence was provided due to some studies being rated as doubtful in quality and the remainder very good. All full scale and individual scales internal consistency were rated as indeterminate due to unclear evidence of unidimensionality. Therefore, the quality of evidence on internal consistency could not be graded. There was high quality evidence to suggest the full scale, and its subscales, had sufficient construct validity. Overall, as structural validity was considered insufficient, it is recommended that further research be conducted on the quality of this outcome measure before it can be recommended for use.

ProQOL-5 (Full Scale and STS subscale)

Full Scale

There was high quality evidence that a three-factor model for the ProQOL-5 was insufficient. Therefore, this scale would be recommended against use in its current form. Further research is recommended to assess its other psychometric properties including content validity and internal consistency.

STS subscale

When considered in isolation the STS subscale from the ProQOL-5 demonstrated high quality evidence that its structural validity, internal consistency and construct validity were sufficient. Therefore, the STS subscale is recommended for use. However, this goes against the recommendation by Stamm (2010b) that the ProQOL subscales not be used in isolation.

Table 1.6

Individual study results per psychometric property

Outcome Measure	Reference	Sample	Sample Size	Content Validity (reviewers rating only)			Structural Validity Result (rating)	Internal Consistency Result (rating)	Construct Validity Comparator Construct, Result(rating)
				Relevance	Comprehensiveness	Comprehensibility			
STSS 17-item 3 Factors: Intrusion, Avoidance and Arousal	Bride (2002)	Social Workers	200	(+)	(+)	(+)	CFA: CFI = 0.93, RMSEA = 0.076 (-)	Intrusion α = 0.83 (?) Avoidance α = 0.89 (?) Arousal α = 0.85 (?)	
	Bride et al. (2004)	Social Workers	287				CFA: CFI =0.94, RMSEA = 0.069 (-)	Intrusion α = 0.80 (?) Avoidance α = 0.87 (?) Arousal α = 0.83 (?)	Anxiety *r* = 0.461 (+) Depression *r* = 0.391 (+) Anxiety *r* = 0.507 (+) Depression *r* = 0.516 (+) Anxiety *r* = 0.563 (+) Depression *r* = 0.461 (+)
	Ting et al. (2005)	Mental Health Social Workers	275				CFA: CFI=0.92, RMSEA=0.080 (-)	Intrusion α = 0.79 (?) Avoidance α = 0.85 (?) Arousal α = 0.87 (?)	
	Zivanovic and Vukcevic Markovic (2020)	Refugee Workers	270				EFA: Factor loadings of each item on its factor was >.30. 48.39% Variance accounted for by the	Intrusion α = 0.77 (?) Avoidance α = 0.81 (?) Arousal α =0.82 (?)	

Outcome Measure	Reference	Sample	Sample Size	Content Validity (reviewers rating only)			Structural Validity Result (rating)	Internal Consistency Result (rating)	Construct Validity Comparator Construct, Result(rating)
				Relevance	Comprehensiveness	Comprehensibility			
							retained 3 factors. 20% of items had factor loadings of >.30 on multiple factors. (-) CFA: TLI = 0.88 CFI = 0.90 RMSEA = 0.079 [CI 0.069–0.090], SRMR = 0.058 (-)		
1 Factor Structure: Full Scale	Bride (2002)	Social Workers	200					STSS Full Scale α = 0.94 (?)	
	Bride et al. (2004)	Social Workers	287					STSS Full Scale α = 0.93 (?)	Anxiety *r* = 0.553 (+) Depression *r* = 0.502 (+)
	Ting et al. (2005)						CFA: CFI=0.92, RMSEA= 0.079 (-)	STSS Full Scale α = 0.94 (?)	
	Zivanovic and Vukcevic Markovic (2020)	Refugee Workers	270				CFA: TLI = 0.86, CFI = 0.88, RMSEA = 0.085	STSS Full Scale α = 0.92 (?)	Anxiety *r* = 0.706 (-) Depression *r* = 0.711 (-) Quality of life *r* = -0.438 (-)
	Ahmed et al. (2022)	Physicians	375				*STS, CF and Burnout in CFA model as separate latent constructs* CFA: TLI =		Burnout *r* = (0.821) (-) CF *r* = 0.77 (-)

Outcome Measure	Reference	Sample	Sample Size	Content Validity (reviewers rating only)			Structural Validity Result (rating)	Internal Consistency Result (rating)	Construct Validity Comparator Construct, Result(rating)
				Relevance	Comprehensiveness	Comprehensibility			
							0.89, SRMR = 0.103, RMSEA = 0.080 (-)		
ProQOL-5 3 Factor Model: Full Scale	Belletti (2023)	Clinical Psychologists, masters-level clinicians and doctoral students	50					STSS Full Scale α = 0.89 (?)	VT *r* = 0.39 (-)
	Keesler and Fukui (2020)	Direct Support Professionals	495				CFI = 0.82, TLI = 0.80, SRMR = 0.09, RMSEA = 0.08 (-)		
	Singh et al. (2024)	Psychologists, Counsellors and Psychotherapists	366				CFI = 0.764, TLI = 0.745, RMSEA = 0.066 90% CI (0.061, 0.071), SRMR = 0.077 (-)	Coefficient Omega STS: 0.837 95% CI (0.809, 845)	
STS Subscale	Hemsworth et al. (2018)	Palliative Care Workers	651	(+)	(+)	(+)	CFI= 0.98, RMSEA= 0.066 (+)	α = 0.78 (+)	
	Hemsworth et al. (2018)	Australian Nurses	273				CFI = 0.98, RMSEA = 0.071 (+)	α = 0.82 (+)	Stress *r* = 0.56 (+) Depression *r* = 0.43 (+) Anxiety *r* = 0.51 (+)
	Hemsworth et al. (2018)	Canadian Nurses	303				CFI =0.96, RMSEA = 0.097 (+)	α = 0.85 (+)	Stress *r* = 0.43 (+) Depression *r* = 0.39 (+)

Outcome Measure	Reference	Sample	Sample Size	Content Validity (reviewers rating only)			Structural Validity Result (rating)	Internal Consistency Result (rating)	Construct Validity Comparator Construct, Result(rating)
				Relevance	Comprehensiveness	Comprehensibility			
									Anxiety *r* = 0.43 (+)
	Heritage et al. (2018)	Nurses/Nurse officers	1615				NR (?)	α = 0.85 (+)	
	Ang et al. (2020)	Nurses	1338				NR (?)	α = 0.8 (+)	Positive Affect *r* = -0.181 (-) Negative Affect *r* = 0.45 (+)
	Deaton and Whitbeck (2024)	Counsellors	543					α = 0.84 (+)	
FST				(+)	(+)	(+)			
	Weitkamp et al. (2014) Sample 1	Counsellors and Psychotherapists	371				EFA: Six factors were extracted which explained a total of 59.2% of variance. Factors eigenvalues ranged from 1.47 -5.36. Factor Loadings: Over 10% of items had factor loadings >.30 on multiple factors. (-)	Full Scale α = 0.94 (+)	
	Weitkamp et al.	Refugee Counsellors	195				EFA: Six factors were	Full Scale α = 0.94 (+)	

Outcome Measure	Reference	Sample	Sample Size	Content Validity (reviewers rating only)			Structural Validity Result (rating)	Internal Consistency Result (rating)	Construct Validity Comparator Construct, Result(rating)
				Relevance	Comprehensiveness	Comprehensibility			
	(2014) Sample 2						extracted which explained a total of 63.6% of variance. Factors eigenvalues ranged from 2.50 -5.04. Factor Loadings: Over 10% of items had factor loadings >.30 on multiple factors. (-)		
CFST Psychotherapists	Weitkamp et al. (2014) Sample 3	Trainee Psychotherapists	80	(+)	(+)	(-)		Full Scale α = 0.92 (+)	
	Jenkins and Baird (2002)	Counsellors	99					Full Scale α = 0.90 (?) Compassion Fatigue (CF) subscale α = 0.84 (?)	VT *r* = 0.58 (+) Burnout *r* = 0.38 (-) General psychological distress *r* = 0.61 (-) VT *r* = 0.58 (+) Burnout *r* = 0.52 (+) General psychological distress *r* =

Outcome Measure	Reference	Sample	Sample Size	Content Validity (reviewers rating only)			Structural Validity Result (rating)	Internal Consistency Result (rating)	Construct Validity Comparator Construct, Result(rating)
				Relevance	Comprehensiveness	Comprehensibility			
CFST – Caregivers				(+)	(+)	(-)			0.65 (-)
	Adams et al. (2006)	Social Workers	236				NR (?)		Psychological Distress *r* = 0.462 (+)
VTS				(+)	(-)	(+)			
	Aparicio et al. (2013) (6 items only)	Social Workers	157				EFA: Two Factors identified, 3 items loading on each factor with a factor-loading cut-off of .4 (?) CFA: Two factor model CFI = 0.99, TLI = 0.99, RMSEA = 0.05 (+)	Full Scale α = 0.77 (?) Factor 1: Affective Impact of Working with Traumatized Clients α = 0.72 (?) Factor 2: Cognitive Impact of Working with Traumatized Clients α = 0.74 (?)	
	Belletti (2023)	Clinical Psychologists, masters-level clinicians and doctoral students	50					Full Scale α = 0.81 (?)	
Trauma Work Impact Scale				(+)	(+)	(+)			
	Van De Water (1996)	Therapists	165				PCA: 14 revised subscales. Many of the originally proposed subscales were statistically	Full Scale α = 0.90 (?) Subscale reliabilities ranged from α = 0.39 - 0.80 (?)	

Outcome Measure	Reference	Sample	Sample Size	Content Validity (reviewers rating only)			Structural Validity Result (rating)	Internal Consistency Result (rating)	Construct Validity Comparator Construct, Result(rating)
				Relevance	Comprehensiveness	Comprehensibility			
							supported in the factor analysis. The cut-off for items included in each factor was designated at an Eigenvalue of .30. (?)		

CFA=confirmatory factor analysis, CFI= comparative fit index, EFA= exploratory factor analysis, PCA= principal component analyses, RMSEA= Root Mean Square Error of Approximation, SRMR= Standardised Root Mean Residuals, TLI= Tucker-Lewis Index. (+): sufficient, (?) indeterminate and (-) insufficient

FST

There was high quality evidence to suggest that a two-factor structure was insufficient, thus lacking support for structural validity. Based on the assumption that the scale may be single factor, high quality evidence was found to suggest internal consistency was sufficient. However, no conclusions can be drawn on its recommendation for use and further research is needed on the quality of its psychometric properties.

CFST-Psychotherapists (Full Scale and CF Subscale)

The outcome measure structure suggested two distinct scales, one assessing compassion fatigue, and the other burnout (Figley, 1995a). The full scale and CF scale were referred to in the assessment of STS. No studies were identified that assessed the structural validity of either the full scale or CF subscale. Only one study for internal consistency was identified for the CFST-psychotherapist measure, therefore results could not be summarised. All internal consistency scores identified for these outcome measures (CFST and CF) were rated as indeterminate. Assessment for construct validity was reviewed for the full scale, and CF subscale. The summarised results were inconsistent, and of low quality. Thus, more research on the quality of this outcome measure is required before recommendations can be made for its use.

CFST-Caregivers

Only one article was reviewed for the CFST-Caregivers measure, therefore, it was not possible to summarise the results (Adams et al., 2006). Even so, the one study on structural validity did not provide enough information for the results to be rated. Another study on this outcome measure was identified on construct validity with sufficient rating as it was found to correlate as hypothesised with a measure of psychological distress. Therefore, no conclusions

were drawn on this outcome measure. Instead, it is recommended that its psychometric quality be assessed in future research.

VTS

The summarised structural validity results were of low quality and inconsistent. The results were based on an EFA that did not report all relevant data to appropriately rate the results. As such an indeterminate rating was provided. The CFA indicated the assessed two-factor structure was sufficient. The summarised internal consistency score was indeterminate, and the quality of evidence could not be graded.

Trauma Work Impact Scale

Only one article was found on the trauma work impact scale which appeared to be on its initial conception (Van De Water, 1996). It contained two studies relevant for evaluation with the COSMIN tool covering structural and construct validity. No further studies were identified on its psychometric qualities. No firm conclusions can be drawn as there is not suffice evidence. As such it is recommended that, if researchers want to use this tool with healthcare professionals, further psychometric data is collected and evaluated. It was only one of two VT measures identified for use with healthcare workers. However, based on the tools number of items (65) its feasibility is questioned.

Table 1.7.

Summarised Results, Ratings and Quality of Evidence.

		STSS – Intrusion Subscale Avoidance Subscale Arousal Subscale	STSS – Full Scale	ProQOL – Full Scale	ProQOL – STS Subscale	FST	CFST- Psychotherapists	VTS
Structural Validity	Summarised Result	CFI <0.95, TLI<0.95, RMSEA>0.06, SRMR>0.08	CFI <0.95, TLI<0.95, RMSEA>0.06, SRMR>0.08	CFI <0.95, TLI<0.95, RMSEA>0.06 , SRMR>0.08	CFI or TLI >0.95, or RMSEA<0.06 , or SRMR<0.08	Six factors. Explained variance range from 59.2% - 63.6%. Factor eigenvalues ranged from 1.47 - 5.36. >10% of items loaded onto multiple factors at ≥ .30.		Inconsistent Evidence on the 2-factor structure proposed.
	Rating of Summarised Result	-	-	-	+	-		±
	Quality of Evidence	Moderate	Moderate	High	High	High		High
Internal Consistency	Summarised Result	Intrusion α = 0.77 – 0.83 Avoidance α = 0.81 – 0.89 Arousal α = 0.82- 0.87	α = 0.92 – 0.94		α = 0.78 – 0.85	α = 0.92 -0.94		Full Scale α =0.77-0.81
	Rating of Summarised Result	?	?		+	+		?
	Quality of Evidence	NA	NA		High	High		NA
Hypothesis Testing for Construct Validity	Summarised Result	Intrusion:2+ Avoidance: 2+ Arousal: 2+	3+, 5-		7+ 1-		Full Scale: 2+, 1- CF Subscale: 1+, 2-	
	Rating of Summarised Result	Intrusion (+) Avoidance: (+) Arousal: (+)	±		+		Full Scale: ± CF Subscale: ±	
	Quality of Evidence	High	Moderate		High		Low	

NA = not assessed, ± = inconsistent.

Discussion

This systematic review sought to identify the outcome measures that have been used in the assessment of VT and/or STS in healthcare professionals and to establish the quality of the psychometric evidence for their use in this context. The results showed that at least seven full outcome measures with available information on their psychometric properties have been used to assess STS and/or VT within healthcare professionals. However, no single measure reported on all of the psychometric properties outlined by the COSMIN methodology. Only one measure (the STSS subscale of the ProQOL-5) met the COSMIN psychometric standards and can be recommended for further use (Stamm, 2010b). Nonetheless, the ProQOLO-5 authors themselves have counselled against the sole use of subscales within their measures. This suggests that there is a significant need in the field for further psychometric development of associated measures.

Measurement properties included most frequently were structural validity, internal consistency and construct validity. No studies reported on content validity, measurement error, criterion validity or responsiveness. The majority of the identified outcome measures identified were developed or used to assess the construct of STS, and most studies evaluated these measurement tools. Only one of these outcome measures were found to be recommended for use in its current format as high quality evidence was found for structural validity, internal consistency and construct validity – the STSS subscale of the ProQOL-5 (Stamm, 2010b). Other measures of STS included: STSS and its subscales (Bride, 2002), which were found to have insufficient structural validity (high quality evidence); FST (Weitkamp et al., 2014) was found to have insufficient structural validity and sufficient internal consistency only (high quality evidence); CFST-Psychotherapists (Figley, 1995a) internal consistency was indeterminate, and construct validity for both full scale and CF

subscale were inconsistent and of low quality; CFST Caregivers (Gentry et al., 2002) did not have enough evidence to be summarised.

Only two outcome measures were identified in the assessment of VT that had evaluated their psychometric quality in the target population. However, no conclusions could be drawn on these tools due to low quality and limited data on their psychometric properties. Therefore, more research is required assessing the psychometric quality of these outcome measures. Critically, the main article provided data on the VTS scale assessed only items 3-8 of the scale, as they deemed the first two items to be more appropriate for screening exposure to VT (Aparicio et al., 2013).

This is the first known COSMIN review of VT and STS outcome measures used within the healthcare professional population. Previous research on the STSS scale had suggested that the STSS scale was preferrable for use with nurses over the ProQOL (Watts & Robertson, 2015) as at the time there was limited research on its psychometric rigour. This review's results do not fall in line with these findings as based on the COSMIN criteria the STSS and its subscales were not found to be recommended for use. Furthermore, the review also highlighted that a 3-factor structure was insufficient, suggesting that compassion satisfaction, STS and burnout overlap. Instead, when tested in isolation the STS subscale of the ProQOL-5 showed sufficient psychometric quality for structure, internal consistency and construct validity.

There were a number of limitations in the studies reviewed. Firstly, there were a limited number of eligible articles identified for review, with the included studies being distributed unequally amongst the identified outcome measures. Thus, evidence for the outcomes measures was unfairly weighted. Secondly, Aparicio et al. (2013) altered the VTS scale in their assessment of its psychometric properties, therefore, the conclusions drawn in this review only relate to the six-items it examined. Also, the evidence identified on the

CFST (Figley, 1995a) may be considered irrelevant as this measure is considered to be an earlier version of the ProQOL-5 (Stamm, 2010b). Nonetheless, if research does use these measures with healthcare professionals, they may want to consider the current lack of psychometric rigor identified in this review.

The review process was not without its flaws. Most notably the rating of studies' results was conducted in majority by one reviewer alone and is not in line with the recommended two raters as advised by the COSMIN manual (Mokkink et al., 2024). As such, caution should be taken when interpreting the strength of these results. Future reviews may want to address this by establishing a review team of experts to conduct the review jointly to strengthen the conclusions made.

They may also consider including qualitative studies in their search strategy to better capture data on the content validity of the outcome measures, which is considered the most important psychometric property (Prinsen et al., 2018). It is notable that early concept studies for both STSS (Bride, 2002) and Trauma Work Impact Scale (Van De Water, 1996) did not utilise qualitative methods to evaluate their measures. Instead, content validity was assumed based on feedback from experts, and a review of the existing literature. This suggests that the inclusion of qualitative methods in measure development could be an important step forward in this field.

Additionally, the COSMIN criteria for good measurement properties does not currently provide criteria for rating internal consistency in IRT studies, or those that assess reliability using Omega (Mokkink et al., 2024). Therefore, studies that included such data were unable to be rated or considered in the summarised results. Furthermore, as aforementioned, it was not possible to assess two of the identified outcome measures due to accessibility of papers providing details of their characteristics. Therefore, the results should be taken in light of this, as such it is unknown how psychometrically sound, they are.

However, the mere fact that an original copy of these measures could not be located would suggest a lack of feasibility, rendering them impractical for future use. Additionally, no eligible articles were identified for the TABs outcome measure that has been used historically to assess VT (Pearlman, 2003). Thus it is unclear whether this measure can be recommended for use.

Lastly, this review did not set out to directly address cross-cultural validity, one of the named psychometric properties of the COSMIN-tool. The outcome measures in this review were used in several countries including the UK, US, Australia, Canada and Singapore. Some have also been translated to many different languages i.e. ProQOL-5 (Stamm, 2010b). Therefore, the cross-cultural utility of the outcome measures could be explored in future reviews considering the implication of VT and STS is not limited to healthcare professionals in the United Kingdom or those who understand English.

Implications for practice, policy, and future research

The lack of validity identified in this review may explain why there is existing confusion in the literature about how best to operationalise these terms (Branson, 2019) and why the measures are used inconsistently between the two constructs. Nevertheless, it still remains unclear if VT and STS are different and distinct phenomena. This is further clouded by the term compassion fatigue, which when initially introduced was thought to be an interchangeable term to STS (Figley, 1995a). Yet the ProQOL-5 (Stamm, 2010b) measure suggests that STS is one component of CF alongside its second component, burnout. Thus, it would be important for future research to critically appraise the content validity of measures claiming to assess these constructs.

Another implication is that the STSS measure (Bride, 2002; Bride et al., 2004) is not recommend for use, instead its psychometric properties should continue to be evaluated in

future studies with focus given to its content and structural validity. This is especially important given that the measure was developed based on DSM-IV criteria for PTSD symptomology (Bride, 2002) and the latest DSM-V criteria for PTSD could be argued to incorporate STS as it now includes indirect exposure to traumatic experiences (American Psychiatric Association, 2022). Therefore, the utility of STSS measure may be limited, and the construct may be better assessed by measures of PTSD.

Overall, the early contributors to the field highlighted the potential costs to providing care by identifying the constructs STS and VT (Figley, 1995b; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). These terms are important in naming the experience some healthcare professionals will face during their career. However, to accurately evaluate the existence and impact of these phenomena psychometrically, sound outcome measures are required. This review highlighted that there was a lack of strong psychometric evidence based on the COSMIN criteria in the reviewed outcome measures. None of the measures assessing VT could be recommended for use and only one of the STS measures met the threshold for sufficient properties, the STS subscale of the ProQOL-5. Despite this, using the STS subscale in isolation is not recommended (Stamm, 2010b). Therefore, there is a need for further research investigating the psychometric quality of outcome measures designed to assess VT and STS as currently the current psychometric quality of the available measures' risks threatening the validity of research findings.

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Service Improvement Project

Title: Understanding the experience of mental health self-disclosure within a Gender Identity Clinic

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Submission Date: Hilary Term 2025

Proposed Journal: Psychology of Sexual Orientation and Gender Diversity

This journal has been chosen due to its focus on gender diversity in relation to various aspects of life including healthcare. Author submission guidelines are presented in appendix 2.1.

Abstract

Minimal research exists on the experience of disclosing mental health difficulties to healthcare professionals working within Gender Identity Clinics (GICs). This study aimed to understand the barriers and facilitators of mental health disclosure experienced by service-users at a GIC in England. Six semi-structured interviews were completed between November 2022 and June 2023. The interviews were analysed using Interpretative Phenomenological Analysis (IPA). Four superordinate themes were interpreted from the data: *Facing and overcoming challenges in accessing gender care*; *The journey to the true self*: *Who have I been and who I am now?; The flow of power, and creating personal agency,* and *The true lived experience of the Gender Clinic*. The themes revealed multiple barriers in the pursuit of gender-affirming healthcare. They reflect participants' views on power, self-identity and the GIC's strengths/limitations. These findings are related to existing literature on disclosure and healthcare barriers. Recommendations were generated, including greater service-user involvement in the development of care-plans, clearer definition of terminology, and increased accessibility to the GIC through person-centred approaches.

Keywords: *Gender Identity Clinic, gender dysphoria, mental health, self-disclosure*

Introduction

Transgender and gender non-conforming (TGNC) are terms used to describe individuals whose gender identity (one's internal sense of self as male, female or other) is incongruent with their sex assigned at birth (American Psychiatric Association, 2013). Gender Dysphoria (GD) is the psychological distress which results from the incongruence between a person's sex and their gender identity. People experiencing GD typically pursue gender-affirming healthcare, such as medical and surgical treatments, aimed at aligning one's body with their gender identity. Within England, gender-affirming healthcare can be sought from a gender identity clinic (GIC). Currently in England's National Health Service (NHS) there are seven specialist adult GICs; they offer assessment, diagnosis, and treatment (NHS England, 2023). GICs are in high demand and wait times are around 4-5 years for a first appointment (NHS, 2023).

TGNC people are more likely to experience mental health difficulties (e.g. anxiety/depression) when compared to non-TGNC groups ((Murphy et al., 2020; Stonewall, 2018; Su et al., 2016). Higher rates of mental health difficulties in the TGNC population may be related to the experience of GD and minority stress (Ellis et al., 2015; Meyer, 1995, 2003). This theory posits that individuals from a minority group with a felt sense of difference, in this case gender identity, experience higher levels of psychological distress created by fear of prejudice and discrimination (Puckett et al., 2020). Mental health difficulties are therefore a common concern for TGNC people, warranting additional support.

TGNC individuals face barriers when accessing healthcare systems. Barriers include lack of knowledgeable clinicians (Hines et al., 2019; Wright et al., 2021), lack of holistic care (Wright et al., 2021), and prejudice/discrimination (Cicero et al., 2019; Costa et al., 2018; Gonzales & Henning-Smith, 2017). This has resulted in service-users withholding information related to their gender expression (the way one publicly indicates their gender)

and their mental health, to avoid compromising access to gender-affirming healthcare (Ellis et al., 2015; Taylor et al., 2019).

Mental health should not prevent individuals from receiving gender-affirming healthcare (Coleman et al., 2022). Importantly, experiences of gender identity affirmation and a stronger trans identity have been associated with greater wellbeing (Doyle et al., 2021). However, GD service guidelines stipulate to access gender-affirming healthcare, health conditions like mental illness should be "reasonably well-controlled" (NHS England, 2013, p. 16). The term reasonably-well controlled is not clearly defined although guidance specifies that treatment of co-existing mental health difficulties may need to be incorporated into the care-plan (Coleman et al., 2012). The lack of practical guidance suggests there is more to be understood about TGNC peoples' experience of mental health difficulties and access of GICs. For the GIC to be aware of individuals' mental health difficulties, disclosure to healthcare professionals is required. As GICs now accept self-referrals they may rely more on self-disclosure (NHS England, 2023), instead of accessing this information through service-users' healthcare records. This was apparent for the GIC involved in the project who found some individuals who accessed the psychology service had not disclosed their mental health needs to other healthcare professionals at the GIC. Furthermore~~However~~, little is known about how, when, and to whom service-users self-disclose mental health whilst accessing a GIC, and what helps and hinders this process.

Disclosure is an ongoing social process that involves continual decision-making primarily focused on goal-attainment (Chaudoir & Fisher, 2010). As such, disclosure has many levels between disclosure and non-disclosure (Rüsch & Kösters, 2021). The decision to voluntarily disclose involves consideration of costs and benefits (Corrigan & Matthews, 2009). Benefits of mental health disclosure include alleviating psychological distress, facilitating help-seeking, and increasing social acceptance and support (Corrigan et al., 2014;

Mayer et al., 2021). Costs include stigma (Rüsch et al., 2014), loss of jobs, social avoidance, and harm (Grice et al., 2018).

Stigma can be a challenge for TGNC individuals and those with mental health difficulties (Oexle & Corrigan, 2018). Research suggests that stigma could lead to mental health concealment to avoid potential costs of disclosing (Clement et al., 2015). In this context, perceived costs of mental health disclosure may include increased prejudice, delayed care, or treatment denial. However, it remains unclear what barriers and facilitators are experienced by GIC service-users when disclosing their mental health needs.

Service Context

The GIC is one of the seven national gender services in the UK. The Psychology Service within the GIC identified that some of their service-users who were experiencing mental health difficulties had not previously disclosed this information to other professionals during their period of care. Additionally, a mental health service within the NHS Trust shared feedback highlighted service-users' concern that if they were to disclose their mental health needs to the GIC their experience of gender dysphoria would not be taken seriously and gender-affirming health care would be denied. This was confirmed by service-users who had already accessed treatment at the GIC, who in consultation during the project development shared that they had not disclosed their mental health needs to GIC professionals due to concerns that their treatment would be denied.

Rationale

The present study aimed to better understand experiences of mental health self-disclosure within the ~~a~~ GIC to inform clinical and theoretical developments. It aimed to answer the following research questions:

- What are service users' experiences of mental health disclosure to healthcare professionals at a GIC?
- What are the barriers and facilitators to mental health disclosure?
- How can service-users who have disclosed their diagnosed mental health condition be supported throughout their gender transition journey?

Method

Design

A semi-structured interview design employing interpretive phenomenological analysis (IPA) (Smith et al., 2009) was used.

Participants

The below eligibility criteria were adopted following consultation with service-users and healthcare professionals at the GIC:

- Aged over 17 years.
- Transgender (inclusive of non-binary identities).
- Receiving treatment at the GIC and undergoing hormone therapy for at least 6 months.
- Diagnosed mental health condition that had been disclosed to a GIC professional.
- Access to Microsoft Teams
- English speaking

Procedure

The project was peer reviewed by the host institution's NHS Research and Development team (appendix 2.2). The study information was emailed to potential participants; in turn they

expressed interest. Participant information sheets and consent forms were provided electronically (appendix 2.3). A screening questionnaire was adopted to ensure the criteria was met (appendix 2.4). Recruitment and interviews took place between November 2022 and June 2023. Interview questions were developed with service-users and the research team. Statements were used to provide context and prompts to aid responses (Table 2.1). Interviews were held on Microsoft Teams, audio recorded and transcribed verbatim. Demographic data was collected at the start of the interview.

Table 2.1

Sample of Interview Questions.

Questions, prompts, and statements.
Questions
• What led you to take part in this service improvement project?
• Could you tell me about your experience of information sharing from the Gender Clinic?
• Could you tell me about a time when you told someone in the Gender Clinic about your mental health condition? *(The first time, a time that it went well, a time that it didn't go so well)*
Prompts
• How did you tell someone about your mental health condition?
• What was that like?
Statements
• Now I would like to ask you some questions about your experience of the Gender

Clinic after you told a professional about your mental health condition.

Analysis

Transcripts were analysed using IPA and followed the stages outlined by Smith et al. (2009) (Table 2.2). This was an iterative process; the stages were followed for each transcript before cross-case analysis.

Table 2.2.

IPA Analysis Stages

Stage	Overview
1	Reading and relistening to each interview transcript to familiarise self, noting initial responses to the text.
2	Exploratory descriptive, linguistic, and conceptual notes were then formulated to describe the participant's experiences.
3	Exploratory notes were used to develop participant's experiential statements. These are a succinct summary of the quotes and narrative in the transcript.
4	Experiential statements were then compiled and clustered to identify emergent themes.
5	Personal experiential themes were named from the clustered statements to represent the convergence identified amongst the experiential statements.
6	Thematic patterns were explored through a cross-case analysis to identify superordinate and subordinate themes.

Positioning Statement

The first author is a White British cis-gendered female and acknowledges a critical realist position (Willig, 2016), as such conclusions are considered one potential interpretation on participants' lived experience and were influenced by the research team's subjectivity. The team acknowledge clinical and research interests in understanding stigma within minoritized groups. The first author was completing her doctoral training in Clinical Psychology at the time of the project. The other two authors are qualified Clinical Psychologists, both of whom identify as White British, cis-gendered males, one with professional experience of working therapeutically and conducting research with TGNC people, and one with particular interest in IPA methodology.

To ensure credibility, validity checks were completed throughout the research process. Bracketing interviews were completed to elicit any preconceived ideas that may have influenced the narrative and interpretation of the data (Rolls & Relf, 2006). User involvement continued throughout the project, with the initial research question, interview schedule and initial proposed themes all being discussed with trans individuals.

Results

Six interviews were completed; participants included those identifying as transgender and non-binary (Table 2.3). All self-identified as having a diagnosed mental health condition.

Table 2.3.

Overview of Key Demographic Details

Participant Demographics	Number of participants
Gender	
Transgender Male	3
Transgender Female	1

Non-binary	2
Sex Assigned at Birth	
Male	3
Female	2
Prefer not to say	1
Age in years	
20-30	4
31-40	1
41-50	1
Ethnicity	
White (English, Welsh, Scottish, Northern Irish or British, Irish, Gypsy or Irish Traveller, Roma or any other White background)	5
Asian or Asian British (Indian, Pakistani, Bangladeshi, Chinese or any other Asian background)	1
Number of approx. years accessing the Gender Identity Clinic	
1-3	1
4-6	4
7-9	1
Self-Reported Mental Health Diagnosis	
	Anxiety comorbid with depression

Depression

Anorexia Nervosa

Emotionally Unstable Personality disorder

Data Analysis

Four superordinate themes were interpreted from the data: 1. *Facing and overcoming challenges in accessing Gender Care*, 2. *The journey to the true self*: *who have I been and who I am now?*, 3. *The flow of power and creating personal agency* and 4. *The true lived experience of the Gender Clinic*. Participant's endorsement of the superordinate and subordinate themes can be viewed in Table 2.4.

Table 2.4.

Participant Endorsement of Themes

SUPERORDINATE AND SUBORDINATE THEMES	**Total**	**Sophia**	**Blake**	**Tao**	**Alex**	**Dennis**	**R**
1. Facing and Overcoming Challenges in Accessing Gender Care							
1a. Mental Health as a barrier to Gender-affirming Care	4	•	•	•			•
1b. Practical difficulties	2			•			•
1c. Other obstacles to gender-affirming care	3			•	•	•	
1d. Factors perceived to facilitate access and disclosure	4	•			•	•	•
1.e Anticipating future challenges	2				•	•	
2. The Journey to the True Self: Who have I been and who I am now?							
2a. Questioning self-identity	2		•		•		
2b. Discovering self-identity and	4	•	•		•	•	

acceptance							
2d. The influence of others	3	•	•			•	
3. The flow of power and creating personal agency							
3a. Noticing the power held by the gender clinic	3		•	•			•
3b. Lack of personal power	3	•	•				•
3c. Self as powerful	4	•	•		•		•
4. The true lived experience of the Gender Clinic							
4a. Limits to provision of care	4	•	•	•	•		
4b. Discovering service strengths and personal values	6	•	•	•	•	•	•
4c. Differences in expectations and reality	3			•	•	•	

Overview of themes

Each superordinate's subtheme will be explored in turn alongside direct quotations. Table 2.5 provides additional quotes for each theme (appendix 2.5).

Facing and overcoming challenges in accessing gender care

This theme highlights the barriers participants faced and future difficulties they anticipated. Furthermore, it describes the strategies some participants adopted to increase their chances of obtaining gender-affirming healthcare.

Mental Health as a barrier to Gender-affirming Care

Note pseudonym participant names are used throughout.

Mental health was considered a barrier to gender-affirming healthcare. Tao described his existing knowledge of gender-affirming healthcare as not enough to “know how much I should disclose”. This implied a fear of sharing mental health information that could impact access to gender-affirming healthcare. R also shared how he anticipated that disclosure would affect his access to hormone therapy if he were “fully honest” with the GIC. The importance of access to hormones and fear that treatment would be denied was echoed by Blake. This challenge spoke to the participants’ motivation to receive medical intervention to reduce GD, whereby the uncertainty experienced, and lack of information on the service criteria led them to conceal.

Sophia indicated that following disclosure she was further assessed to ensure there were no “psychotic mental health problems” that might lead to “an illusory state of me being trans”. Sarcasm was used to imply mental health difficulties triggered professionals to question her transgender identity. Participants appeared to convey treatment was the priority which they were not willing to jeopardise.

Practical difficulties

Beyond mental health, Tao and R faced practical difficulties such as long journeys for appointments, which was deemed a cost to accessing the GIC. Tao and R referenced that appointments were “short” leading them to question their worth. The GIC was described as difficult to contact, R: “was quite hard to get in contact with anyone”. These experiences highlight the practical challenges faced in accessing a UK GIC. It further highlights the effort required from service-users to attend appointments which can vary depending on existing resources.

Other obstacles to gender care

Three participants faced additional barriers. For example, Tao described how “autism” perhaps led him to “always tell them that I’m fine”, suggesting that his communication needs were missed. This further implies participants expected the GIC to know them well enough to facilitate effective communication and maximise their potential.

This sense that the GIC holds responsibility was further emphasised by Alex as they believed attending appointments would immediately resolve their GD: “I'll wake up completely different and cured of all my ills”. This illustrated a passive approach to accessing the GIC insinuating that healthcare professionals alone could resolve their distress.

Alex also described how they experienced difficulties in accessing surgical intervention which they related to their non-binary identity: "He basically said you won't get surgery because you don't identify as a binary trans female.". This suggests that GICs may hold a limited view on what gender-affirming healthcare might include for different gender identities.

Factors perceived to facilitate access and disclosure

In response to the challenges participants found strategies to cope and manage. This was illustrated by R who stated a need to be “strategic” which he achieved by presenting as “healthy”. He feared that if the GIC knew the truth “they would probably not let me get the surgery". This suggested R believed he gained access to gender-affirming healthcare by minimising his mental health. The language used indicated that R saw this as his only option.

Conversely, Dennis described openness and honesty about mental health as crucial to accessing gender-affirming healthcare "If you can't do that, you're not gonna get anywhere ". Sophia suggested “trust” in the GIC facilitated her mental health disclosure. This was aided by a perceived “cultural shift” in society’s openness to talk about mental health. Importantly she implied a desire for the GIC to have a greater understanding of the impact GD had on her. This reflects the role relational and societal factors played in the decision-making process of what was disclosed and to whom.

Anticipating future challenges

Participants also hypothesised that future service-users would experience difficulties in accessing gender-affirming healthcare. Alex suggested that TGNC people may present as binary to achieve their transition goals (line 665-66). Similarly, Dennis expressed their concern for how those without a support network would cope with the increasing wait time: " I do worry about people that are on their own". This theme reflects the empathy that service-users have for those waiting to access the GIC.

The superordinate theme highlights the significant role anticipated stigma and its consequence had on some participants’ disclosure decision-making. Anticipated stigma led some people to actively conceal parts of their experience to facilitate acceptance, whilst others took the opposite approach and were honest about their mental health diagnoses. This seemed to be facilitated by trusting relationships with healthcare professionals.

The journey to the true self: who have I been and who I am now?

This theme encapsulated most of the participants' journey in understanding themselves. It represents the multiple identities people have over time, how one's sense of self is integrated and the desire to be accepted.

Questioning self-identity

For Alex and Blake, the journey started with a questioning of their identity. Both described feeling as though they were not "trans enough". Blake appeared to suggest that healthcare professionals would question his identity because he had a mental health diagnosis. Alex's questioning of their identity resulted in a pause in their transition journey; they suggested the reason they did not feel better was, "because I'm not trans". However, they acknowledged that substance misuse may have played a role in how they felt. This suggests that accessing the GIC repeats the internal questioning one experiences when exploring their gender identity.

Discovering Self-identity and self-acceptance

Several participants spoke of how access to gender-affirming healthcare led to a revealing of who they are. For example, Blake shared that hormone therapy enabled him to see himself as who he was "underneath". Medical intervention appeared to create congruence in their gender identity increasing self-acceptance and reducing concern over 'passing'. Sophia also described acceptance from the GIC, stating it was a "magical thing".

The influence of others

This theme recognises the role others play in identity formation and self-acceptance, with many participants seeking to feel understood. For Sophia, the GIC provided a place for them to be their true self without doubt or worry for the repercussions of this “generally reassured me that the way that I am now is okay”. However, Dennis illustrated that they know themselves best "I live myself inside” suggesting that it is not possible for the GIC to know and understand all parts of them. Overall, this superordinate theme demonstrates how one’s gender identity forms, adapts, and is influenced by others over time.

The flow of power and creating personal agency

This theme illustrates participants’ experiences of being in a position they considered as powerless, and how they created and found power within a system they saw as having control. All participants spoke about recognising their position relative to healthcare professionals or cis-gendered individuals.

Noticing the power held by the gender clinic

Tao talked to the power the GIC held in society which enabled their social and legal transition. Others reflected on their experience of healthcare professionals having the final say in the access of surgical interventions. Blake: “two freaking doctors to sign off on everything” and R said, “part of it was like, assess me and see if that I was like in the right mind to like, make the decision”. This suggested the service procedures limited service-user’s power. This was further emphasised by Tao who stated, “nobody else in the entire country can help”. This sense that only the GIC could help was echoed by Sophia.

Lack of personal power

“your body is kind of going in the wrong direction and there's nothing you can do to stop it on your own” Sophia.

Sophia highlighted how crucial GICs were in her transition goals as they provided gender-affirming healthcare. This demonstrates the little perceived power she alone had in reducing her gender incongruence. Blake implied his power was less than gender-conforming individuals, “because a woman can go and get a boob job and she doesn’t need to have no psych assessment”. Whilst these procedures are arguably different, the bold statement Blake made accentuates the sense of injustice felt by service-users.

R described how he didn’t have a choice about sharing his mental health difficulties; "I had to talk”. He suggests that this information was used to decide whether he had the capacity to make treatment decisions. The lack of choice in disclosing was further evidenced by Blake who suggested his disclosure stemmed from a belief that the GIC already had existing knowledge of his mental health status.

Self as powerful

Despite this, participants described strategies they adopted to create power. For Sophia this involved being a “fully compliant” service-user to achieve her priority of addressing “gender dysphoria” because it made her “suicidal”. Others like R predetermined what information they were going to share with the clinic, choosing not to disclose matters they did not see as “relevant to the treatment”. Alex similarly decided on a set approach, noting “I’m taking quite a stubborn approach” which they~~he~~ achieved by sharing their~~his~~ non-binary identity. Overall, this summarises how participants established control by deciding how to present themselves to the GIC.

The true lived experience of the Gender Clinic

This theme begins to acknowledge the positive experiences found through accessing the GIC. Participants talked to discovering their values in the care they received and more widely. Some appeared to conclude that whilst they value a holistic care approach there are limitations to the GIC's capacity to achieve this.

Limits to the provision of care

All participants described a limit to the care provided by the GIC acknowledging that it is a specialist gender service. Therefore, professionals could not be all knowing. Alex: "they you know, can only probe so much". Tao also said he is "a gender specialist not a psychologist or therapist" illustrating how different professionals meet different needs.

Others appeared to want a holistic approach. Blake shared that he felt the healthcare professionals didn't want to "understand me as a person"". Instead, he felt the process was about "whether or not I tick the box of the criteria". R likewise described contact with the GIC as "very like transactional" and perhaps "insensitive" towards their mental health recovery needs. However, for Tao having a private counsellor to support his mental health needs seemed to be a positive experience. This illustrates how service criteria and procedures can be interpreted by service-users.

Sophia and Alex spoke to their awareness of the GIC being in high demand. Sophia: "they're oversubscribed" and Alex noted: an "8 month wait". Many suggested that the GIC could streamline services to reduce the wait times offering suggestions such as same-day appointments from the different healthcare professionals.

Lastly, Alex seemed to feel let down as they perceived the NHS to lack support for their transition goals. Although Alex appeared sensitive to the potential reasoning for the GIC to

be hesitant in supporting them “I think they're scared of making quite decisive decisions about things because they don't want me to change my mind’.

Discovering service strengths and personal values

All participants spoke to aspects of care they valued that ultimately influenced their experience of the GIC. Sophia, Tao, and Alex spoke of feeling understood by the GIC, which differs to some of the experiences discussed earlier. Sophia described the GIC as people “who understood” and made her feel like a “normal person”. Alex also felt “understood” and Tao felt that every challenge he raised had a “response whether there were solutions or not” suggesting he felt listened to.

R spoke to the value of others raising the topic of mental health they described this as “nice” perhaps insinuating a sense of relief. They also implied ~~-~~it had not been made explicit that it was “safe” (R) for them to talk openly about their mental health. This perhaps suggests that boundaries around disclosure, and consequences of such are unclear for service-users.

Differences in expectations and reality

Others were surprised by their experience, Tao said, “there weren't many like gate keeping stuff” and Dennis found the GIC were responsive to their non-binary identity. Ultimately the experience differed from what they anticipated based on online sources like Reddit.

Alex implied that the GIC could infer their mental health needs “it was obvious right from the beginning that there was more going on” and “they would have had an idea” suggesting that it was perhaps apparent to the GIC that they~~he~~ were~~as~~ concealing their~~his~~

substance misuse difficulties. However, from their~~his~~ experience this did not appear to be the actual case.

Overall, this superordinate theme highlights the stark difference in individuals' experiences of GD and treatment needs. However, nearly all participants desired being understood and accepted indicating the importance of a flexible approach that is suited to understanding the service-user.

Table 2.5.

Supporting Participant Quotes

THEME 1: Facing and overcoming challenges in accessing Gender Care	
1a. Mental Health as a barrier to Gender-affirming Care	
Sophia	"The mental health condition did get in the way even early on, trying to access the gender clinic."
Blake	"So it's almost like trying to, you know, try to tread a tight rope because in order to get treatment, you need to show you how your discomfort and you need to show that you're unhappy yourself. But then if you're not, if you're too unhappy or not, what, like, really unwell, then all of a sudden, no, we can't support you because you need to be stable. So I think it is a bit of a balancing act."
1b. Practical difficulties	
Tao	"So I had like, huge trouble attending the appointments themselves. That's kind of part or large part of the reason why I was discharged subsequently."
R	"think just the fact that I've been asked them so many times before. I guess it would have been. It would have been nice for that information to kind of get carried over from my previous clinics? But I also understand that like they

	need for their own records to like hear it from me or whatever”
1c. Other obstacles to gender-affirming care	
Tao	“they really didn't connect with what my needs were umm or trying to dig deeper into it”
Alex	“the NHS as a whole seems to be flawed by the fact that. And I think they seem to be quite. Uh, not confused, but they don't really know how to manage people who have kind of a a non-binary identity”
Dennis	“one of the doctors had suggested, you know well, "why are you not fully transitioning?" Well, that's my decision that I don't want to fully transition. Because fully transition part of it is it's, so I'm I'm not well enough really to be perfectly honest.”
1d. Factors perceived to facilitate access and disclosure	
Alex	“that's why I lied, because I was petrified of not having support because there's still quite a lot of negativity around GICs”
R	“And I was so used to like answering questions that that it was like very rehearsed for me”
1e. Anticipating future challenges	
Alex	"they all feel that they need to present in a way that gets them the results that they want”
	“I think trans people probably will be in danger of making decisions because they don't want to lose that support”
Dennis	“Yeah, the I think another another thing when another problem with it is is is with other things on the Internet now is so accessible, isn't it? So people like, even if you're waiting like if you go and REDDIT or or on the Internet or whatever and and look up say [Location] waiting times or whatever it comes

	up and then you got people moaning and moaning and moaning.”
THEME 2: The journey to the true self: who have I been and who I am now?	
2a. Questioning self-identity	
Blake	"are they gonna think I'm trans enough? Am I gonna be, you know? Or they gonna see that as because I'm not trans enough because I've got mental health problem and well, because I'm autistic, therefore I can't be trans and I don't know my own self."
Alex	"well, I'm obviously not feeling any better because I'm not trans and I didn't think that actually, it was the fact that I hadn't stopped drinking was making me feel really ropey"
2b. Discovering self-identity and acceptance	
Blake	"once you start hormones, you start seeing yourself in the way that you you saw yourself before as such, like underneath then you feel a lot more confident in yourself and you fit in when you go to a bathroom or an area use of, you know, same-sex spaces"
Alex	"I don't think that you should deny me what support I think need, because I know how I feel when I'm in the shower and I know how my life is and I'm I know that I'm lonely."
Dennis	“Yeah I like to sit in the middle. I'm happy where I am. But I've needed some medical treatments from them or whatever to get my mind and myself in in the right space.”
2c. The influence of others	
Sophia	“But prior to accessing the gender clinic, other clinicians in the NHS certainly wouldn't, were nowhere near as understanding as that.”
Blake	"I'm sorry if somebody does have EUPD, let's say that's gonna mean

	different things to different people. And unfortunately, when I was like, they've already made an assumption as to what that was for me, without me even telling them"
Dennis	"They don't understand. They don't know what you're going through. They don't, you know? OK, their doctors and their GPS or whatever. They don't, they don't fully understand what you're going through."
THEME 3: The flow of power and creating personal agency	
3a. Noticing the power held by the gender clinic	
Tao	“Also like changing my name on my BRP. Although it took me a year for it to be approved with the government, but then those the letter was is there was really helpful”.
R	"I don't remember them saying telling me that it was like a safe place for me to be honest. I guess. Umm. And maybe they thought that was a given."
3b. Lack of personal power	
Sophia	“And hmm yeah, it was, yeah, just really difficult, emotionally painful and to the point where, you know, I couldn't, I couldn't take it. So I had to go private with the gender GP just to get started on hormones kind of in the meantime. Ummm until I finally was seen by the general clinic”
Blake	“I knew I couldn't lie because it they're gonna have all my my medical medical records in front of them."
R	"I think I wouldn't be able to like bring it up on my own accord."
3c. Self as powerful	
Sophia	“I'm going to just be fully compliant with them because without a doubt, hands down, gender dysphoria was the number one priority in my life thing to address like without a shadow, shadow of a doubt. And umm I knew. I

	mean it made me suicidal, so, I knew that I had to take it seriously and so I just wanted to be fully cooperative and umm to to do it properly.”
Alex	“I'm taking quite, I'm quite taking quite a stubborn approach and just saying this exactly who I am”
R	“I haven't talked to him about my ADHD but I don't think it's relevant to the treatment. So that's fine.”
THEME 4: The true lived experience of the Gender Clinic	
4a. Limits to provision of care	
Blake	"So for me, what's been frustrating is the fact that you always need two freaking doctors to sign off on everything because one doctor would say yes, and then you then have to wait another six months before you see somebody else. Umm. So I think that could be streamlined a lot better as well"
Tao	“the fact that they don't really know how long those referrals might take and they themselves are not really familiar with the procedures they are referring to us too”
Alex	“[Gender Clinic] only know as much as I tell them I guess”
R	“So yeah, that that was that was also frustrating and kind of felt like I could make that whole trip and do do a little more at a time, like maybe see the endocrinologist and then do the physical straight away if that was like a that was a green light from the endocrinologist”
4b. Discovering Service Strengths and Personal Values	
Alex	“And plenty of other people gave up on me, but [GIC Name] didn't”
Dennis	“So he was actually very, very knowledgeable and it was actually I found that quite uh quite reassuring you know.”
R	“I don't remember them saying telling me that it was like a safe place for me

	to be honest”
4c. Differences in expectations and reality	
Tao	“there weren't many like gate keeping stuff”
Dennis	“And you read it online and people ohh, you know, they're not interested in people like like myself. And that they only want to deal what I said like male, female, female to male and I er man, they are so wrong”

Discussion

The superordinate themes encapsulate the barriers and facilitators TGNC faced in the active or passive decision to disclose their mental health diagnosis to healthcare professionals at the GIC. Theme one depicts the main obstacles people faced, or anticipated, when accessing the GIC. It highlighted the strategies adopted to meet their treatment goals. Theme two reflected the questioning of one’s identity that was raised in the process of accessing the GIC. The experience often led to an uncovering or rediscovering of the self and the desire to be accepted. It also illustrated how others were involved in defining one’s self-identity. Theme three addressed the different types of power differences experienced by service-users, and their attempts to utilise the power they had by controlling how they presented to, and what they shared with the GIC. Theme four conveyed the ups and downs of accessing the service and how everyone had their own needs, but all were ultimately seeking to feel understood and respected as to who they were.

Disclosure decisions have been hypothesised as being made based on approach and avoidance-focused goals (Chaudoir & Fisher, 2010). This was evident in participants’ narratives, for most the overarching goal was to gain access to gender-affirming healthcare.

For some mental health disclosure was viewed as moving them closer to this goal by fostering understanding from healthcare professionals. Whilst others avoided disclosure as they anticipated that it would prolong their wait for gender-affirming healthcare by raising doubt to their experience of GD.

Furthermore, mental health stigma often prevents help-seeking due to fear of potential consequences (Corrigan et al., 2014), with disclosure concerns being the most commonly reported internalised stigma barrier (Clement et al., 2015). This was evident throughout the data; from mental health being an actual or perceived barrier, or the opposite where participants chose to conceal aspects of their mental health experience as a strategy to gain access to gender-affirming healthcare.

Participants' experiences appeared to be influenced by their interactions with the healthcare professionals beyond their access to gender-affirming healthcare. Those who felt heard and understood spoke more highly of their overall GIC experience. These findings mirror that of Howell and Maguire (2023) who found healthcare interactions strongly influenced the experience of transgender people pursuing gender-affirming healthcare. The interactions with professionals appeared to shape and support the exploration and development of individuals self-identity in relation to their gender, and mental health. Being accepted by the GIC seemed to generate self-acceptance, and confidence.

Additional barriers discussed by participants included limits to the care provision provided by the GIC. Previous research suggested that lack of knowledgeable clinicians and lack of a holistic approach were barriers to gender-affirming healthcare (Hines et al., 2019; Wright et

al., 2021). Whilst participants acknowledged this in their narratives, they also appeared to be sympathetic to the clinician's position; particularly that they could not be all knowing. Though others found the lack of knowledge surrounding mental health and more broadly the needs/desires of TGNC people led professionals to misunderstand their experiences. Moreover, there was a sense that professionals were directed by the existing policies and treatment pathways which perhaps were favourable to binary gender identities.

Overall, the present study identified barriers and facilitators to mental health disclosure and more generally to accessing the GIC. The following recommendations are provided to enhance the experience of TGNC individuals with mental health conditions disclosing their needs to healthcare professionals. It is hoped that this can lead to improvements that will benefit TGNC individuals seeking to access gender-affirming healthcare at the GIC.

The possible service recommendations to be considered can be found in Table 2.6.

Table 2.6.

Service Recommendations

Recommendations	**Related themes, theories and literature.**
Recommendation one. Healthcare professionals to work with service-users and policy makers to provide a clear definition of what having "reasonable well controlled" mental health condition means. This is hoped to support both healthcare professionals	This recommendation was generated from themes one and three, as participants highlighted a lack of transparency with what would or would not prevent access to gender-affirming care. It is also supported by guidance on the incorporation of mental

and service-users when working with individuals experiencing mental health conditions in addition to GD. Though it is acknowledged that the impact of mental health on the individual may need to be evaluated on a case-by-case basis in addition to any guidance to ensure person-centred care.

Recommendation two.

To continue to develop healthcare professionals' understanding of how different treatments and service may resolve the gender incongruence and GD experienced by different TGNC individuals. This may be supported further by *recommendation four*.

Recommendation three.

Healthcare professionals to continue to develop and create safe spaces for mental health disclosure to occur through the strengthening of interpersonal skills, as Howell and Maguire (2023) found interactions with professionals to have a strong influence on individuals' health needs into individuals care-plans (Coleman et al., 2012).

This is of particular importance to themes one and three as some service-users described concealing parts of their identity or withholding information about their experience of GD due to fear of, or actual, rejection from the service. Further, previous literature suggested clinicians' lack of knowledge and non-holistic approaches could act as barriers to care (Hines et al., 2019; Wright et al., 2021).

This related to themes one and two whereby service-users described a fear that their transgender identity would be questioned once their mental health diagnosis was revealed, and others highlighted the importance of acceptance and safety allowing them to share their mental health needs with

experiences.	professionals.
Recommendation four. If possible, employ and involve more peer support workers who are able to share experiences with newer service-users which may challenge any preconceived negative expectations of the service. Alternatively, share feedback from service-users on the experience of disclosure, in an attempt to reduce the anxiety and anticipated stigma surrounding mental health disclosure.	This is supported by the findings of themes one, two and four; in particular the anticipated stigma most participants referred to in disclosing their mental health needs (consistent with existing disclosure literature (Corrigan et al., 2013)), as well as some describing a positive difference in how the professionals and wider service responded to them.
Recommendation five. To continue seeking service-user involvement in the development of individualised care plans, particularly considering communication and access needs. More broadly services-users to contribute to the development of service care pathways.	This recommendation is supported by themes one and four. By having autonomy over their care-plan and/or pathway this could support individuals to develop a strong trans-identity and move closer to an affirmed identity, improving overall wellbeing (Doyle et al., 2021).
Recommendation six. Recruit an individual to be a Mental Health Services lead. This may help to develop and foster connections with other NHS Trusts healthcare services, or charity organisations.	This recommendation aligned with theme four and would aim to move towards a more holistic approach to healthcare acknowledging previously highlighted barriers to gender-affirming healthcare

This would aim to provide healthcare professionals and service-users with relevant knowledge of local mental health support available to them, as well as an understanding of referral systems.	(Wright et al., 2021).

Limitations

The conclusions drawn from this study are not without their limitations. The findings relate to individuals who have disclosed their mental health diagnoses to the GIC and may not generalise to those who have not disclosed their mental health status. Additionally, some differences were noted in the experience of those with a transgender and non-binary identity. Therefore, a larger sample may have enabled clear similarities or differences in these groups to emerge through the themes. It is important to acknowledge that whilst participants spoke of aspects of care that they valued, they spoke more to the challenges of the GIC. This may be reflective of the lack of understanding of how mental health difficulties impact GD or vice versa, as well as what it means for mental health to be "reasonably well controlled".

Furthermore, the recommendations generated from this project do not contain directly measurable targets for change and improvement. Currently, any improvements based on the recommendations will rely on feedback from the service and its service users. The ability to track the outcomes of the recommendations may have been improved with an audit, or baseline measurement. Thus, future improvement projects in the GIC could gather baseline

data before implementing recommendations and reassess following the implementation of recommendations. Baseline data for this project could have included: the number of service users who had disclosed their mental health status; an audit of how mental health needs are incorporated into care plans; an assessment of professionals' knowledge of TGNC individuals' experiences of gender dysphoria; and an evaluation of professionals' confidence in exploring clients' mental health needs and referral processes. Finally, when implementing any recommendations, it is acknowledged that the wider context of the GIC's service policies and procedures will need to be considered alongside the political climate to ensure service-user needs are addressed in a sensitive manner.

Conclusions

The current study aimed to explore service-users' experiences of mental health disclosure to healthcare professionals at a GIC. Recommendations were developed in line with the themes and existing literature. They are focused on increasing service-user involvement in the development of treatment pathways, increasing understanding of mental health within the TGNC population, and improving healthcare professional and service-user relations. These aim to support the service in reducing the barriers to mental health self-disclosure, and to improve overall experience of the GIC.

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Theory Driven Research Project

Title: The influence of stigma on PTSD symptom severity and help-seeking intentions in mental health staff experiencing workplace trauma

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This journal was chosen due to its focus on mental health nursing practice and professional issues. The journal's submission guidelines are available in appendix 3.1.

Abstract

Research suggests that negative appraisals predict post-traumatic stress symptoms and play a role in their maintenance. Some research also suggests an association between self-stigma and trauma symptoms exists. However, these relationships have not been explored amongst mental health professionals working in inpatient psychiatric services. Employees in this context are exposed to high levels of violence and are at greater risk of developing post-traumatic stress disorder (PTSD). Moreover, professionals have expressed that potentially stigmatising narratives exist in the workplace. Therefore, the main aim of this study was to investigate the relationship between negative appraisals, anticipatory stigma, self-stigma and post-traumatic stress symptom severity (PTSS) amongst mental health professionals over time. Stigma had also been identified as a barrier to help-seeking in research on correctional officers, and qualitatively in mental health professionals. As such, a secondary aim was to explore the possible relationship between stigma and help-seeking intentions. Thirty-three participants completed survey one, and thirteen completed survey two. The results indicated high levels of negative appraisals amongst participants, and PTSS was indicative of probable PTSD. Analyses suggested that negative appraisals predicted PTSS. However, stigma did not appear to predict PTSS or help-seeking intentions in this study. The findings indicate the importance of targeting negative appraisals in interventions for this group. Future studies are encouraged to further explore the possible role stigma plays in predicting PTSS and help-seeking ee in sufficiently powered studies.

Keywords: workplace trauma, stigma, post-traumatic stress, help-seeking, mental health professionals.

Introduction

Understanding the cognitive mechanisms that maintain post-traumatic stress disorder (PTSD) symptoms in mental health staff following workplace trauma is important to inform interventions and increase staff's help-seeking intentions. It can also help inform healthcare strategies, policies, and procedures to support those exposed to traumatic incidents in their workplace. Cognitive models of PTSD have identified negative appraisals of the trauma event and its sequalae as key in predicting the maintenance of symptoms (Ehlers & Clark, 2000). However, research to date has yet to explore the possible role of stigmatising cognitions, specifically anticipatory and self-stigma beliefs, in the maintenance of PTSD symptoms following workplace trauma amongst mental health professionals. Preliminary research shows that stigma has been associated with PTSD symptoms in samples of veterans and UK adults (Bonfils et al., 2018; Lewis et al., 2022), thus it is important to understand whether a similar relationship exists between stigma and PTSD amongst mental health professionals. This study aimed to identify whether negative appraisals, including anticipatory stigma and self-stigma, are predictive of (i) post-traumatic symptom severity (PTSS) and (ii) help-seeking intentions in mental health professionals who have experienced workplace trauma.

Background Literature

Workplace violence is common within healthcare settings and rates of violence are higher in psychiatric units compared to other healthcare settings (Liu et al., 2019; Mento et al., 2020). Exposure to workplace violence is potentially traumatising and can lead to detrimental psychological impacts such as stress, reduction in sense of safety, anxiety and PTSD for nursing staff (Edward et al., 2014; Edward et al., 2016; Schuster & Dwyer, 2020; Tonso et al., 2016). Furthermore, qualitative accounts from mental health staff working in a forensic

personality disorder unit indicate a broad range of consequences of workplace violence including intrusive images, memories, emotional detachment, avoidance and rumination (Mistry et al., 2021). Other consequences included impact on the therapeutic relationship, such as anger, frustration, and avoidance of the patient (Mistry et al., 2021).

Critically, workplace trauma has led to the development of PTSD symptoms amongst those working in forensic and mental health settings (Finklestein et al., 2015; Jacobowitz, 2013; Lauvrud et al., 2009; Lee et al., 2015). PTSD symptoms include re-experiencing the event, avoidance of trauma-related factors, changes in mood and cognitions, and interrupted sleep (American Psychiatric Association & Association, 2013). PTSD prevalence rates in nursing staff are varied; rates range from 8.5% to 20.8% of nurses meeting the full criteria for PTSD (Schuster & Dwyer, 2020). The PTSD prevalence rates among nurses are higher in comparison to those cited in a representative sample from inner London, 5.5% (Frissa et al., 2013). Thus, highlighting PTSD is a professional concern.

Gender, chronic workplace stressors, cumulative exposure, workload and working in a forensic psychiatric unit are predictors of PTSD amongst mental health staff (Hilton et al., 2022; Hilton et al., 2020; Rodrigues, Ham, Hilton, et al., 2021). Research by Newman et al. (2021) indicates that forensic mental health staff who experience mild or multiple forms of workplace trauma over a prolonged period, or are exposed to severe incidents, are likely to be at increased risk of physical injury, psychological stress, physiological symptoms and absenteeism.

Negative Appraisals of the trauma event

The cognitive model of PTSD stipulates that PTSD develops from the cognitive processing that occurs during a traumatic event, that leads to feelings of current threat (Ehlers & Clark, 2000). Symptoms of trauma are said to persist as a result of the individuals' appraisal of the

trauma and its sequalae (Ehlers & Clark, 2000). Critically, negative appraisals lead individuals to engage in unhelpful coping strategies that prevent the negative appraisals and trauma memories from changing (Freeman et al., 2013). Many studies have found a consistent relationship between negative appraisals and PTSD symptoms regardless of population or trauma type (Dunmore et al., 2001; Foa et al., 1999; Halligan et al., 2003). Specifically, negative appraisals about the self, the world, and others were found to predict and maintain PTSD symptomology (Beierl et al., 2020; Brown et al., 2019; Dunmore et al., 2001; Foa et al., 1999){Brown, 2019 #396;Abu Khait, 2022 #369}. NICE recommends trauma-focused CBT as the treatment for PTSD (National Institute for Health and Care Excellence, 2018). It has been found to lead to a significant decrease in unhelpful trauma appraisals and PTSD symptoms across the course of treatment, with changes in appraisals predicting symptom change (Kleim et al., 2013). Taken together research suggests that negative appraisals are key in the persistence and treatment of PTSD symptoms.

Additionally, self-stigma is prevalent amongst those experiencing PTSD (Bonfils et al., 2018; Lewis et al., 2022) and it has been found to be associated with increased risk of lifetime and current PTSD and greater symptom severity (Lewis et al., 2022; Schneider et al., 2018). Self-stigma is the internalisation of other people's negative attitudes and beliefs of a particular attribute/phenomena such as mental illness (Corrigan, 2004; Link et al., 1989). It is associated with a loss of positive beliefs about oneself following identity transformation (Yanos et al., 2008). PTSD and self-stigma are conceptually alike, sharing similarities in their cognitive, affective and behavioural symptoms (Benfer et al., 2023). For example, they are both centred on negative appraisal (Benfer et al., 2023), which may explain their cooccurrence (Lewis et al., 2022). Therefore, self-stigmatising appraisals may play a role in predicting the persistence of PTSD symptoms over time.

Research has indicated that prior to the development of self-stigma individuals may go through a process of anticipating stigma; which can increase feelings of shame and embarrassment leading to the internalisation of stigma (Corrigan & Watson, 2002). There are specific cognitions relating to the appraisal of workplace trauma/its sequalae evident within the qualitative healthcare literature that appear to reflect anticipatory stigma; one's belief that others will and do hold stigmatising or negative attitudes about one's condition (Corrigan et al., 2009). These cognitions often suggest that "violence is part of the job" (Rodrigues, Ham, Kirsh, et al., 2021), with many psychiatric nurses underreporting traumatic events out of concern that their experiences will not be taken seriously (Arnetz et al., 2015; Hilton et al., 2021; Rodrigues, Ham, Kirsh, et al., 2021). Furthermore, nurses express that their colleagues and workplace have minimised the impact of traumatic events, invalidating their reactions (Cranage & Foster, 2022; Hilton et al., 2021; Rodrigues, Ham, Kirsh, et al., 2021). These cognitions illustrate how staff working in inpatient psychiatric settings anticipate others' responses towards them following a traumatic experience, such as the expectation to cope. Critically the role of these types of cognitions (anticipatory stigma) have not been explored in relation to PTSD.

Help-seeking Intentions

To access PTSD treatment, individuals need to seek professional help. Cornally and McCarthy (2011) defined help-seeking as "a problem focused, planned behaviour, involving interpersonal interaction with a selected health-care professional". However, psychiatric staff exposed to workplace trauma who met the cut-off for probable PTSD, anxiety or depression perceived more barriers to help-seeking (Seto et al., 2020).

Research suggests that stigma is a barrier to accessing mental health support because individuals are less likely to access services to avoid the negative consequences of being labelled (Corrigan et al., 2014; Link et al., 1989). Similar themes exist in research on

correction officers and emergency workers, whereby stigma within the workplace was an identified barrier to help-seeking (Auth et al., 2022; Wills et al., 2021). Specifically, officers feared that by seeking help they would be considered unsafe to do their jobs (Wills et al., 2021). Critically, psychiatric staff described not seeking help due to fear of being labelled as weak and not able to cope by their colleagues (Rodrigues, Ham, Kirsh, et al., 2021). Thus, nursing staff who anticipate and endorse stigmatising cognitions following workplace trauma may have fewer intentions to seek-help. In turn their PTSD symptoms may remain unchanged, contributing to poor psychological health, negative impacts on their therapeutic relationships, and staff absenteeism (Mistry et al., 2021; Newman et al., 2021).

Present Research

This study aimed to identify whether anticipatory and self-stigma beliefs were predictive of PTSD following workplace trauma. Additionally, the relationship between stigma and help-seeking intention had not been quantitatively explored in this population. However, it is important for understanding how to best support staff following workplace trauma in mental health settings, and potential barriers to treatment. Consequently, the study also aimed to explore whether anticipatory and self-stigma are predictive of staff intentions to seek-help following workplace trauma.

Hypotheses

H1. Negative post-traumatic cognitions about the self, others, and the world will predict PTSD symptom severity, and over time.

H2. Anticipatory stigma beliefs will predict greater post-traumatic symptom severity beyond that of negative appraisals, and over time.

H3. Self-stigma will predict greater post-traumatic symptom severity beyond that of negative appraisals, and over time.

Exploratory hypotheses

H4. Anticipatory stigma beliefs will predict lower help-seeking intentions, and over time.

H5. Self-stigma will predict lower help-seeking intentions, and over time.

Methodology

Design

This study had a within-group repeated-measures design. Ethical approval was received from the University of Oxford Research Ethics Committee (reference: R89110; appendix 3.2)).

Participants

A priori power analysis indicated a sample size of 77 was required to detect a medium effect ($F^2 = 0.15$) with 80% power and $\alpha = .05$. To allow for a 20% attrition rate the target sample size was 91.

Sixty-two individuals were recruited online via social media (Instagram, Facebook, X, and LinkedIn) between July and December 2024. The research team also approached healthcare services and professionals via email, X or LinkedIn with a request to share the study details share the study's advert with their professional networks (appendix 3.32). For example, a Facebook group for psychologists' working in inpatient settings in the UK were contacted and study details shared within the group. The main researcher also identified professionals via LinkedIn and the British Psychological Society website and contacted those who had work experience in UK acute mental health/forensic settings. Potential participants could then access the study via the link provided in the advert description or the poster's QR code (appendix 3.4).. No financial incentives were offered to advertise or participate in the study.

Of the 62 participants, five were excluded as they did not meet the final inclusion criteria.

Final Inclusion Criteria:

- Aged 18 and over.
- A current UK based student or qualified mental healthcare professional. This included for example, nurses, healthcare assistants, support workers, therapists, psychologists, counsellors and occupational therapists or assistants.
- Trained in physical intervention and restraint.
- Currently working in a UK mental health/psychiatric inpatient setting or had worked in this setting within the last six months
- At least one exposure (direct/indirect) to workplace violence whilst working in a psychiatric inpatient setting. This included death, threatened death, actual or threatened serious injury or actual or threatened sexual violence, actual or threatened racial violence.
- Exposure to traumatic incident occurred within the work context and at least one month ago but no more than 6 months ago.
- English speaking.

Recruitment originally targeted forensic mental health staff, however, due low recruitment rates this was expanded to include all mental health staff working within inpatient psychiatric wards. The rationale for recruiting forensic mental health staff originally was due to greater exposure to potentially traumatic events (Newman et al., 2021), however, research indicates it is likely mental health staff in inpatient psychiatric wards are exposed to traumatic workplace events, therefore the inclusion criteria were expanded.

Procedure

Participants accessed the online study via the web-link/QR code provided in the study advertisement. After providing informed consent, participants provided their email address and created a unique ID code before completing the measures in survey one in the order detailed in Table 3.1. Approximately two months after completing survey one, participants were sent up to 3 email reminders to complete survey two via the web-link provided. At the start of survey two participants were asked to enter their unique identifier code. All participants were shown signposting and debriefing information, either at the end of the measures or following the eligibility questions if they did not meet the inclusion criteria.

Table 3.1.

Measures completed at each time-point in the specified order

Survey one:	Survey two:
1. **Demographic Details**	1. **Workplace Trauma History**
2. **Workplace Trauma History**	2. **PTSS**
3. **Negative appraisals**	3. **Help-seeking intentions**
4. **Anticipatory stigma**	
5. **Self-stigma**	
6. **PTSS**	
7. Help-seeking intentions	

Measures

Participants completed the following measures. All measures were assessed for internal consistency Cronbach's α scores ranged between 0.7 – 0.94 suggesting sufficient reliability for each scale (appendix 3.53).

Demographics

Demographic questions included age, gender, ethnicity, and inclusion criteria questions (e.g. Do you currently work in an inpatient forensic and/or mental health service?).

Workplace Trauma History

Participants were asked to report the frequency, and the type of traumatic events experienced (directly or indirectly/witnessed) in the workplace in the past 6 months (appendix 3.64). To ascertain the frequency of incidents in survey two participants were asked to indicate the number of incidents, if any, they had experienced since the completion of survey one. Questions were informed by the DSM-5 criteria of PTSD, and experts by experience. Participants were ~~also~~ asked to provide an in the moment threat rating for their most recent potentially traumatic experience "How great do you think the danger was that you/others would actually be harmed?". This was scored on a five-point scale (1, none; 2, small; 3, moderate; 4, great; 5, overwhelming).

Negative Appraisals

The Post Traumatic Cognitions Inventory (PTCI; (Foa et al., 1999) consists of 36 statements focused on assessing negative appraisals about the self, the world, and self-blame from 1 (*totally disagree*) to 7 (*totally agree*). A total score was calculated, and interpreted in line with Foa et al. (1999), with scores under 45 indicating no trauma, scores of 49 and above representing traumatised participants without PTSD, and scores of 133 and above representing traumatised participants with PTSD.

Anticipatory Stigma

The concerns about stigma in the workplace subscale from the Endorsed and Anticipatory Stigma Inventory (EASI) was used to measure anticipatory stigma (Vogt et al., 2014). The subscale contains 8-items that participants rated on a 5-point-likert scale ranging from 1, strongly disagree to 5 strongly agree. A total score was calculated with higher scores reflecting greater stigmatising beliefs.

Self-stigma

Self-stigma was captured through the Internalised Stigma of Mental Illness Scale 9 (ISMIS-9; (Hammer & Toland, 2017). Participants rated whether they strongly disagree (1), disagree (2), agree (3), or strongly agree (4) with each of the 9 items. For example, “stereotypes about the mentally ill apply to me”. A mean score was calculated with higher scores indicating higher internalised stigma. Scores can be split into two categories with scores between 1.00-2.50 indicating high internalised stigma is not reported and those that fall between 2.51-4.00 are reporting high internalised stigma (Ritsher & Phelan, 2004).

PTSS

PTSS was measured using the PLC-5 (Weathers et al., 2013). Participants were asked to rate how bothered they had been in the past month by each of the 20-items, on a 5-point Likert scale, from 0 not at all, to 4 extremely. A total score was calculated with, higher scores indicating greater symptom severity, with a cut-off score of 31 and above indicating probable PTSD (Bovin et al., 2016).

Help-seeking intentions

Help-seeking intention was measured using an adapted version of the ‘General Help-Seeking Questionnaire’ (Wilson et al., 2005). The instructions were adapted to focus on help-seeking from professional sources only (Mental health professional/GP/Helpline/Other professional listed/I would not seek help from anyone). Responses ranged from 1, extremely unlikely, to 7, extremely likely. Responses for the statement “I would not seek help from anyone” were reverse coded. A total score was calculated, with higher scores representing greater intentions to seek help.

Data Analyses

To test whether negative appraisals and different types of stigma were related to post-trauma symptom severity, a hierarchical regression was conducted with negative appraisals (H1), anticipatory stigma, and self-stigma as predictors (H2 and H3), and PTSS (survey one) as the outcome. Gender and number of incidents were entered as control variables. The original plan was to use PTSS from survey two as the outcome with PTSS from survey one as a control variable. Due to the low response rate only the data from survey one was used for the main analysis.

To assess the relationship between stigma and help-seeking (H4 and H5), both stigma variables were entered into a separate hierarchical regression as predictors with help-seeking intentions as the outcome. Gender and number of incidents were control variables.

As the original analysis plan included using survey two data for outcome measures (PTSS and help-seeking), available data was analysed. Given the small amount of data, standardised coefficients were evaluated, rather than p-values. All assumptions for analyses were checked and were mostly met. There was a minor violation of normality for help-seeking intentions, however, it was deemed to be approximate enough and correlations between independent variables were below 0.8. See table 3.2 for correlations between variables. Pearson's correlations ranged from -0.143 to 0.793 across all included variables. The majority of correlations were positive, however, the correlations between the stigma variables and help-seeking intentions were negative.

Table 3.2.

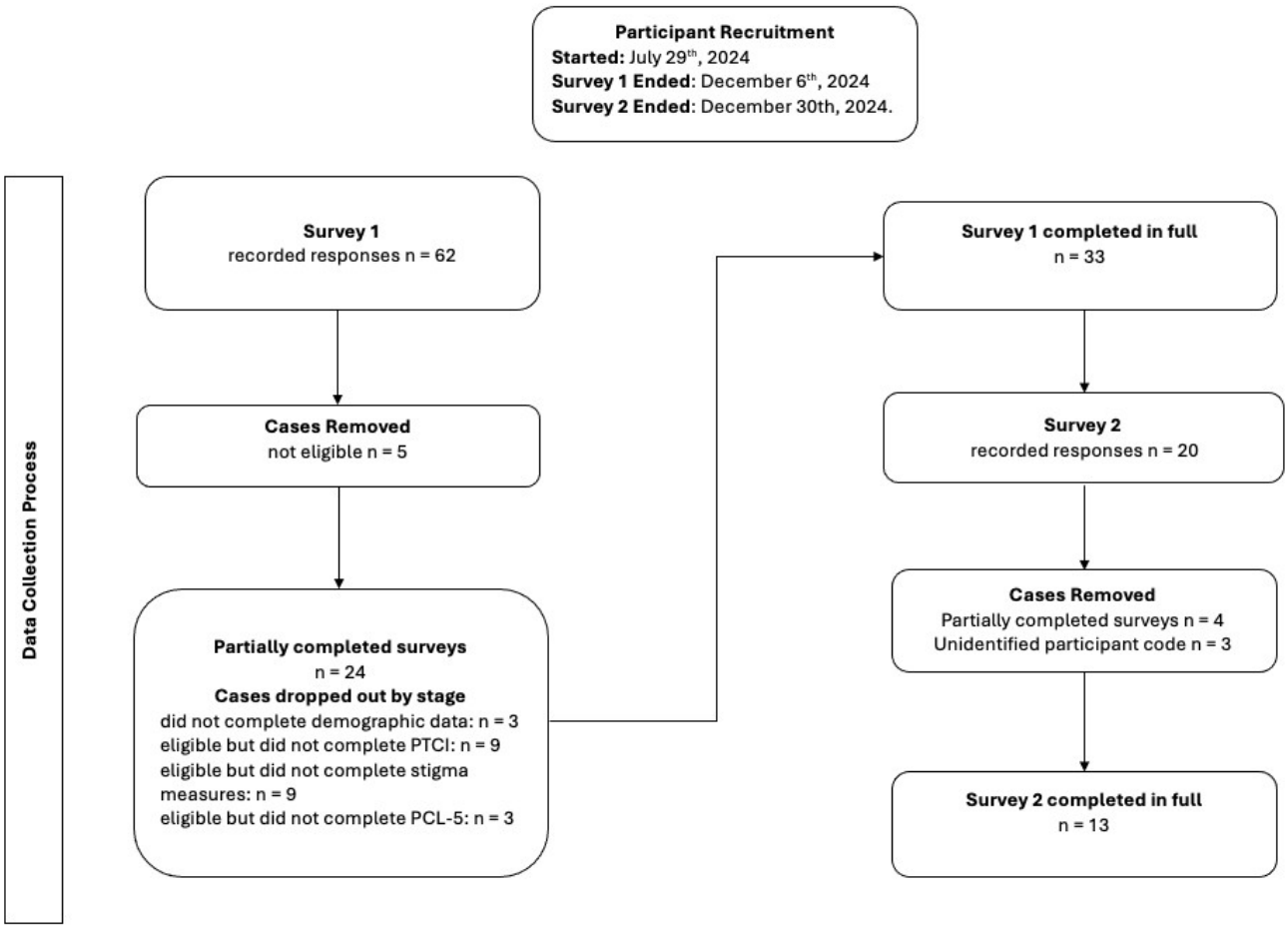
Correlation Matrix of Predictor and Outcome Variables

	Negative appraisals	**Anticipated stigma**	**Internalised stigma**	**PTSS (survey one)**	**Help-seeking intentions (survey one)**	**PTSS (survey two)**	**Help-seeking intentions (survey two)**
Negative appraisals	-	0.459	0.793	0.688	-	0.509	-
Anticipated stigma	0.459	-	0.509	0.403	-0.143	0.435	-0.217
Internalised stigma	0.793	0.509	-	0.715	-0.371	0.635	-0.488
PTSS (survey one)	0.688	0.466	0.715	-	-	0.466	-
Help-seeking intentions (survey one)	-	-0.143	-0.371	-	-	-	0.619
PTSS (survey two)	0.509	0.435	0.635	0.466		-	
Help-seeking intentions (Survey two)	-			-	0.619		-

Results

A dropout rate of 42.1% was observed, see Figure 1 for details. A total of 33 participants completed survey one in full. Participant characteristics for survey one and two are displayed in Table 3.3.

Figure 1. Data Collection Process



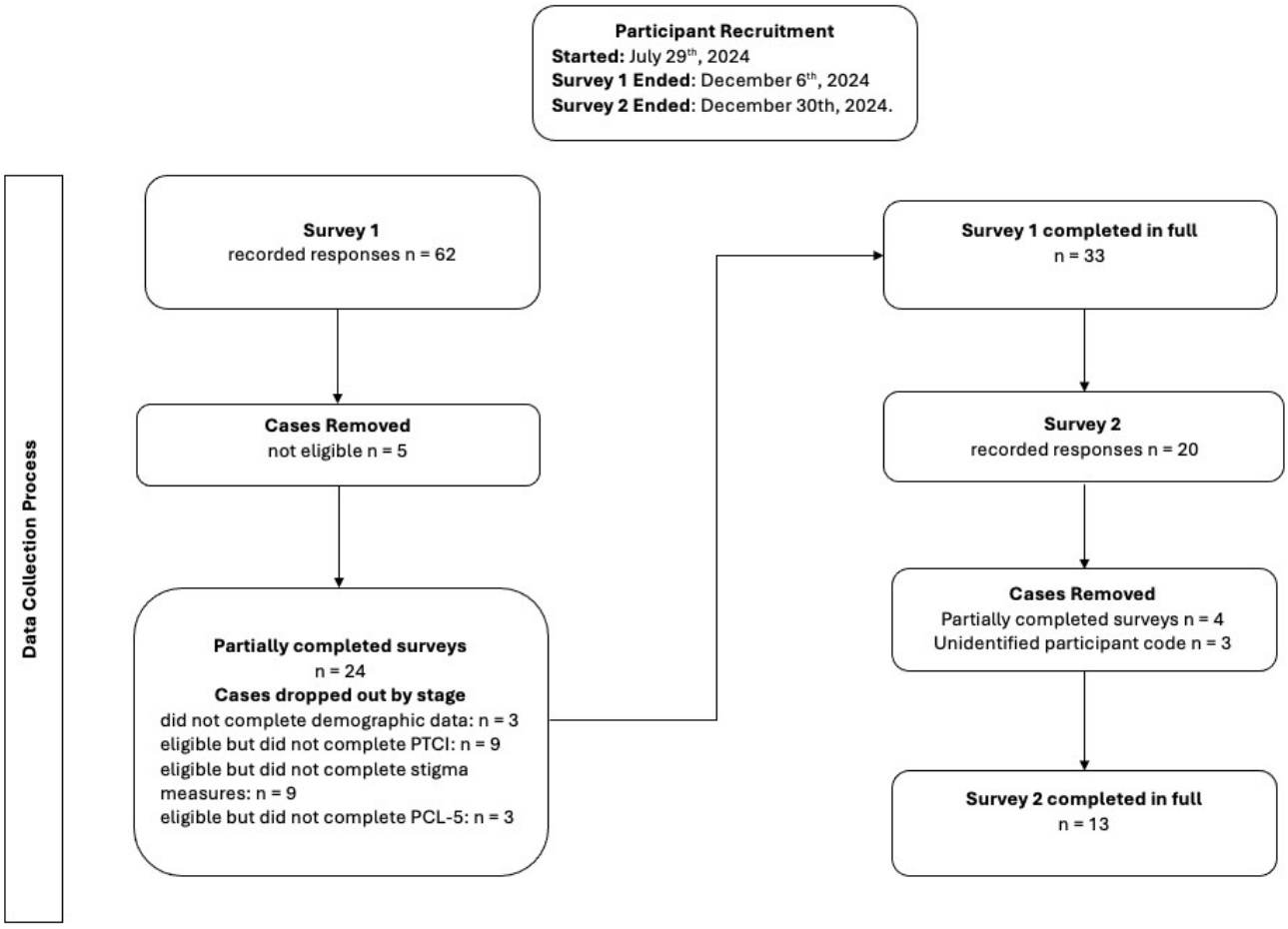


Table 3.3.

Participant Characteristics for Survey One and Two

	All Participants	Survey One	Survey Two

			Completed	Completed
		(n=57)	**(n=33)**	**(n=13))**
Age	Mean	31.4	32.15	32.62
(years)	Standard Deviation	7.58	7.57	8.81
Gender	Female	50	30	11
(n)	Male	7	3	2
Ethnicity	White	51	29	11
(n)	Black/African/Caribbean	2	1	0
	Asian	2	1	0
	Mixed	1	1	1
	Other	1	1	1
Work Environment (n)	Inpatient Mental Health	25	15	4
	Inpatient Forensic Mental Health			
	Worked in either or both within the last 6 months.	21	13	8
		11	5	1
Job Role	Registered Nurse	23	13	4
(n)	Student Nurse	3	1	0
	Occupational Therapist	1	1	0
	Occupational Therapy Assistant	2	0	0
	Healthcare Assistant	9	6	3
	Support Worker	4	2	0
	Psychologist	3	3	1
	Trainee Psychologist	2	2	1
	Assistant Psychologist	9	4	3
	Psychiatrist	1	1	1

Length of	Less than 1 year	2	1	1
service within	1-10 years	46	27	9
psychiatric	11-20 years	6	4	3
services	20 + years	3	1	0
(n)				[1]

Descriptive Statistics

Overall 66.6% of the participants reported experiencing over 10 incidents in the past 6-months. Table 3.4 displays the type of incidents experienced. 'Other' types of incidents included actual and threated use of weapons, spitting, psychological abuse, self-harm and false allegations (appendix 3.75). Between survey one and two, 10 participants experienced on average between 1-10 further incidents including all types of incidents. The average rating for the likelihood the incident would cause them harm was 3 for survey one and two.

For survey one, negative appraisal (PTCI) scores were suggestive of individuals who experienced trauma (Foa et al. (1999). Self-stigma scores did not indicate high internalised stigma in survey one, however, survey two results indicated high internalised stigma (Ritsher & Phelan, 2004). PTSS scores across both surveys were suggestive of probable PTSD as scores were above the cut-off of 31 (Bovin et al., 2016). PTSS decreased between survey one and two, and help-seeking intentions slightly increased (see table 3.5).

Table 3.4.

[1] The demographics of those who dropped out of survey one wwasas compared where possible to the included participants who completed it. N and there were no significant obvious differences in demographic variables were observed. Therefore, participants appeared to dropout at random.

Types of incidents experienced by participants

	Survey One Frequency (%)	Survey Two Frequency (%)
Type of incident		
Death or threatened death	47.3%	38.5%
Actual or threatened serious injury	98.2%	84.6%
Actual or threatened sexual violence	43.6%	23.1%
Actual or threatened racial violence	72.7%	46.2%
Other	18.2%	7.7%
In the moment threat rating		
5	9.1%	7.7%
4	30.3%	0%
3	36.4%	61.5%
2	21.2%	23.1%
1	3.0%	7.7%

Table 3.5.

Mean scores on Measures for Survey One and Two

Questionnaire	Survey 1 (n=33)	Survey 2 (n=13)
Negative Appraisals		
M(*SD*)	94.36(*29.89*)	-
Anticipated stigma		
M(*SD*)	18.58(*6.88*)	-
Self-stigma		
M(*SD*)	2.45(*0.45*)	-
PTSS		
M(*SD*)	47.24(*16.43*)	32.85(*8.86*)
Help-Seeking Intentions		
M(*SD*)	17.70(*4.55*)	18.08(*4.23*)

Regression Analyses – survey one

Results of the hierarchical regression testingTo address hypotheses 1-3 two separate multiple hierarchal regressions were completed. The first regression was on survey one data only to investigate the relationship between negative appraisals, stigma variables and PTSS at the time of survey one. ,The first regression analyses showed that the control variables did not explain significant variance in PTSS (survey one) (R^2_{adj} = .02, F(2, 32) = 1.26 p = .299). Adding negative appraisals to the model explained 42% of the variance in PTSS (survey one) (R^2_{adj} = .42, F(3, 29) = 8.73 p < .001). Negative appraisals were a significant positive predictor of PTSS (survey one); β = .67, t(29) = 4.68, p <.001, whilst controlling for gender and number of incidents experienced. Whilst the model remained significant when entering

both stigma variables (R^2_{adj} = .38, F(5, 27) = 5.08 p = .002), neither anticipated stigma or self-stigma made a significant contribution to the final model (β = -0.96, t (27) = -0.65, p = .52; β = 0.06, t(27) = 0.35, p = .73, respectivelyrefer to Table 3.6 for coefficient values). Negative appraisals remained a significant positive predictor in the final model (β = .67, t(27) = 3.48, p <.05). See Table 3.6 below for details of the regression coefficients and calculated power for each variable in the models.

Table 3.6

Hierarchal Multiple Regression predicting post-traumatic stress symptoms in survey one

	Variables	**Unstandardized Coefficients**		**95% Confidence Interval**	**Standardized Coefficients**	***t***	***p***	***Power achieved***
		B	*SE*		β			
Model 1								
	Gender	-9.21	9.94	[-29.51,11.09]	-.16	-.93	.36	-
	Number of Incidents	2.20	1.58	[-1.04,5.43]	.25	1.39	.18	-
Model 2								
	Gender	-8.89	7.63	[24.49,6.71]	-.16	-1.17	.25	-
	Number of Incidents	.11	1.30	[-2.54,2.76]	.01	.09	.93	-

	Negative Appraisals	.37	.080	[.21,.53]	.67	4.68	<.001	0.99
Model 3								
	Gender	-8.58	7.87	[-24.72,7.57]	-.15	-1.09	.29	-
	Number of Incidents	-.040	1.37	[-2.85,2.77]	-.004	-.03	.98	-
	Negative Appraisals	.37	.11	[.15,.58]	.67	3.48	.002	0.86
	Anticipated Stigma	-.230	.35	[-.95,.50]	-.096	-.65	.52	0.07
	Self-Stigma	2.24	6.41	[-10.91,15.39]	.06	.35	.73	0.05

A second hierarchical regression was computed to explore the relationship between negative appraisals, stigma variables and PTSS over time (H1-H3). A regression model examined whether negative appraisals, anticipated and self-stigma as measured at survey one predicted PTSS on survey two, whilst controlling for gender, number of incidents and PTSS at survey one. The model containing the control variables was not significant (R^2_{adj} = .021, F(4,8) = 1.064 p = .43). The results indicated that after accounting for gender, number of incidents experienced, and PTSS (survey one), negative appraisals did not make a significant contribution to explaining PTSS (survey two) (β = .41, t(7) = .938 , p = .38, the model was not significant (R^2_{adj} = .006, F(5,7) = 1.014 p = .48). The final model including the stigma variables (anticipated β = -.063, t(5) = -.114 , p = .914 and self-stigma β =.396 , t(5)= .523, p = .623) was not significant (R^2_{adj} = -.31, F(7,5) = 0.60 p = .74).

The A third hierarchal regression examineding hypotheses 4 and 5 to ascertain whether stigma significantly predicted lower intentions to seek-help at the time of survey one. The regression analysis, found that the control variables alone were not significant in predicting help-seeking intentions (survey one), (R^2_{adj} = -.07, F(4,28) = 0.51 p = .73 ()see Table 3.7 for details of the variable coefficients in each model). The model remained non-significant when stigma variables were added (R^2_{adj} =-.07, F(4,28) = 0.51 p = .73), neither type of stigma significantly predicted help-seeking intentions (anticipated β = -.13, t(28) = -.71, p= .486 and self-stigma β = -.175 , t(28) = -.922 , p = .364), whilst controlling for gender and number of incidents experienced.

Regression Analyses - survey one and two

Table 3.7

Hierarchical Multiple Regression predicting help-seeking intentions in survey one from anticipated and self-stigma.

	Variables	**Unstandardized Coefficients**		**95% Confidence Interval**	**Standardized Coefficients**	***t***	***p***	***Power achieved***
		B	*SE*		*β*			
Model 1								
	Gender	-.62	2.85	[-6.44, 5.20]	-.40	-.22	.83	-
	Number of Incidents	-.20	.45	[-1.13, .73]	-.80	-.44	.66	-

Model 2							
Gender	-.37	2.87	[-6.24, 5.51]	-.02	-.13	.90	-
Number of Incidents	-.18	.47	[-1.13, .77]	-.07	-.39	.70	-
Anticipated Stigma	-.09	.13	[-.35, .17]	-.13	-.71	.49	0.09
Self-Stigma	-1.76	1.91	[-5.68, 2.15]	-.18	-.92	.36	0.12

The regression analyses above were repeated using the available survey two data. The first examined whether negative appraisals, anticipated and self-stigma from survey one predicted PTSS on survey two, whilst controlling for gender, number of incidents and PTSS at survey one. The model containing the control variables only was not significant (R^2_{adj} = .021, F(4,8) = 1.064 p = .43). The results indicated that after accounting for gender, number of incidents experienced, and PTSS (survey one), negative appraisals did not make a significant contribution to explaining PTSS (survey two) scores (β = .41, t(7) = .938 , p = .38, the model was not significant (R^2_{adj} = .006, F(5,7) = 1.014 p = .48). The final model including the stigma variables (anticipated β = -.063, t(5) = -.114 , p = .914 and self-stigma β =.396 , t(5)= .523, p = .623) were not significant (R^2_{adj} = -.31, F(7,5) = 0.60 p = .74).

AThe final hierarchical regression explored whether stigma variables were related to lower help-seeking intentions over time (H4 & H5). The model assessed whether anticipated and self-stigma from survey one predicted help-seeking intentions in survey two whilst controlling for gender, number of incidents and help-seeking intentions from at survey one. .

None of the control variables significantly predicted help-seeking intentions (survey two), thus the model with control variables only was not significant (R^2_{adj} = .207, F(4,8) = 1.78 p = .226). The model remined non-significant when the stigma measures variables were added (R^2_{adj} = .137, F(6,6) = .679 p = .373), neither anticipated (β = -.125, t(6) = -.331 , p = .752) or self-stigma (β = .279, t(6) = -.798, p = .455)were significant predictors of help-seeking intentions (survey two) (anticipated β = -.125, t(6) = -.331 , p = .752 and self-stigma β = .279, t(6) = -.798, p = .455).

Discussion

Firstly, the study aimed to investigate whether negative appraisals, anticipated and self-stigma predicted PTSS amongst mental health professionals working in inpatient psychiatric services and whether this relationship was evident over time (H1). The relationship between anticipated stigma and self-stigma was explored to identify whether these factors contributed to symptom severity as well as that of existing negative appraisals. The results revealed that negative appraisals predicted PTSS in survey one data (H1). This is in line with similar findings on the significance of negative appraisals in relation to PTSD symptomology (Dunmore et al., 2001; Foa et al., 1999; Halligan et al., 2003). Moreover, as outlined in H1 it was hypothesised that negative appraisals would also predict PTSS over time. TWhile these results were not significant. Thus, H1 was partially supported as negative appraisals were a significant predictor of PTSS at the time of survey 1, but not overtime. This is somewhat in line with previous research that found negative appraisals were significant predictors of PTSD andTherefore, the current study results are unable to provide support for previous research that suggested negative appraisals were a significant contributor to the its

maintenance of trauma symptoms overtime (Beierl et al., 2020; Brown et al., 2019; Dunmore et al., 2001; Foa et al., 1999).

H2 and H3 proposed that anticipated and self-stigma would predict PTSS beyond that of negative appraisals at survey one and over timeAdditionally, . tThe relationship between anticipated stigma and self-stigma was explored to identify whether these factors contributed to PTSD symptom severity as well as that of existing negative appraisals. Therefore, H2 and H3 proposed that anticipated and self-stigma would predict PTSS beyond that of negative appraisals at survey one and over time. The results indicated that neither anticipated or self-stigma held a significant relationship with PTSS, nor did they appear to predict PTSS over time. The standardised beta coefficient for anticipated stigma in survey one and two was similar suggesting that it does not influence PTSS. However, for self-stigma the beta coefficients differed indicating that self-stigma may have a medium positive relationship to PTSS over time. Overall, H2 and H3 were not supported. . These results cannot corrobatepartially corroborate existing research that found suggests self-stigma leads to increased risk of PTSD following traumatisation (Schneider et al., 2018), and greater symptom severity (Lewis et al., 2022).

Secondly, the research aimed to explore whether stigmatising cognitions played a role in mental health professionals help-seeking intentions. H4 and H5 anticipated that self-stigma and anticipated stigma would relate to fewer intentions to seek-help amongst mental health professionals at survey 1 and overtime. As stigma had been identified as a barrier to help-seeking in similar professional fields (Auth et al., 2022; Wills et al., 2021). The results suggested that anticipated and self-stigma were not significant factors in predicting help-seeking intentions amongst mental health professionals following experiences of workplace

trauma. Furthermore, the stigma variables did not predict lower help-seeking intentions over time. The standardised betas for anticipatory stigma were similar over time indicating suggesting no effect, while self-stigma had a small positive effect over time compared to in survey one where it had a small negative effect. Taken together H4 and H5 were not supported, suggesting that stigma does not influence help-seeking intentions. However, due to the small sample size, and low presence of anticipatory and self-stigma in the current study, future studies should further explore these relationships further.

Overall, participants experience of negative appraisals were suggestive of trauma without PTSD according to Foa et al. (1999). Additionally, the results indicated that there were high levels of PTSS among participants, scores were suggestive of potential PTSD based on the cut-off of 31 (Bovin et al., 2016). Due to the study being focused on traumatic events in the workplace, it is likely that the most severe experiences of post-traumatic stress were underreported in this study owing to the general nature of PTSD whereby individuals act to avoid triggers of the traumatic event (Ehlers & Clark, 2000). However, experience of stigmatising beliefs, both anticipatory and self-stigma, appeared to be relatively low. Lastly, intentions to seek help did not appear either predominately high or low, suggesting participants may seek help.

Limitations and future research:

The number of participants recruited for the study was lower than the target sample size, due to slow recruitment and the dropout rate. Thus, the analyses were underpowered and results should be interpreted with caution. The study should be replicated in appropriately powered samples.The results of negative appraisals relationship with PTSS were the only sufficiently powered findings on the analyses of survey one data. Thus, the majority of analyses were

underpowered, and results should be interpreted with caution. The study should be replicated in appropriately powered samples, to reduce the risk of type II errors.

Another critique is that the study had a two-month time gap between the measurement of PTSD symptoms, which is less time than in studies of similar design (Beierl et al., 2020; Ehring, Ehlers & Glucksman, 2008). Ideally the study would have had a 6-month time gap between measurement points, however this was not practically possible. Future studies may look to track symptom change more frequently and over a longer time period, to more accurately explore negative appraisals and stigma and if/how they relate to the maintenance of PTSD symptoms in this population.

The study's recruitment strategy was aimed at social media, and despite recruitment lasting several months participation remained low. Future research should utilise alternative recruitment approaches for example working directly with healthcare services, or paid participation. It is also worth exploring what barriers potential participants face within this field of study. Participant demographics appeared similar for those who remained in the study and those who dropped out, though no formal test of significance is reportedWhile no meaningful difference between those who completed survey one and those who dropped out were identified. , Tthe largest drop outdrop in participants was observed following completion of the workplace trauma history questions. This suggests that participants did not want to complete the questionnaires once they were asked about their most recent workplace incident. Alternatively, the time to complete the questionnaires may have been too long leading to boredom or fatigue. Future studies may overcome this by coproducing research, using fewer and shorter questionnaires, or exploring why professionals may drop out of research on this topic using qualitative methods.

The stigma measures were not specifically developed for assessing stigmatising cognitions related to the experience of workplace trauma amongst mental health staff. Thus, it is unclear if the stigma levels identified are reflective of the current sample only or whether mental health professionals are generally unlikely to experience high levels of stigma associated with workplace trauma. It may be that the measures used were too broad. Future research should evaluate stigma measures in this context or develop measures to specifically address this phenomena. Alternatively, future studies could explore the role of stigma as a barrier to help-seeking utilising qualitative research methods. This would be important considering the consequences of trauma on healthcare professionals which can include reduced quality of patient care, absenteeism, and psychological difficulties (Mistry et al., 2021; Newman et al., 2021).

Conclusion

This study supports the importance of negative appraisals in predicting PTSS after workplace trauma for mental health professionals in inpatient psychiatric settings. However, additional appraisals associated with stigmatising beliefs did not predict PTSS or help-seeking intentions in this study, although self-stigma may predict PTSS over time and future research should explore this. This research highlights that mental health professionals in inpatient settings show indications of PTSD and that negative appraisals are a prime target for interventions in this group. While levels of stigma were low, preliminary evidence suggests it may relate to PTSS and help-seeking intentions over time. Given the limitations of the study future research should explore the role of stigma using more specialised measures in well-powered studies.

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Executive Summary

Mental health professionals working in psychiatric inpatient settings are exposed to workplace violence which has been associated with the development of post-traumatic stress disorder (PTSD). The cognitive model of PTSD proposes that there are specific thoughts about the self, the world and others following traumatic events (negative appraisals) that maintain PTSD symptoms. However, qualitative research indicates that there are unique and stigmatising narratives associated with workplace trauma within mental health work settings. These stigmatising cognitions have not been considered in the development and maintenance of PTSD symptoms. Although some early research has suggested that self-stigma may lead to greater PTSD symptoms. Stigma has also been identified as a barrier to help-seeking.

Therefore, the study aimed to firstly aimed to identify whether anticipatory and self-stigma beliefs were predictive of PTSD symptoms following workplace trauma. Secondly the study aimed to explore whether anticipatory and self-stigma were predictive of staff intentions to seek-help following workplace trauma. This is important for understanding how to best support mental health professionals following workplace trauma, and potential barriers to treatment.

The study examined the following hypotheses:

1. Negative appraisals about the self, others, and the world will predict PTSD symptom severity, and over time.
2. Anticipatory stigma beliefs will predict greater post-traumatic symptom severity beyond that of negative appraisals, and over time.
3. Self-stigma will predict greater post-traumatic symptom severity beyond that of negative appraisals, and over time.

4. Anticipatory stigma beliefs will predict lower help-seeking intentions, and over time.
5. Self-stigma will predict lower help-seeking intentions, and over time.

Method

A longitudinal approach was adopted, and participants were recruited via online platforms including LinkedIn, Facebook, X and Instagram. Additionally the main author emailed known contacts and other professionals within relevant fields to advertise the study. Participation required the completion of an online survey at two different time points (Survey one and Survey two) via the Qualtrics platform. Participants were asked to complete a set of validated and modified questionnaires related to the impact of experiencing difficult incidents within the workplace, and their intentions to seek professional help. They were asked to create a unique identifier code, so that their responses could be matched and analysed over the two time points.

Survey one required the completion of a questionnaire pack as well as range of demographic questions including age, gender, and ethnicity. Some questions were asked to ensure participants met the eligibility criteria. If participants did not meet these criteria, they were directed to the end of the study debrief and their data was subsequently deleted by the researcher.

Survey two was sent to participants approximately two months after they completed survey one. It required participants to respond to a questionnaire pack only including questionnaires on the two main outcomes: PTSD symptom severity and help-seeking intentions.

Results

A total of 33 people completed survey one, and 13 went on to complete survey two. Participants appeared to endorse a high number of negative appraisals, whilst there appeared to be low levels of stigma experienced in the sample. Scores on the PTSD symptom scale was high and suggestive of probable PTSD amongst the sample (Bovin et al., 2016). Analyses showed that only negative appraisals significantly predicted PTSD symptom severity at survey one. However, the relationship between negative appraisals and PTSD symptom severity did not remain significant over time. The stigma variables did not significantly predict PTSD symptom severity or help-seeking intentions or over time.

Conclusion

This study supports the importance of negative appraisals in predicting PTSD symptom severity as applied to the area of workplace trauma for mental health professionals in inpatient psychiatric settings. However, additional appraisals associated with stigmatising beliefs did not predict PTSD symptom severity or help-seeking intentions. This research highlights that mental health professions show signs of PTSD and emphasises negative appraisals as a key treatment target. Further research would be beneficial to ascertain the barriers to research participation in this professional group.

Connecting Narrative

To say I had a passion for research before undertaking the doctorate would be false. Instead, I had passion for those who I had worked with, and alongside, during my volunteering and paid experiences prior to training. As well as a desire to improve their experiences. Whilst the topics appear to have little in common, they all stem from my interests and share the theme of hidden experiences within the healthcare system either as a professional or as a service user. Though, I do not have first-hand experience of what it is like to access a gender clinic, I do have experience of working with transgender individuals accessing acute and forensic mental health inpatient services. Despite doing their best, these services were ill-equipped to offer a holistic approach. Additionally, in these settings I witnessed the severe and enduring impact of workplace trauma on staff, who appeared to be avoidant of acknowledging the toll the work takes. All of these experiences left me curious as to what was going on at a deeper psychological level. Hence, I was able to explore my passions in a valuable and constructive way through research, in hope to give back to those who had a strong influence on my journey to becoming a clinical psychologist.

Systematic Literature Review

As I outlined above, my interest in the impact that working with other's distress and trauma has on healthcare professionals had been of interest to me since working on a Forensic Inpatient Medium Secure Unit. I then came across the term Vicarious Trauma in my initial searches of what I might be able to cover with a literature review. This, alongside the term Secondary Trauma Stress, finally gave a name to what I had not only experienced myself but witnessed in others. For me, it then made sense to explore this topic further through a literature review, and through exploring existing research and discussions with supervisors, it

became apparent there was a gap in the assessment of the outcome measures used within much of the literature. This stood out for me in particular on reading an interesting review by Branson, (2019), which really called into question current research in the area which frequently used the terms interchangeably and assessed the constructs with a variety of measurement tools. Ultimately, it left me questioning how we could help improve people's experiences and the care we provide if we do not know whether the research, we are doing is measuring what we are believing it to. Overall, this was a time intensive project. Nevertheless, I found the critical appraisal of research an important experience.

Service Improvement Project

The service improvement project was the first one I undertook, and I have to say my most enjoyed. Whilst it was not a co-produced piece, the ideas stemmed from the service users, and their input throughout the process was greatly appreciated. It made me question my lens and widened my perspective as to what factors are of greatest concern to the individuals who access the service versus that of a clinician. What concerned me most about this project was the very real experience of most participants who described their journey in discovering their gender non-conforming identity, only to feel a need to conform once again to who they believed the service was most likely to accept and provide the treatment to. Whilst they all described experiencing mental health diagnoses, either related to their gender incongruence or separate to this, the overriding goal of moving closer to their desired gender identity took priority. This made me wonder how our services can be better shaped and work towards a holistic understanding of individuals experiences. Whilst not all service users of gender clinics will have a mental health diagnosis, the idea that a false narrative is being consumed by clinicians based on service users, very real, fear of rejection is concerning for the future of these services. Specifically, our knowledge and understanding of this group of people. I am

hopeful that the project will allow clinicians to be more conscious of the questions they ask, their intentions, and how they can best support individuals in disclosing mental health diagnoses should they wish to.

Theory Driven Research Project

As aforementioned, my interest in the impact that working in mental health inpatient wards has on professionals came from my own experience; firstly working as a support worker then an assistant psychologist. I initially was intrigued by the influence of workplace culture on the development of PTSD following exposure to workplace violence. However, it was a challenge to find such a measure. Instead, I considered the narratives that existed in these environments, which I believed could be considered cognitive aspects of the CBT model for PTSD, and how these influenced professional's experience of trauma symptoms and intentions to seek help. I had a lot of faith that this project would bring about meaningful findings that could be applied back to the workplace. Even so, there were moments when I thought it would not be possible to complete as we faced challenges with recruitment that led to the participant criteria widening. I found the recruitment process disheartening. Especially, after working on a forensic learning disability inpatient ward for my final placement. The staff members here were acutely concerned about the psychological impact on themselves from being repeatedly abused by service users. It has made me wonder how we can increase research involvement from healthcare professionals, as their psychological and physical safety are of great importance.

Acknowledgements

I am very appreciative to the individuals who gave up their time to contribute to the research development, as well as those who participated in these research projects. Without your contributions, time and effort these projects would not have been possible.

Thank you to all of my research supervisors throughout this process, and I do mean all of you, there were quite a few over the years! Each one of you helped tweak, shape, and progress these projects into what they are. Also thank you for supporting me to better understand research at this level, and through the highs and lows of my doctorate journey. A special thanks goes to my course tutor, Emily, who has not only supported me in navigating the doctorate but helped with the many personal journeys I have faced alongside it.

To my family – thank you for always being my biggest believers, drying my tears, and encouraging me to keep going even when I felt like giving up. To my mum, thank you for being my guiding light, and my biggest inspiration, your strength has repeatedly carried me through. Lastly, to my late dad, while you may not have made it to the end of this doctorate journey with me, I am grateful you got to be there for the beginning. I know you will be looking down with pride, forever your warrior queen.

Appendices

Systematic Literature Review Appendix 1.1

Author Guidelines

Preparing your manuscript for submission

Your article must be within the scope of the journal and be of sufficient quality. If not, it will not be reviewed. Please read the journal's Aims and Scope to see if your article is appropriate.

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Article types

Reviews:

TVA accepts comprehensive reviews of research or legal reviews that address any aspect of trauma, violence, or abuse. Reviews must be based on a sufficient number of studies to justify synthesis. Reviewed literatures may come from the social or behavioral sciences or the law.

Reviews should begin with a clear description of the knowledge area that is being researched or reviewed and its relevance to understanding or dealing with trauma, violence, or abuse and provide a clear discussion of the limits of the knowledge that has been reviewed.

Please include two summary tables: one of critical findings and the other listing impications of the review for practice, policy, and research. Please also include a discussion of diversity as it applies to the reviewed research. See below for the journal's policy on addressing diversity in manuscripts for more information.

Length: No longer than 40 double-spaced pages, inclusive of references, tables, and figures. Title page, main document (including references), tables, figures, author biographies, and any supplemental materials should be uploaded as separate files.

Abstract: Up to 250 words describing the topic of review, method of review, number of research studies meeting the criteria for review, criteria for inclusion, how research studies were identified, and major findings

Formatting: All files must be formatted according to the Publication Manual of the American Psychological Association (7th edition). All files must be submitted as Word docs, not PDFs. Text should be in Times New Roman, 12-point font. Margins must be at least one inch on all sides.

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Please include an unstructured abstract of no more than 250 words between the title and main body of your manuscript that concisely states the purpose of the research, major findings, and conclusions. If your research includes clinical trials, the trial registry name and URL, and registration number must be included at the end of the abstract. Submissions that do not meet this requirement will not be considered.

For clinical trials, the trial registry name and URL, and registration number must be included at the end of the abstract.

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Please include a minimum of 4 keywords, listed after the abstract. Keywords should be as specific as possible to the research topic.

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- Acknowledgments section
- Declaration of conflicting interest
- Funding statement
- Ethical approval and informed consent statements
- Data availability statement

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Acknowledgments

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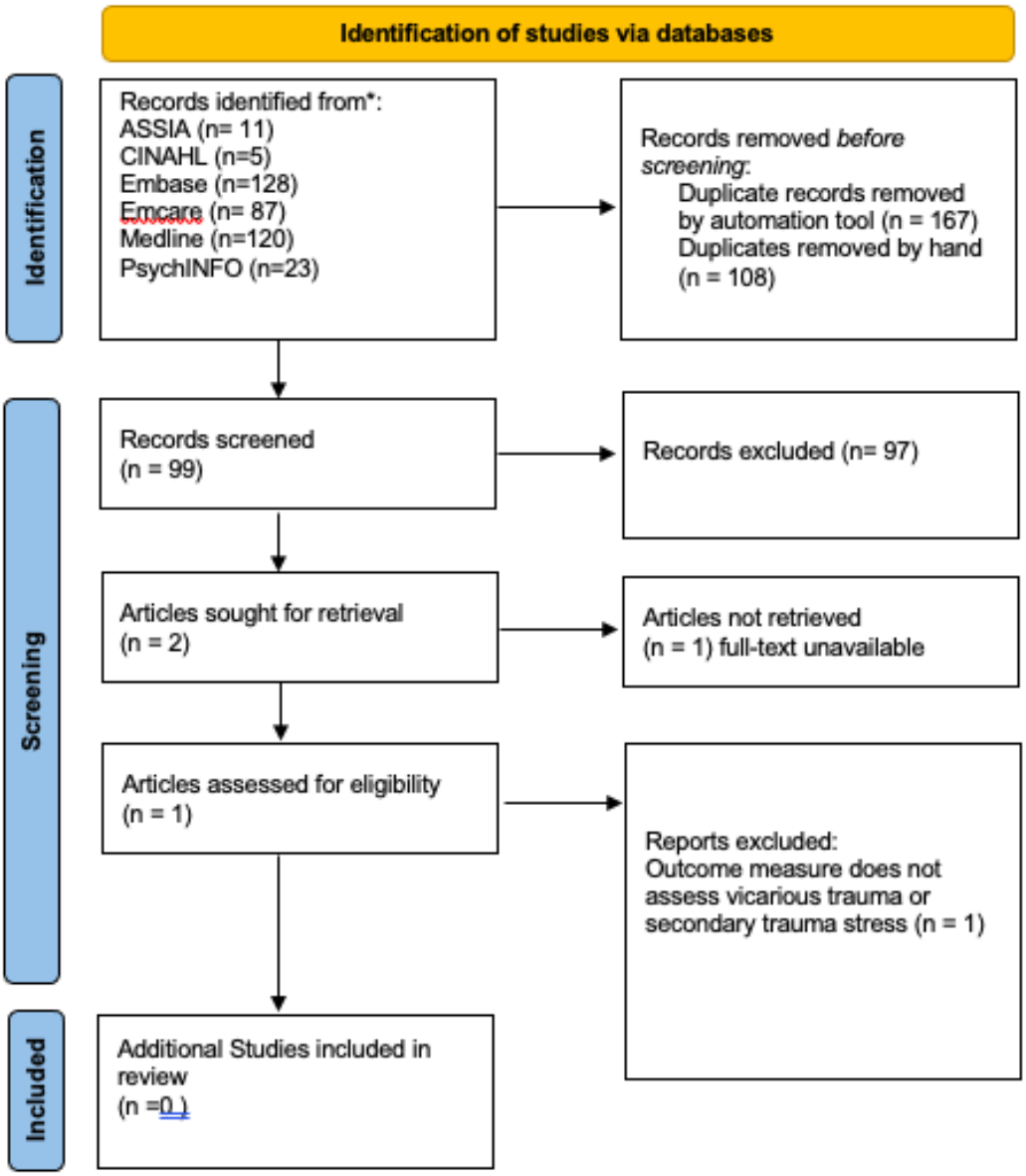
Appendix 1.2

Search run on 7th January 2025. Updated Literature Search of Papers from July 2024 to January 2025



Appendix 1.3

Search terms for each database

ASSIA

noft("Vicarious Trauma*" OR VT OR "Secondary Trauma*" OR STSS OR "occupational stress" OR "job stress") AND noft("Mental Health Professional*1" OR "healthcare professional*1" OR therapist*1 OR psychologist*1 OR counsellor*1 OR clinician*1 OR doctor*1 OR "nurs*" OR "healthcare staff" OR "social worker*1" OR interpreter*1 OR psychiatrist) AND noft("Outcome measure" OR measure* OR questionnaire OR assessment OR screening OR tool OR "self-report" OR scale OR instrument OR "rating scale" OR "PRoQoL-5" OR "TSI belief scale" OR "Trauma Attachment Belief Scale" OR "TSI-LEC" OR "Secondary Traumatic Stress Scale" OR "Impact of events scale" OR "PCL-5") AND noft(psychometr* OR "outcome assessment" OR "outcome measure*" OR "observer variation" OR reproducib* OR reliab* OR unreliab* OR valid* OR coefficient OR homogeneity OR (cronbach* AND (alpha OR alphas)) OR (item AND (correlation* OR selection* OR reduction*)) OR test-retest OR (test AND retest) OR (reliab* AND (test OR retest)) OR stability OR interrater OR "inter-rater" OR intrarater OR "intra-rater" OR intertester OR inter-tester OR intratester OR "intra-tester" OR interobserver OR "inter-observer" OR intraobserver OR "intra-observer" OR intertechnician OR "inter-technician" OR intratechnician OR "intra-technician" OR interexaminer OR "inter-examiner" OR intraexaminer OR "intra-examiner" OR interassay OR "inter-assay" OR intraassay OR "intra-assay" OR interindividual OR "inter-individual" OR intraindividual OR "intra-individual" OR interparticipant OR "inter-participant" OR intraparticipant OR "intra-participant" OR kappa OR kappa's OR kappas OR generaliza* OR generalisa* OR concordance OR (intraclass AND correlation*) OR discriminative OR "known group" OR "factor analysis" OR "factor

analyses" OR "factor structure" OR "factor structures" OR dimension* OR subscale* OR (multitrait AND scaling AND (analysis OR analyses)) OR "item discriminant" OR "interscale correlation*" OR error OR errors OR "individual variability" OR "interval variability" OR "rate variability" OR (variability AND (analysis OR values)) OR (uncertainty AND (measurement OR measuring)) OR "standard error of measurement" OR sensitiv* OR responsive* OR (limit AND detection) OR "minimal detectable concentration" OR interpretab* OR ((minimal OR minimally OR clinical OR clinically) AND (important OR significant OR detectable) AND (change OR difference)) OR (small* AND (real OR detectable) AND (change OR difference)) OR "meaningful change" OR "ceiling effect" OR "floor effect" OR "Item response model" OR IRT OR Rasch OR "Differential item functioning" OR DIF OR "computer adaptive testing" OR "item bank" OR "cross-cultural equivalence")

CINAHL

S1 AND S2 AND S3 AND S4

S4 (MH "Outcome Assessment") OR (MH "Factor Analysis+") OR (MH "Discriminant Analysis") OR "psychometr* or "outcome assessment" or "outcome measure*" or "observer variation" or reproducib* or reliab* or unreliab* or valid* or coefficient or homogeneity or (cronbach* and (alpha or alphas)) or (item and (correlation* or selection* or reduction*)) or test-retest or (test and retest) or (reliab* and (test or retest)) or stability or interrater or "inter-rater" or intrarater or "intra-rater" or intertester or inter-tester or intratester or "intra-tester" or interobserver or "inter-observer" or intraobserver or "intra-observer" or intertechnician or "inter-technician" or intratechnician or "intra-technician" or interexaminer or "inter-examiner" or intraexaminer or "intra-examiner" or interassay or "inter-assay" or intraassay or "intra-assay" or interindividual or "inter-individual" or intraindividual or "intra-individual" or interparticipant or "inter-participant" or intraparticipant or "intra-participant" or kappa or

kappa's or kappas or generaliza* or generalisa* or concordance or (intraclass and correlation*) or discriminative or "known group" or "factor analysis" or "factor analyses" or "factor structure" or "factor structures" or dimension* or subscale* or (multitrait and scaling and (analysis or analyses)) or "item discriminant" or "interscale correlation*" or error or errors or "individual variability" or "interval variability" or "rate variability" or (variability and (analysis or values)) or (uncertainty and (measurement or measuring)) or "standard error of measurement" or sensitiv* or responsive* or (limit and detection) or "minimal detectable concentration" or interpretab* or ((minimal or minimally or clinical or clinically) and (important or significant or detectable) and (change or difference)) or (small* and (real or detectable) and (change or difference)) or "meaningful change" or "ceiling effect" or "floor effect" or "Item response model" or IRT or Rasch or "Differential item functioning" or DIF or "computer adaptive testing" or "item bank" or "cross-cultural equivalence" OR (MH "Interrater Reliability") OR (MH "Rasch Analysis")

S3 (MH "Scales") OR (MH "Impact of Events Scale") OR ""Outcome measure" or measure* or questionnaire or assessment or screening or tool or "self-report" or scale or instrument or "rating scale" or "PRoQoL-5" or "TSI belief scale" or "Trauma Attachment Belief Scale" or "TSI-LEC" or "Secondary Traumatic Stress Scale" or "Impact of events scale" or "PCL-5""

S2 (MH "Health Personnel+") OR ""Mental Health Professional*1" or "healthcare professional*1" or therapist*1 or psychologist*1 or counsellor*1 or clinician*1 or doctor*1 or "nurs*" or "healthcare staff" or "social worker*1" or interpreter*1 or psychiatrist"

S1 (MH "Stress, Occupational+") OR ""Vicarious Trauma*" or VT or "Secondary Trauma*" or STSS or "occupational stress" or "job stress"" Expanders - Apply equivalent subjects

EMBASE

exp vicarious trauma/

secondary traumatic stress/

("Vicarious Trauma*" or VT or "Secondary Trauma*" or STSS or "occupational stress" or "job stress").ab,ti.

1 or 2 or 3

("Mental Health Professional*1" or "healthcare professional*1" or therapist*1 or psychologist*1 or counsellor*1 or clinician*1 or doctor*1 or "nurs*" or "healthcare staff" or "social worker*1" or interpreter*1 or psychiatrist).ab,ti.

social worker/

exp health care personnel/ or exp medical staff/

5 or 6 or 7

("Outcome measure" or measure* or questionnaire or assessment or screening or tool or "self-report" or scale or instrument or "rating scale" or "PRoQoL-5" or "TSI belief scale" or "Trauma Attachment Belief Scale" or "TSI-LEC" or "Secondary Traumatic Stress Scale" or "Impact of events scale" or "PCL-5").ab,ti.

exp outcome assessment/

exp questionnaire/

9 or 10 or 11

exp psychometry/

exp observer variation/

exp health status indicator/

exp reproducibility/

exp discriminant analysis/

(psychometr* or "outcome assessment" or "outcome measure*" or "observer variation" or reproducib* or reliab* or unreliab* or valid* or coefficient or homogeneity or (cronbach* and

(alpha or alphas)) or (item and (correlation* or selection* or reduction*)) or test-retest or (test and retest) or (reliab* and (test or retest)) or stability or interrater or "inter-rater" or intrarater or "intra-rater" or intertester or inter-tester or intratester or "intra-tester" or interobserver or "inter-observer" or intraobserver or "intra-observer" or intertechnician or "inter-technician" or intratechnician or "intra-technician" or interexaminer or "inter-examiner" or intraexaminer or "intra-examiner" or interassay or "inter-assay" or intraassay or "intra-assay" or interindividual or "inter-individual" or intraindividual or "intra-individual" or interparticipant or "inter-participant" or intraparticipant or "intra-participant" or kappa or kappa's or kappas or generaliza* or generalisa* or concordance or (intraclass and correlation*) or discriminative or "known group" or "factor analysis" or "factor analyses" or "factor structure" or "factor structures" or dimension* or subscale* or (multitrait and scaling and (analysis or analyses)) or "item discriminant" or "interscale correlation*" or error or errors or "individual variability" or "interval variability" or "rate variability" or (variability and (analysis or values)) or (uncertainty and (measurement or measuring)) or "standard error of measurement" or sensitiv* or responsive* or (limit and detection) or "minimal detectable concentration" or interpretab* or ((minimal or minimally or clinical or clinically) and (important or significant or detectable) and (change or difference)) or (small* and (real or detectable) and (change or difference)) or "meaningful change" or "ceiling effect" or "floor effect" or "Item response model" or IRT or Rasch or "Differential item functioning" or DIF or "computer adaptive testing" or "item bank" or "cross-cultural equivalence").ab,ti.

10 or 13 or 14 or 15 or 16 or 17 or 18

4 and 8 and 12 and 19

EMCARE

exp secondary traumatic stress/

("Vicarious Trauma*" or VT or "Secondary Trauma*" or STSS or "occupational stress" or

"job stress").ab,ti.

1 or 2

exp social worker/

exp health care personnel/

("Mental Health Professional*1" or "healthcare professional*1" or therapist*1 or psychologist*1 or counsellor*1 or clinician*1 or doctor*1 or "nurs*" or "healthcare staff" or "social worker*1" or interpreter*1 or psychiatrist).ab,ti.

4 or 5 or 6

exp questionnaire/

("Outcome measure" or measure* or questionnaire or assessment or screening or tool or "self-report" or scale or instrument or "rating scale" or "PRoQoL-5" or "TSI belief scale" or "Trauma Attachment Belief Scale" or "TSI-LEC" or "Secondary Traumatic Stress Scale" or "Impact of events scale" or "PCL-5").ab,ti.

8 or 9

exp discriminant analysis/

exp reproducibility/

exp psychometry/

(psychometr* or "outcome assessment" or "outcome measure*" or "observer variation" or reproducib* or reliab* or unreliab* or valid* or coefficient or homogeneity or (cronbach* and (alpha or alphas)) or (item and (correlation* or selection* or reduction*)) or test-retest or (test and retest) or (reliab* and (test or retest)) or stability or interrater or "inter-rater" or intrarater or "intra-rater" or intertester or inter-tester or intratester or "intra-tester" or interobserver or "inter-observer" or intraobserver or "intra-observer" or intertechnician or "inter-technician" or intratechnician or "intra-technician" or interexaminer or "inter-examiner" or intraexaminer or "intra-examiner" or interassay or "inter-assay" or intraassay or "intra-assay" or interindividual

or "inter-individual" or intraindividual or "intra-individual" or interparticipant or "inter-participant" or intraparticipant or "intra-participant" or kappa or kappa's or kappas or generaliza* or generalisa* or concordance or (intraclass and correlation*) or discriminative or "known group" or "factor analysis" or "factor analyses" or "factor structure" or "factor structures" or dimension* or subscale* or (multitrait and scaling and (analysis or analyses)) or "item discriminant" or "interscale correlation*" or error or errors or "individual variability" or "interval variability" or "rate variability" or (variability and (analysis or values)) or (uncertainty and (measurement or measuring)) or "standard error of measurement" or sensitiv* or responsive* or (limit and detection) or "minimal detectable concentration" or interpretab* or ((minimal or minimally or clinical or clinically) and (important or significant or detectable) and (change or difference)) or (small* and (real or detectable) and (change or difference)) or "meaningful change" or "ceiling effect" or "floor effect" or "Item response model" or IRT or Rasch or "Differential item functioning" or DIF or "computer adaptive testing" or "item bank" or "cross-cultural equivalence").ab,ti.

11 or 12 or 13 or 14

3 and 7 and 10 and 15

PsychInfo

exp secondary traumatic stress/

("Vicarious Trauma*" or VT or "Secondary Trauma*" or STSS or "occupational stress" or "job stress").ab,ti.

exp social worker/

exp health care personnel/

("Mental Health Professional*1" or "healthcare professional*1" or therapist*1 or psychologist*1 or counsellor*1 or clinician*1 or doctor*1 or "nurs*" or "healthcare staff" or "social worker*1" or interpreter*1 or psychiatrist).ab,ti.

3 or 4 or 5

exp questionnaire/

("Outcome measure" or measure* or questionnaire or assessment or screening or tool or "self-report" or scale or instrument or "rating scale" or "PRoQoL-5" or "TSI belief scale" or "Trauma Attachment Belief Scale" or "TSI-LEC" or "Secondary Traumatic Stress Scale" or "Impact of events scale" or "PCL-5").ab,ti.

7 or 8

exp psychometric/

(psychometr* or "outcome assessment" or "outcome measure*" or "observer variation" or reproducib* or reliab* or unreliab* or valid* or coefficient or homogeneity or (cronbach* and (alpha or alphas)) or (item and (correlation* or selection* or reduction*)) or test-retest or (test and retest) or (reliab* and (test or retest)) or stability or interrater or "inter-rater" or intrarater or "intra-rater" or intertester or inter-tester or intratester or "intra-tester" or interobserver or "inter-observer" or intraobserver or "intra-observer" or intertechnician or "inter-technician" or intratechnician or "intra-technician" or interexaminer or "inter-examiner" or intraexaminer or "intra-examiner" or interassay or "inter-assay" or intraassay or "intra-assay" or interindividual or "inter-individual" or intraindividual or "intra-individual" or interparticipant or "inter-participant" or intraparticipant or "intra-participant" or kappa or kappa's or kappas or generaliza* or generalisa* or concordance or (intraclass and correlation*) or discriminative or "known group" or "factor analysis" or "factor analyses" or "factor structure" or "factor structures" or dimension* or subscale* or (multitrait and scaling and (analysis or analyses)) or "item discriminant" or "interscale correlation*" or error or errors or "individual variability" or "interval variability" or "rate variability" or (variability and (analysis or values)) or (uncertainty and (measurement or measuring)) or "standard error of measurement" or sensitiv* or responsive* or (limit and detection) or "minimal detectable concentration" or

interpretab* or ((minimal or minimally or clinical or clinically) and (important or significant or detectable) and (change or difference)) or (small* and (real or detectable) and (change or difference)) or "meaningful change" or "ceiling effect" or "floor effect" or "Item response model" or IRT or Rasch or "Differential item functioning" or DIF or "computer adaptive testing" or "item bank" or "cross-cultural equivalence").ab,ti.

10 or 11

1 or 2

6 and 9 and 12 and 13

Medline

exp vicarious trauma/

exp secondary traumatic stress/

("Vicarious Trauma*" or VT or "Secondary Trauma*" or STSS or "occupational stress" or "job stress").ab,ti.

exp social worker/

exp Health Personnel/

("Mental Health Professional*1" or "healthcare professional*1" or therapist*1 or psychologist*1 or counsellor*1 or clinician*1 or doctor*1 or "nurs*" or "healthcare staff" or "social worker*1" or interpreter*1 or psychiatrist).ab,ti.

exp outcome assessment/

exp questionnaire/

("Outcome measure" or measure* or questionnaire or assessment or screening or tool or "self-report" or scale or instrument or "rating scale" or "PRoQoL-5" or "TSI belief scale" or "Trauma Attachment Belief Scale" or "TSI-LEC" or "Secondary Traumatic Stress Scale" or "Impact of events scale" or "PCL-5").ab,ti.

1 or 2 or 3

4 or 5 or 6

7 or 8 or 9

exp observer variation/

exp health status indicator/

exp discriminant analysis/

(psychometr* or "outcome assessment" or "outcome measure*" or "observer variation" or reproducib* or reliab* or unreliab* or valid* or coefficient or homogeneity or (cronbach* and (alpha or alphas)) or (item and (correlation* or selection* or reduction*)) or test-retest or (test and retest) or (reliab* and (test or retest)) or stability or interrater or "inter-rater" or intrarater or "intra-rater" or intertester or inter-tester or intratester or "intra-tester" or interobserver or "inter-observer" or intraobserver or "intra-observer" or intertechnician or "inter-technician" or intratechnician or "intra-technician" or interexaminer or "inter-examiner" or intraexaminer or "intra-examiner" or interassay or "inter-assay" or intraassay or "intra-assay" or interindividual or "inter-individual" or intraindividual or "intra-individual" or interparticipant or "inter-participant" or intraparticipant or "intra-participant" or kappa or kappa's or kappas or generaliza* or generalisa* or concordance or (intraclass and correlation*) or discriminative or "known group" or "factor analysis" or "factor analyses" or "factor structure" or "factor structures" or dimension* or subscale* or (multitrait and scaling and (analysis or analyses)) or "item discriminant" or "interscale correlation*" or error or errors or "individual variability" or "interval variability" or "rate variability" or (variability and (analysis or values)) or (uncertainty and (measurement or measuring)) or "standard error of measurement" or sensitiv* or responsive* or (limit and detection) or "minimal detectable concentration" or interpretab* or ((minimal or minimally or clinical or clinically) and (important or significant or detectable) and (change or difference)) or (small* and (real or detectable) and (change or difference)) or "meaningful change" or "ceiling effect" or "floor effect" or "Item response

model" or IRT or Rasch or "Differential item functioning" or DIF or "computer adaptive testing" or "item bank" or "cross-cultural equivalence").ab,ti.

13 or 14 or 15 or 16

10 and 11 and 12 and 17

Appendix 1.4

Table of study population details

Reference	VT/STS outcome measure	Country	Sample	Sample Size	Age M (SD)	Sex % Male/Female
Bride (2002)	STSS	US	Social Workers	200	41.06(10.83)	Female 82.9%
Bride et al. (2004)	STSS	US	Social Workers	287	44.8 (10.5)	Female 81.9%
Ting et al. (2005)	STSS	US	Mental Health Social Workers	275	51.73(8.56)	Female 75.6%
Zivanovic and Vukcevic Markovic (2020)	STSS	Serbia	Refugee Workers	270	33.66(9.58)	Female 57%
Ahmed et al. (2022)	STSS	US	Physicians	375	52.43(11.70)	Female 42.4%
Belletti (2023)	STSS and VTS	US	Clinical Psychologists, masters-level clinicians and doctoral students	50	40.88(12.97)	Female 84%
Keesler and Fukui (2020)	ProQol-5	US	Direct Support Professionals	495	NR	Female 79.8%
Singh et al. (2024)	ProQol-5	UK	Psychologists, Counsellors and Psychotherapists	366	NR	Female 82.79%
Hemsworth et al. (2018) sample 1	ProQol-5	Canada	Palliative Care Workers	651	52.85(NR)	Female 85%
Hemsworth et al. (2018) sample 2	ProQol-5	Australia	Australian Nurses	273	39.58(NR)	Female 93.4%
Hemsworth et al. (2018) sample 3	ProQol-5	Canada	Canadian Nurses	303	40(NR)	Female 86.5%
Heritage et al. (2018)	ProQol-5	Australia	Nurses/Nurse officers	1615	46.48(11.78)	Female 92.8%
Ang et al. (2020)	ProQol-5	Singapore	Nurses	1338	NR	Female 93%

Deaton and Whitbeck (2024)	ProQol-5	US	Counsellors	543	NR	Female 86.4%
Weitkamp et al. (2014) Sample 1	FST	Germany, Austria, Switzerland and others.	Counsellors and Psychotherapists	371	48.33(8.81)	Female 83.3%
Weitkamp et al. (2014) Sample 2	FST	Germany, Austria, Switzerland and others.	Refugee Counsellors	195	43.91(10.15)	Female 76.5%
Weitkamp et al. (2014) Sample 3	FST	Germany, Austria, Switzerland and others.	Trainee Psychotherapists	80	52.53(7.33)	Female 80%
Jenkins and Baird (2002)	CFST-Psychotherapist	US	Counsellors	99	NR	Female 95.95%
Adams et al. (2006)	CFST-Caregivers	US	Social Workers	236	NR	Female 80%
Aparicio et al. (2013) (6 items only)	VTS	US	Social Workers	157	45.7(13.2)	Female 85%
Van De Water (1996)	Trauma Work Impact Scale	US	Therapists	165	40(NR)	Female 79%

Service Improvement Project

Appendix 2.1

Submission Guidelines

Prior to submission, please carefully read and follow the submission guidelines detailed below. Manuscripts that do not conform to the submission guidelines may be returned without review.

Submission

To submit to the editorial office of M. Paz Galupo, PhD, please submit manuscripts electronically through the Manuscript Submission Portal in Microsoft Word (.docx) or LaTex (.tex) as a zip file with an accompanied Portable Document Format (.pdf) of the manuscript file.

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the *Publication Manual*). APA Style and Grammar Guidelines for the 7th edition are available.

SUBMIT MANUSCRIPT

M. Paz Galupo
Washington University at St. Louis
Missouri

Manuscript types

Psychology of Sexual Orientation and Gender Diversity® (*PSOGD*) accepts a variety of article types consistent with the journal's mission, including:

Standard articles containing a maximum of 7,500 words of text (excluding tables and references). These will be the most typical articles.

Longer, monograph-style articles containing a maximum of 12,000 words of text. These longer contributions will not be typical and to be considered, must provide a particularly enhanced coverage of the topic addressed.

This can take the form of:

- especially extensive literature review with a methodological critique and/or public policy implications explicated
- description of an interlocked series of research projects
- synthesis of material on sexual orientation and gender diversity with material from other aspects of psychology and/or other disciplines
- similarly extensive contributions

AUTHORS MUST OBTAIN APPROVAL OF THE EDITOR PRIOR TO SUBMITTING THIS ARTICLE TYPE.

Brief reports are research-oriented and contain a maximum of 4,000 words of text.

Letters to the editor should be limited to 500 words. In unusual circumstances, the editor may allow a longer limit with the author.
Commentaries may address developments in the behavioral sciences and related fields, the legal system, national or world events, as these pertain to the content areas of *PSOGD*. These should be a maximum of 1000 words, unless a longer length is allowed by the founding editor.
As a rule of thumb one double-spaced page of standard font and size text contains about 300 words. If submissions contain an unusually larger number of references for the article type and/or unusually large tables/charts/graphs, authors may be required to reduce these. "Words" refers to words and other symbols or characters.

Qualitative research

PSOGD welcomes a variety of methodologies in its submissions, including quantitative, qualitative, and mixed quantitative/qualitative methodologies.
All submissions are expected to maintain word limits specific to the type of manuscript (see manuscript types); offer replicable methodology; involve an *N* commensurate with the purpose of the research and which allows reasonable inference; and be written in a concise and focused manner.
In particular, extensive quotations from research participants are ill-advised, and should be limited to a few which are especially evocative of key themes. The theme descriptions should be the predominant vehicle for conveying participants' responses in qualitative research.

Manuscript preparation

Review APA's Journal Manuscript Preparation Guidelines before submitting your article.
Since *PSOGD* first began publishing in 2014, a number of recurring questions and situations have arisen.
This material attempts to respond to these proactively, in the hope that potential authors have a clearer sense of *PSOGD's* expectations and procedures.
Please feel free to contact the editor with any inquiries about these topics below or others.

Masked submission

Nothing in your manuscript should indicate authors' identities, institutional affiliation, or other identifying features. Common examples include: naming the institution that granted institutional review board approval; citing by name previous publications on which the current submission explicitly builds; naming specific organizations that cooperated in data collection, etc.
The words "MASKED FOR REVIEW" should be substituted.
When masking earlier work on which the current submission is based, remember to remove the identifying citation both from the text and the references. Insufficiently

masked submissions will be returned to authors for masking before being sent for review, which slows the review process.
If the article is accepted for publication, the identifying information can be added subsequently.
Please ensure that the final version for production includes a byline and full author note for typesetting.

Language guidelines

Authors should be cognizant that language and terminologies used to describe sexual orientation and gender diversity have been used in pejorative ways, have undergone transitions, may likely undergo more transitions, and should be used in ways that convey respect yet maintain precision.
When APA offers language guidelines or policy statements that address terminology, authors are generally expected to use these guidelines and statements. There are exceptions to this, such as accurately quoting or describing older literature which might use outdated or problematic terminology.

Revisions

Revisions must be accompanied by a description of changes made, including previously rejected and rewritten papers incorporating feedback.
As the decision letters state, when submitting a revision, authors must include a letter or memo describing the changes made in response to reviewer and editor feedback. This letter should address all the points raised by the editor and reviewers. It is acceptable to disagree with feedback and reject or modify a requested change; this should be clearly stated, and a rationale provided for the disagreement.
Resubmission of a previously rejected manuscript is generally not recommended without consultation with the editor. If resubmission of a previously rejected manuscript is made, authors should note the manuscript number of the earlier rejected submission, and include the same full description of changes made as described in the above paragraph.
Revisions/resubmissions without a description of changes made will not be read and will be returned to authors with instructions to provide this description.

Abstract and keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page.
After the abstract, please supply up to five keywords or brief phrases.
PSOGD encourages submissions from all countries and aspires to disseminate knowledge about sexual orientation and gender diversity internationally.
To this end, authors should submit abstracts and keywords in English and, if they wish, in addition provide abstracts in any other language(s) relevant to the submission in question.

Specifically, authors may submit abstracts and keywords in languages in addition to English in the following circumstances:

- When the research subjects or content matter involve non-English speaking populations
- When the authors are based in a non-English speaking country or comprise a multi-national team with some members from non-English speaking countries.
- There may be other circumstances where authors wish abstracts in other languages to be included. These should be reviewed and approved by the editor.

Note that all submissions must include an abstract and keywords in English.

Non-English language abstracts

PSOGD is committed to encouraging and disseminating scholarship on sexual orientation and gender diversity world-wide as much as is feasible. To facilitate this goal, authors working in a non-English speaking country, or whose sample is from a non-English speaking country, should submit another abstract in their other language, or that of the sample. This will appear below the English abstract if the article is published.

If authors or samples are from multiple non-English speaking countries, abstracts in all the relevant languages should be included. These additional abstracts need not be provided until the final accepted revision.

PSOGD does not have the resources to provide a final copyediting of non-English abstracts, so authors should carefully check the non-English abstracts.

PSOGD can publish the main article text only in English.

Public significance statement

Authors submitting manuscripts to PSOGD are required to provide a short statement of one to two sentences to summarize the article's findings and significance to the educated public (e.g., understanding human thought, feeling, and behavior and/or assisting with solutions to psychological or societal problems). This description should be included within the manuscript on the abstract/keywords page.

- View Guidance for Translational Abstracts and Public Significance Statements

Equity, Diversity, and Inclusion in *Psychology of Sexual Orientation and Gender Diversity*

Psychology of Sexual Orientation and Gender Diversity is committed to improving equity, diversity, and inclusion (EDI) in scientific research, in line with the APA Publishing EDI framework and APA's trio of 2021 resolutions to address systemic racism in psychology.

To promote a more equitable research and publication process, *Psychology of Sexual Orientation and Gender Diversity* has adopted the following standards for inclusive research reporting.

Author contribution statements using CRediT

The *APA Publication Manual (7th ed.)* stipulates that "authorship encompasses…not only persons who do the writing but also those who have made substantial scientific contributions to a study." In the spirit of transparency and openness, *Psychology of Sexual Orientation and Gender Diversity* has adopted the Contributor Roles Taxonomy (CRediT) to describe each author's individual contributions to the work. CRediT offers authors the opportunity to share an accurate and detailed description of their diverse contributions to a manuscript.

Submitting authors will be asked to identify the contributions of all authors at initial submission according to the CRediT taxonomy. If the manuscript is accepted for publication, the CRediT designations will be published as an author contributions statement in the author note of the final article. All authors should have reviewed and agreed to their individual contribution(s) before submission.

CRediT includes 14 contributor roles, as described below:

- **Conceptualization**: Ideas; formulation or evolution of overarching research goals and aims.
- **Data curation**: Management activities to annotate (produce metadata), scrub data and maintain research data (including software code, where it is necessary for interpreting the data itself) for initial use and later re-use.
- **Formal analysis**: Application of statistical, mathematical, computational, or other formal techniques to analyze or synthesize study data.
- **Funding acquisition**: Acquisition of the financial support for the project leading to this publication.
- **Investigation**: Conducting a research and investigation process, specifically performing the experiments, or data/evidence collection.
- **Methodology**: Development or design of methodology; creation of models.
- **Project administration**: Management and coordination responsibility for the research activity planning and execution.
- **Resources**: Provision of study materials, reagents, materials, patients, laboratory samples, animals, instrumentation, computing resources, or other analysis tools.

- **Software**: Programming, software development; designing computer programs; implementation of the computer code and supporting algorithms; testing of existing code components.
- **Supervision**: Oversight and leadership responsibility for the research activity planning and execution, including mentorship external to the core team.
- **Validation**: Verification, whether as a part of the activity or separate, of the overall replication/reproducibility of results/experiments and other research outputs.
- **Visualization**: Preparation, creation and/or presentation of the published work, specifically visualization/data presentation.
- **Writing—original draft**: Preparation, creation and/or presentation of the published work, specifically writing the initial draft (including substantive translation).
- **Writing—review & editing**: Preparation, creation and/or presentation of the published work by those from the original research group, specifically critical review, commentary or revision—including pre- or post-publication stages.

Authors can claim credit for more than one contributor role, and the same role can be attributed to more than one author. Not all roles will be applicable to a particular scholarly work.

Participant description, sample justification, and informed consent

Authors are encouraged to include a detailed description of the study participants in the Method section of each empirical report, including (but not limited to) the following:

- Age
- Sexual orientation
- Gender
- Racial identity
- Ethnicity
- Nativity or immigration history
- Socioeconomic status
- Clinical diagnoses and comorbidities (as appropriate)
- Any other relevant demographics (e.g., disability status; sexual orientation)

In both the abstract and in the discussion section of the manuscript, authors are encouraged to discuss the diversity of their study samples and the generalizability of their findings (see also the constraints on generality section below).

Authors are also encouraged to **justify their sample demographics** in the Discussion section. If Western, educated, industrialized, rich, and democratic (WEIRD) or all-White samples are used, authors should justify their samples and describe their sample inclusion efforts (see Roberts, et al., 2020 for more information on justifying sample demographics).
The Method section also must include a statement describing how informed consent was obtained from the participants (or their parents/guardians), including for secondary use of data if applicable, and indicate that the study was conducted in compliance with an appropriate Internal Review Board.

Reporting year(s) of data collection

Authors are encouraged to disclose the year(s) of data collection in both the Abstract and in the Method section in order to appropriately contextualize the study.

Positionality statements

Authors are encouraged to include a positionality statement in the author note. Positionality statements are intended to address potential author bias by transparently reporting how the identities of the authors relate to the research/article topic and to the identity of the participants, as well as the extent to which those identities are represented in the scientific record. The statement should be included in the author note and expanded upon in the Discussion section. See this example from Jovanova, et al. (2022):

- Sample positionality statement: “Mindful that our identities can influence our approach to science (Roberts, et al. 2020), the authors wish to provide the reader with information about our backgrounds. With respect to gender, when the manuscript was drafted, four authors self-identified as women and four authors as men. With respect to race, six authors self-identified as white, one as South Asian and one as East Asian.”

For more guidance on writing positionality statements, see Roberts, et al. (2020) and Hamby (2018).

Inclusive reference lists

Research has shown that there is often a racial/ethnic and gender imbalance in article reference lists, and that Black women’s work is disproportionately not credited or cited as often as White authors’ work (Kwon, 2022). Authors are encouraged to ensure their citations are fully representative by both gender and racial identity before submitting and during the manuscript revision process. Authors are encouraged to evaluate the race and gender of the authors in their reference lists (see this open-source code by Zhou, et al., 2020, that authors can use to predict the gender and race of the authors in their reference lists) and to report the results in

a **citation diversity statement** in the author note or Discussion section of the manuscript.

See Dworkin, et al. (2020)'s sample citation diversity statement:

> "*Citation Diversity Statement*. Recent work in neuroscience and other fields has identified a bias in citation practices such that papers from women and other minorities are under-cited relative to the number of such papers in the field (Caplar et al., 2017, Chakravartty et al., 2018, Dion et al., 2018, Dworkin et al., 2020, Maliniak et al., 2013, Thiem et al., 2018). Here, we sought to proactively consider choosing references that reflect the diversity of the field in thought, gender, race, geography, seniority, and other factors. We used automatic classification of gender based on the first names of the first and last authors (Dworkin et al., 2020, Zhou et al., 2020), with possible combinations including man/man, man/woman, woman/man, and woman/woman. Code for this classification is open source and available online (Zhou et al., 2020). We regret that our current methodology is limited to consideration of gender as a binary variable. Excluding self-citations to the first and last authors of our current paper, the references contain 12.5% man/man, 25% man/woman, 25% woman/man, 37.5% woman/woman, and 0% unknown categorization. We look forward to future work that could help us to better understand how to support equitable practices in science."

Data, materials, and code

Authors must state whether data and study materials are available and, if so, where to access them. Recommended repositories include APA's repository on the Open Science Framework (OSF), or authors can access a full list of other recommended repositories.

In both the author note and at the end of the method section, specify whether and where the data and material will be available or note the legal or ethical reasons for not doing so. For submissions with quantitative or simulation analytic methods, state whether the study analysis code is available, and, if so, where to access it (or the legal or ethical reason why it is not available).

For example:

- All data have been made publicly available at the [repository name] and can be accessed at [persistent URL or DOI].
- Materials and analysis code for this study are not available.
- The code behind this analysis/simulation has been made publicly available at the [repository name] and can be accessed at [persistent URL or DOI].

Public significance statement

Authors submitting manuscripts to PSOGD are required to provide a short statement of one to two sentences to summarize the article's findings and significance to the educated public (e.g., understanding human thought, feeling, and behavior and/or assisting with solutions to psychological or societal problems). This description should be included within the manuscript on the abstract/keywords page.
View Guidance for Translational Abstracts and Public Significance Statements.

Clinicians' Digest

PSOGD includes a Clinicians' Digest section providing practitioners with clinically useful, yet scientifically robust ideas from articles published in the journal.
The Digest, consisting of one- or two-paragraph synopses of clinically relevant concepts from articles in that issue, presented together as one piece, is written by a rotating team coordinated by Kim Skerven, PhD.
Authors of the source articles from which the Digest synopses are drawn have the prerogative to decline their articles' participation in the Digest. They are, however, strongly encouraged to allow their articles to be included in order to facilitate their findings being maximally useful to practitioners.
Digest authors will work with source articles' authors to maintain fidelity with the source article.
The synopses in the Clinicians' Digest are intended to be used with the source article and its abstract, but offer original clinically relevant ideas based on the source article.

Formatting

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*.
Additional guidance on APA Style is available on the APA Style website.
Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.
To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can

convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.
Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

In online supplemental material

We request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.

In the text of the article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.)
If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's insert table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Academic writing and English language editing services

Authors who feel that their manuscript may benefit from additional academic writing or language editing support prior to submission are encouraged to seek out such services at their host institutions, engage with colleagues and subject matter experts, and/or consider several vendors that offer discounts to APA authors.
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Submitting supplemental materials

APA can place supplemental materials online, available via the published article in the PsycArticles® database. Please see Supplementing Your Article With Online Material for more details.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the references section.
Examples of basic reference formats:

Journal article

McCauley, S. M., & Christiansen, M. H. (2019). Language learning as language use: A cross-linguistic model of child language development. *Psychological Review*, *126*(1), 1–51. https://doi.org/10.1037/rev0000126

Authored book

Brown, L. S. (2018). *Feminist therapy* (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000092-000

Chapter in an edited book

Balsam, K. F., Martell, C. R., Jones. K. P., & Safren, S. A. (2019). Affirmative cognitive behavior therapy with sexual and gender minority people. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision* (2nd ed., pp. 287–314). American Psychological Association. https://doi.org/10.1037/0000119-012

Figures

Preferred formats for graphics files are TIFF and JPG, and preferred format for vector-based files is EPS. Graphics downloaded or saved from web pages are not acceptable for publication. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file. When possible, please place symbol legends below the figure instead of to the side.

Resolution

- All color line art and halftones: 300 DPI
- Black and white line tone and gray halftone images: 600 DPI

Line weights

- Adobe Photoshop images
  - Color (RGB, CMYK) images: 2 pixels
  - Grayscale images: 4 pixels
- Adobe Illustrator Images
  - Stroke weight: 0.5 points

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.
The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., “the red (dark gray) bars represent”) as needed.
For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

- $900 for one figure
- An additional $600 for the second figure
- An additional $450 for each subsequent figure

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On advice of counsel, APA may decline to publish any image whose copyright status is unknown.

- Download Permissions Alert Form (PDF, 13KB)

Publication policies

For full details on publication policies, including use of Artificial Intelligence tools, please see APA Publishing Policies.

Duplicate publication

APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications.

Splitting data sets; data fragmentation

Please read the Open Letter to Authors for APA Journals (PDF, 40KB), but especially, please note the following:

> **Duplicate/fragmented publication**. Duplicate publication involves publishing the same data more than once. Fragmented (or piecemeal) publication involves dividing the report of a research project into multiple articles. Duplicate or fragmented publications are misleading if they appear to represent independent instances. They can distort the scientific literature, especially in reviews or meta-analyses.
>
> On occasion, it may be appropriate to publish several reports referring to the same database. The author should inform the editor at the time of submission about all previously published or submitted reports so the editor can judge if the article represents a new contribution. Readers also should be informed; the

text of an article should cite other reports that used the same sample (or a subsample) or the same data and methods.

Since *PSOGD* allows for longer submissions, up to 12,000 words, there should be few circumstances where publishing several pieces from the same data set is warranted. Data sets that have both quantitative and qualitative components should generally be published as a whole.

PSOGD recognizes, however, that some large data sets, for example as are common in epidemiological research, appropriately lend themselves to multiple publications. Authors are expected to contact the Editor before submitting a piece which may have fragmented data, provide a rationale for this, and obtain the Editor's consultation on the appropriateness.

Authors who undermine these guidelines by covertly splitting data sets and creating separate publications will be denied future consideration for *PSOGD* publication.

Submissions contingent on another article under development or review

If the submission is contingent on data under development or being published elsewhere, authors should wait until the underlying data is at least accepted for publication before submitting a secondary submission to *PSOGD*. For example, if authors rely on a measure whose reliability and validity data have not been published or are under review, authors should delay submission to *PSOGD* until acceptance for publication and final form of those underlying data are confirmed. Submissions that rely on unpublished underlying data will be rejected without review.

Internet posting, disclosure of interests, and copyright

See APA Journals® Internet Posting Guidelines.

APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

- Download Full Disclosure of Interests Form (PDF, 41KB)

Ethical Principles

Previously published data

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

Availability of raw data

APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the

confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).
APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.
On a case by case basis, *PSOGD*'s editor may request that authors provide all or some of the raw data on which research reported in a submission is based. This might typically occur at the request of a reviewer, or when the editor believes there is something unusual, atypical or unclear about the reported results.
Authors are expected to provide the raw data requested in a timely manner. Authors' unwillingness to do so will result in the submission's rejection. Data may not be considered proprietary.

Ethical principles certification

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

- Download Certification of Compliance With APA Ethical Principles Form (PDF, 26KB)

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

General expectations of submissions

Given the wide variety of manuscript types that *PSOGD* accepts, all of these recommendations may not be suitable for all submissions, but are most true for standard and longer research articles.

- **Clear description/intro.** Make certain readers are quickly oriented to the purpose and focus of your manuscript. Make sure that the words used to describe your purpose and focus are the same throughout the manuscript.
- **Literature review to set context.** The literature review should situate your work both in the literature on sexual orientation and gender diversity, and in the behavioral sciences more generally. It should include enough to make a compelling argument for why your study was needed, and should lead directly to your purpose and hypotheses/research questions. Too little, too much, or tangential literature review are common errors. Ensure that your sources present credible scientific findings.

- **Clear methodology.** Could others replicate it? Are the chosen methodologies adequately justified? Provide citations to support your rationale for selecting your given methodology and analytical strategy. Are your data appropriate for the study questions and analyses (e.g., adequate sample size)?
- **Information about measures.** Basic reliability/validity of measures should be summarized and, when possible, these data should be obtained from samples consistent with your study sample. Provide reasons for choosing the specific measures. In addition, report the number of items, scoring procedures, the directionality of scores (e.g., higher scores on this measure indicate higher...), and how scores are computed. If measures were modified in your study, describe the rationale for the modification, the specific modification, and whether this modification was guided by any theory or previous study's methods, and how the measure "behaved" in your study (e.g., reliabilities, factor scores).
- **Sample.** Describe clearly sampling and recruitment procedures. Describe demographics and other characteristics. Have you used up-to-date terminology?
- **Statistics.** Are your statistical results presented in a clear and accessible manner? Does your statistical plan map to your hypotheses? When programs other than SPSS or SAS are utilized to conduct the analyses, report the program (e.g., MPlus). Only identify quantitative results as significant when they meet the generally accepted minimum criterion of $p < .05$ (i.e., do not suggest that scores "trended toward significance" unless you did a trend analysis). Discuss missing data (i.e., amount and whether data were missing at random) and how missing data were addressed. Were the tables/charts/graphs etc. checked for accuracy?
- **APA Style.** Headings, references, citations, and tables/charts are frequently done incorrectly. Please check these carefully.
- **Copyediting.** Your submission should be free of spacing, formatting, grammatical, spelling, and other copyediting errors. Manuscripts judged to contain an unreasonable number of errors will be rejected without review.
- **Conclusions.** Are the conclusions that are drawn clearly supported by the data and congruent with the limitations of your methodology? It is a common mistake to reach beyond your data, especially when discussing implications for practice, advocacy, education, etc. However, not discussing the full implications of one's findings can be problematic as well. Strive for balance,

but err on the side of caution. Attempt to relate the findings to conclusions reached in previous research but watch speculating beyond the data.

- **Limitations.** Do not minimize or avoid. Describe limitations directly, and when possible use your limitations as a springboard for recommendations for future research.

Note compliance with institutional review board and ethical requirements, without sacrificing masking of the manuscript.

Concise writing

Be concise and avoid expansive writing.

Journal space is at a premium. Please review your submissions to keep the writing as concise and focused as possible. The goal is to write just enough to fully communicate the integrity of your work.

Manuscripts with an unnecessarily verbose writing style will be returned to authors, unreviewed, for a more focused and shorter revision. This is also true of references, which should be sufficient to fully justify and contextualize the submission-but no more.

Tables, charts, figures etc. should similarly summarize and clarify, and contribute to the understanding of the research being presented beyond the information reported in the text. If they do not do so, they serve no useful function and authors will be asked to condense or delete them.

Stylistic differences

Be aware of the stylistic differences between student and institutional papers versus journal publications. Papers that are initially prepared as student assignments, reports of research grant activities, internal institution documents, etc., are typically in formats and styles inconsistent with journal publication.

For example, faculty often expect student papers to demonstrate wide-ranging literature reviews and elaborate justifications of methodology and instrumentation; grant and institution-focused papers often address goals and issues uniquely relevant to those entities.

Such papers usually require considerable revision before they are appropriate journal submissions. This is almost always in the direction of sharper focus, more concise writing style, and significant shortening.

Faculty and funding sources usually expect such student and institutional paper authors to demonstrate skill sets and goals that go beyond concise presentation of the material. Journal publications seek only concise presentation of the material. Please edit your work accordingly before submitting it.

Other information

See APA's Publishing Policies page for more information on publication policies, including information on author contributorship and responsibilities of authors, author

name changes after publication, the use of generative artificial intelligence, funder information and conflict-of-interest disclosures, duplicate publication, data publication and reuse, and preprints.

Visit the Journals Publishing Resource Center for more resources for writing, reviewing, and editing articles for publishing in APA journals.

Appendix 2.2

Project Approval from NHS Peer Review Team

Reviewer Recommendation:

Approve: ☐ Approve with amendments described above: ☒ Resubmit after amendment as described above: ☐ Reject: ☐

Signature: **Amy Grosvenor & Clare Marriott**

Date: **07.06.22**

Peer Review Understanding the experience of mental health self-disclosure within a Gender Identity Service.doc

Appendix 2.3

Participant information sheet and consent form.

Understanding the experience of mental health self-disclosure within a Gender Clinic

Participant Information Sheet

Information for participants

You are being invited to take part in a **Service Improvement Project** aimed at understanding the experience of disclosing a diagnosed mental health condition to clinicians working within Northamptonshire Gender Clinic. This project is being conducted in collaboration with the Oxford Institute of Clinical Psychology Training and Research.

Before you decide whether to take part, it is important for you to understand why the service improvement project is being conducted and what it will involve. Please take time to read the following information carefully before deciding whether to take part and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Thank you for taking the time to read this.

About the project

Who will conduct the project?

The lead for this service improvement project is Jodie Collins, Clinical Psychology Trainee at the Oxford Institute of Clinical Psychology Training and Research which is part of the University of Oxford and Oxford Health NHS Foundation Trust. The project will be

supervised by Dr Alastair Pipkin, Senior Clinical Psychologist, Northamptonshire NHS Foundation Trust and Dr Matthew Knight, Clinical Tutor, Oxford Institute of Clinical Psychology Training and Research.

What is the purpose of this project?

The purpose of this project is to understand how self-disclosure of a diagnosed mental health condition to clinicians within the Northamptonshire Gender Clinic is experienced by Transgender and gender non-conforming service users. The project also aims to understand how service users who choose to self-disclose their mental health diagnosis/es can be supported throughout their journey with the Gender Clinic.

Am I suitable to take part?

For you to be eligible to participate in this project, we ask that:

- You are aged 17 years or older
- You identify as either Transgender Male or Transgender Female
- You have been a service user at Northamptonshire Gender Clinic for at least 6 months
- You are receiving treatment in the Gender Clinic and have been undergoing hormone therapy for at least 6 months
- You have or have had a diagnosed Mental Health condition, which you have disclosed to a professional at Northamptonshire Gender Clinic
- You have access to Microsoft Teams
- You are English speaking

This is so we can ensure information gathered in the project accurately captures and reflects the experience of transgender individuals disclosing a diagnosed mental health condition to professionals working at the Northamptonshire Gender Clinic.

Will the outcomes of the Service Improvement Project be published?

We intend to publish the results in a peer-reviewed journal. Participants will not be provided with an individual summary of their interview data. However, we will provide participants with a summary of the overall study findings if they would like this by emailing the lead researcher to request this.

Who has reviewed the research project?

The project has been reviewed and approved by Northamptonshire NHS Research and Development team.

What will participating in the project involve?

To take part in the project please electronically complete and sign the consent form and return to the lead researcher via email.

What would I be asked to do if I took part?

After providing consent to take part in this project, you will then be invited to take part in an online interview conducted by Jodie Collins. You will receive an email with a link to the interview which will take place via video call using the platform Microsoft Teams. You will be able to access Microsoft Teams using any computer, tablet, or smart phone that has internet connection.

You will be asked to complete a demographic questionnaire including questions about your age, ethnicity, and gender identity, this will be completed verbally at the beginning of the interview. It is anticipated that the online interview will last approximately between 1 hour and 1 hour 30 minutes. The interview will be audio recorded for the purpose of transcription.

What happens if I do not want to take part or if I change my mind?

It is up to you to decide whether or not to take part in this project. Should you decide that you do not wish to take part, simply do not complete the consent form.

If you do decide to take part you are advised to keep a record of this information sheet and if you wish to participate you will be sent a consent form to complete, sign and return to the researcher.

If you decide to take part, you are still free to withdraw at any time without giving a reason and without detriment to yourself. However, it will not be possible to remove your data from the project once it has been anonymised as we will not be able to identify your specific data. This means that you have up to four weeks from the date of your completed interview to contact the lead researcher via email to withdraw, at which point all of your data will be deleted. After four weeks have passed, your transcript will have been written up, anonymised and will no longer be associated with you, so it will not be possible to withdraw. This does not affect your data protection rights. If you decide not to take part, you do not need to do anything further.

Data Protection and Confidentiality

How will data be stored and used?

All the information collected will be pseudonymised and will not be attributable to you. The demographic questionnaire measures and the interview will be co-ordinated and analysed by Jodie Collins, Trainee Clinical Psychologist.

Your anonymised data will be stored securely on the Oxford University 'Nexus 365 One Drive', a secure cloud storage facility, for a maximum duration of 5 years, before it will be deleted. Other members of the research team will only be given access to data that has already been anonymised.

Will my participation in the study be confidential?

The information that you choose to share will remain confidential. However, should you choose to disclose any information relating to a current risk of harm to yourself or another person, the researcher will have a duty of care to break confidentiality, seek advice from the project supervisor and the Trust's safeguarding lead may be required to take further action as appropriate.

To support the evidence-base of research in this area, the anonymised data will be analysed, written up and submitted as part of Jodie Collins's research portfolio, examined as part of her evidence for award of the Doctorate in Clinical Psychology. This will also be submitted to a peer reviewed journal so that the wider community of Psychology can learn from, and develop further, the understanding of Transgender people's experiences of mental health disclosure to professionals within healthcare services.

What do I do now?

If you have any remaining queries about the project, then please contact the project lead**.**

Contact details: **Jodie Collins – Trainee Clinical Psychologist**

Jodie.collins@hmc.ox.ac.uk

PARTICIPANT CONSENT FORM

Understanding the experience of mental health self-disclosure within a Gender Clinic

Project Lead: Jodie Collins, Trainee Clinical Psychologist, Oxford Institute of Clinical Psychology Training and Research

Project Supervisors: Dr Alastair Pipkin, Senior Clinical Psychologist, Northamptonshire NHS Foundation Trust and Dr Matthew Knight, Clinical Tutor, Oxford Institute of Clinical Psychology Training and Research

Please tick each box

1. I confirm that I have read and understood the Information sheet for the above project dated 22.09.22 Version 1.4. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw without my medical care or legal rights being affected. I am free to withdraw, without giving any reason, up until 4-weeks post interview at which point my data will be anonymised and no longer identifiable. ☐

3. I understand that the information I provide as part of this project will remain confidential and that the only exception would be if the interviewer were concerned that I, or someone else, might be at immediate risk or harm. ☐

4. I understand that the interview will be audio recorded for the purposes of transcription and once it has been accurately transcribed the recording will be permanently deleted. ☐

5. I understand that the data I provide will be anonymised, that this data will be stored securely,

for a maximum duration of 5 years before it will be deleted in accordance with Northamptonshire NHS foundation Trust Policies. ☐

6. I understand that the information collected about me will be published in anonymised form. It may be shared anonymously with other researchers and may be used to support other research in the future. ☐

7. I understand that I am able to request access to copies of my data up until 4 weeks after the date of my interview at which time my data will have been anonymised and no longer identifiable. ☐

8. I agree to take part in the above project. ☐

_____ _____ _____

Name of Participant Date Signature

_____ _____ _____

Name of Person taking consent Date Signature

Appendix 2.4

Screening Questionnaire

- Do you have access to the Microsoft Teams platform? Yes/No
- Are you aged 17 years old or older? Yes/No

- Have you been diagnosed with a mental health condition? Yes/No
- Are you currently a service-user of the Northamptonshire Gender Clinic? Yes/No
- When did you first start accessing Northamptonshire Gender Clinic? Date.
- Are you currently receiving treatment at Northamptonshire Gender Clinic? Yes/No
- When did you begin undergoing hormone therapy? Date.

Appendix 2.5

Group Experiential Themes and Quotes

Participant Number	Participant Pseudonym
1	Sophia
2	Blake
3	Tao
4	Alex
5	Dennis
6	R

THEME 1: Facing and overcoming challenges in accessing Gender Care					
Subordinate Theme	Participant	PE Theme	PE Subtheme	Quotes	Line Number
1a. Mental Health as a Barrier to Gender Affirming Care	1	The experience of gender gysphoria	Mental health is a barrier to accessing gender care	"The mental health condition did get in the way even early on, trying to access the gender clinic." "There was talk of, you know, oh, we need to do a thorough like a sort of examination to check that there aren't other for example, psychotic mental health problems that producing this illusory state of me being trans, right?" "also energy levels being like low and having low motivation because of depression and also anxiety. All the things that come along with that just add sort of friction to, to accessing the services there"	685-686 686-688 689-691

				"And that was kind of a result of a combination of my depression and the specific treatment I was having for my gender dysphoria." "What effect did that have on accessing it? Perhaps insecurity and self-consciousness? Also low motivation and low energy preventing me from going right forward with it because generally" "so having anxiety and depression probably did exacerbate that and held me back from asking sooner"	705-707 138-140 144-145
	2	Barriers to gender care	Perceived and actual consequences of disclosure	“Assumption. And. Having assumptions as to what that meant or how that applied to me because I'm sorry if somebody does have EUPD, let's say that's gonna mean different things to different people. And unfortunately, when I was like, they've already made an assumption as to what that was for me, without me even telling them” “Umm but yeah, so I think things like that, that's what needs to improve, if I'm honest and they need to stop holding us to account on mental health and using that as the basis to decide whether or not we're dysphoric or not, you know, ohh, because you're struggling therefore you must have, like, with your body therefore you must have dysphoria” “So I think it is a bit of a balancing act. If I’m honest so for me personally, the disclosure itself wasn't the negative problem that the problem wasn't the negative part in itself, because they are gonna be aware of that anyway from the umm the notes, as I said earlier. The problem I had is what they're perceived idea of that diagnosis in relation to myself is the problem. Or when I explained to them that I didn't believe that I did have EUPD and I actually is because I'm autistic. Umm. Again, they just look straight for the notes and then when they went away and did their discussions they brought into an account the idea of that I've got EUPD. When I I told them I really don't believe I do and I've been trying to fight to get to get this looked at. Umm. So yeah, I think that's where the negativity side comes from” “don't really find that it makes someone want to understand me as a person, really, it makes someone want. I don't. It's whether or not I tick the box of the criteria. Almost. It's like ohh do you self-harm or do you know what's	519-522 351-354 193-201 535-543

				your mood like? Mood like on a day-to-day level, or you know. It's just it doesn't really. It's almost like looking at the diagnostic criteria and just sort of looking at what it is and asking the questions as if you're doing the criteria again to know whether or not you've got a struggle or whether you're struggling or you know, trying to figure out how that relates to sort of being trans and whether or not you're gonna regret your transition or not or you're stable enough to be able to make the decision. Umm you know if you got the mental capacities to make that decision. Umm. I don't think it really, that's, that's what's been unhelpful."	
				"Is this assumption and and the the sort of question that doesn't really get them to understand you as a person and and it's more about understanding again the diagnoses they're not, they're not looking at me as a person they're looking at a diagnosis. And I'm more than a diagnosis and I think that's the yeah to turn on its head, that's what they need to do. But yeah, that's what the I think is unhelpful"	543-547
				"Uh a lot of my mental health issues were brought upon because I was in the wrong environment in the first place because I was in hospital, which isn't a good environment for me and makes me worse. So actually, if I had the right support then I wouldn't have been in that place to begin with and therefore I don't feel that they'd have much in the way, but one doctor did while I was in hospital did sign me off for there for the the the uh surgery and they actually agreed to do the referral. I got my first opinion umm and I did that via a zoom zoom thing on here while in hospital and he did it fine. But then the second Doctor I had to do in person and he said no."	456-463
				"So I I didn't and I wouldn't lie anyway. I'm not that sort of person, but I know a lot of people do lie because they don't want to be, you know, to be refused treatment for something that you know they're worried about the consequences if they told the truth, even though it shouldn't, even though it's no different to really, anyway, doesn't matter"	76-79
				" they didn't really care about the hormones. Actually, it's the surgery that was the big one I found. Which is weird because a woman can go and get a boob job and she doesn't need to have no psych assessment."	296-299

				“The first time I did tell them, but I instantly was worried by the look on their face. So I then like tried to then over explain why I was stable and why everything was going well. In order to try and prevent a negative reaction”	313-315
				“And when it comes to disclosing, like, mental health, that is literally the only focus throughout the entire, the entire the entire umm meeting is all about my mental health. In fact, very rarely it takes them two minutes to go through my hormones and that's it. The whole rest of the the consultation is about my mental health. For about the whole out like a a good 40 minutes of it is about my mental health with only like 15 minutes at the end of physical health issues or hormones or whatever.”	282-287
				“don't think it's anything helpful about disclosing mental health, if I'm honest. I'd love to say that it makes them more understanding of you, but it doesn't really. Umm. Because diagnosis only shows a deficit of a person. It doesn't show a positive out of person, just a deficit. It's always a something wrong with you on your inability to cope with the world. That's what the DSM does unfortunately. It's how. It's how you know, something wrong with me? It creates a them and us sort of situation. So disclosing mental health never makes you feel any good, because all it does is it makes you feel even further, like more different than you can imagine from that, that from the professional I think it creates more distance not less.”	489-496
				“Nothing about me disclosing my mental health has made any benefit whatsoever”	
				“So that's where my biggest worry was in are they gonna say yes to allow me to start hormones? Are they gonna say yes to allow me to have surgery and? And yeah, the surgery won't even now I'm really, like, really anxious”	331
				“ And it's always very quite like I say quite invasive questioning. Umm. Not aggressive, but definitely quite, but like definitely quite a lot of questions after another. And so yeah, that gets quite tiring to deal with all the time I have to admit. That's that's. That's the repercussions of the first time I opened up about it.”	401-403 438-441
				“So yeah, I think that's where the negativity side comes from. It's and it's, it's it's restricted my access like I'm worried at the moment about becoming	

				unwell between now and my surgery because if I end up in hospital and worried they are gonna delay my surgery again and then I'll have to go through another set of interviews for people to decide whether or not well enough to have this surgery"	200-204
	2	Barriers to gender care	Waiting has an impact	"So I really did struggle with the wait. Umm. My whole life sort of broke apart, fell apart, really. My, my, my relationships fell apart. Yeah, it was quite significant time for me." "And then it turns out I've been waiting and waiting and waiting to hear from this, from the consultant and going, you know, I've not heard anything from anyone. And it turns out he didn't actually do the referral after all." "Well, this is the thing. They just shouldn't be having such a long wait time. It's the only way you can sort of make that experience better, because it's the the dysphoria that you have to experience every single day. That dysphoria that you know, that's just gets worse and worse and you just, you know, you don't know, you know. Like once, once you start hormones, you start seeing yourself in the way that you you saw yourself before as such, like underneath then you feel a lot more confident in yourself and you fit in when you go to a bathroom or an area use of, you know, same-sex spaces, which when you're when you're at the beginning and early in your transition, you don't always pass." "So I didn't understand why they couldn't still do the referral with the idea of then doing the whole keeping an eye on me thing and which means nothing. Umm and then if they really felt that there was a problem, then we could stop because actually my worry was that the longer I was waiting to get on the waiting list then I would have an even longer wait on the waiting list if they got me on the waiting list at least then I'd only be waiting in that amount of time and then you know if they wanna delay it's only a little bit. Whereas if you're not putting me on the list, it's just growing. So I just wanted to be on there like a lot earlier just so I can get through it. So yeah, they did delay treatment because of that" " And when you're waiting years already to see somebody, then you have to	20-22 467-470 48-55 449-455

				wait another few years just for hormones and then you have to wait again and then you're being told, sorry, you know, your mental health is too, too bad to be able to have surgery but actually the surgery would improve my mental health.”	122-125
				“ So I'm constantly worrying all the time about what is going to happen next and am I going to get the support I need when it's already a very, very long wait. You know how much longer is this going to take? And this is taking this taking up what, six years of my life already like, I haven't even got past the the first bloody hurdle, you know umm. And I just think you know, but I'm gonna be like in my 40s before I've even got anywhere near like completed, like fully finishing on my shir like transition. So it's gonna be a long time in in the in you know a long time in the making and they I think that just delays everything and make things a lot harder. And. And yeah, it does have a significant impact I think, well it has for me anyway.”	204-212
				“ And people just kept, like, the only thing people say is ohh you know, you've been waiting this long already you know, it's only a few months to, like, get, but you keep saying that. But when you’ve been struggling this long already, a few months feels like a long time and then they keep saying ohh and then it's another few months and it's another few months and another few months and it's it's never just a few months. If it was just a few months, then obviously it'll be alright, but it's not. It's never just a few months. It's always that repetitively. Umm so. Yeah, it did cause a big impact for me. Yeah, and I needed a lot of support with that friends and family and to try and sort of just get by generally because I was just so uncomfortable with myself and I didn't wanna go out anywhere because, you know, my chest didn't look like I was worried about my chest and. Yeah, I just struggled anyways as it was. So I think that was just an added pressure that I didn't need if I’m honest.”	574-584
				“ But initially, yeah, they did. They did say no. So every time they just keep saying like no it's getting quite hard. It's hard work and you start losing hope in the service and you start thinking like it's never gonna get anyway.”	477-479

	2	Barriers to gender care	Mental health: a fine line between opening and closing the gate to gender care	"So it's almost like trying to, you know, try to tread a tight rope because in order to get treatment, you need to show you how your discomfort and you need to show that you're unhappy yourself. But then if you're not, if you're too unhappy or not, what, like, really unwell, then all of a sudden, no, we can't support you because you need to be stable. So I think it is a bit of a balancing act." "Umm because I feel that there's not enough education in the services and also I find that unfortunately having a mental health issue does prevent you from getting the treatment that you need, even though they try and tell you it doesn't." "And when you're waiting years already to see somebody, then you have to wait another few years just for hormones and then you have to wait again and then you're being told, sorry, you know, your mental health is too, too bad to be able to have surgery but actually the surgery would improve my mental health. So, you know, I think there needs to be, they need to find the balance." "You can have someone who doesn't self-harm, who is very mentally unstable, but that's OK. And you know, so why is this? Why is this not OK, you know, and trying to prove why, how I'm sort of improving in one area of my life just to be able to receive the treatment that I feel I need shouldn't have to happen." "So other times, like I said, because I was unwell in hospital. Umm they'd ask what was going on and because I was in hospital, they then refused to do the referral for surgery, for example, even though there is an over a year waiting list. And I thought that by the time I get down the line, I would probably be fine by then. Umm. So I didn't understand why they couldn't still do the referral with the idea of then doing the whole keeping an eye on me thing and which means nothing. Umm and then if they really felt that there was a problem, then we could stop because actually my worry was that the longer I was waiting to get on the waiting list then I would have an even longer wait on the waiting list if they got me on the waiting list at least then I'd only be waiting in that amount of time and then you know if they wanna delay it's only a little bit. Whereas if you're not putting me on the list, it's just growing. So I just wanted to be on there like a lot earlier just so I can get through it. So yeah, they did delay treatment because of that"	189-193 (quote) 3-5 122-126 139-142 445-455

				"But then the second Doctor I had to do in person and he said no. When out of hospital and I've been out of hospital for a few months I went to that, did an arrange to do another appointment. I'd shown I've been, I've stable, got, become more stable. And answered the questions about my mental health, I explained how it's been, how I've got support in place, blah blah, blah. And he agreed to do the surgery and he's to do that, to do the referral. He agreed to do the referral and I walked out there so happy it was ridiculous. And then it turns out I've been waiting and waiting and waiting to hear from this, from the consultant and going, you know, I've not heard anything from anyone. And it turns out he didn't actually do the referral after all. He hadn't done it, he said that I had to go to this complex patient meeting, and they turned around and said actually they don't think I'm ready yet to have surgery." "So the effects was that it had a massive effect on my mental health. Unfortunately, when they told me that I wasn't allowed to be referred for surgery, or when I found out that the referral was never sent and that did cause a decline in my moods and and I did get very depressed and my anxiety went through the roof, I was also really worried about, you know, whether or not I was even gonna get the surgery that I wanted cause I felt like I've like pushing against barrier after barrier and jumping hoop through hoops. And I just couldn't get anywhere as I was going round in circles"	462-471 567-573
	3	To share or not to share?	Barriers to disclosure	"they try to discharge me based on the reason that I'm depressed or not well based on some mental health problems" "So that might be the reason why I was afraid to disclose everything and also, I do my own research on, you know, the Trans stuff, the gatekeeper thing that is circling around the Internet and also like I mentioned before, the acne and there's association with depression" "So it's just all these knowledge but not enough knowledge for me to know how much I should disclose and what not and there might have an impact on my access to the GIC because apart from them, nobody else in the entire country can help."	96-97 101-105 106-108

				“I don't think I consciously decide that that it was just how the question was framed, that I just instantly gave them a no, I'm fine answer” “they were quite content with my response, often no, that probably reduced their workload. So they really didn't connect with what my needs were umm or trying to dig deeper into it”	301-302 86-88
	6	Obstacles and tactics to get gender care	Mental health perceived to be a barrier to gendered care	"I feel like I have to be strategic and make sure that I'm presenting is like healthy and have like a healthy weight for my hysterectomy and that's that's about it. I feel like if I if I told them that I would was still like dieting or whatever, they would probably not let me get the surgery" "Yeah, I wasn't sure if like if I was like, fully honest about like about how I was doing, if that would affect. Umm how quickly I got hormones or whatever."	312-313 140-141
1b. Practical difficulties	3	Navigating the gender service	Challenges faced	“The fact that they send out paper letters at that time. I was living in Student Accommodation, so the mail was just everywhere.” “So I had like, huge trouble attending the appointments themselves. That's kind of part or large part of the reason why I was discharged subsequently.” “I called the receptions about like 6 times or e-mail them. A about not giving me early sessions, they still give me that. They just randomly delete my requests and so it was very unhelpful and appointments themselves were very short.” “then the appointments themselves were very short. So it was not really worth the effort.” “Because we are not medical practitioners.” “So that was why I don't really want to attend these sessions, because most of the times they were short and only enough to ask how are you doing?”	38-39 57-59 70-73 12-13 18 79-80
	6	Obstacles and tactics to get gender care	Challenges in accessing the gender clinic	“It was definitely frustrating. I mean, if I I was. I've been waiting so long already and I umm yeah. If I needed to ask about like an appointment or something, or ask about umm like yeah, any questions about treatment? It was hard to get those.”	41-43

				“Was quite hard to get in contact with anyone at the time. I think it's a little better now, but like you could I I remember like anytime I would call the clinic or my GP would call that you just be on, you'd be sent to answer phone or like they would say sorry, there's call back later kind of thing” “think just the fact that I've been asked them so many times before. I guess it would have been. It would have been nice for that information to kind of get carried over from my previous clinics? But I also understand that like they need for their own records to like hear it from me or whatever” “ Nothing from like nothing from the the the the clinic that was helpful. I mean stuff like seeing my therapist and stuff was helpful, but but that wasn't with the clinic yet” “the Gender Clinic didn't like give me any other like therapy. I don't know if that's something that they do that, but I never had like like specialized like gender related therapy like mentally” “ I think some of the appointments may be felt a little like I travelled a long way and not not much had happened kind of thing” “And yeah, it was it was fine. It was a pretty short appointment. Again, it's like, I think it's. Yeah, it's it's just because I live a long way away. It's kind of like I go there for 10-minute appointment its like yeah, but I just had, like, a brief kind of chat about it just to make sure that I understood what I was getting into with the hysterectomy and making sure that I was OK to like not do any like gamete storage or umm, whatever”	31-34 91-94 25-27 124-126 65-66 175-180
1c. Other obstacles to gender affirming care	3	To share or not to share?	The impact of autism	“for instance autism some I don't know how much that plays in my appointments where I just always tell them that I'm fine” “I am still figuring out” “iit might be linked to autism. Was so maybe that was the reason why I always answered, said I'm fine. And no, I don't have anything else to discuss in the initial short sessions” “they really didn't connect with what my needs were umm or trying to dig deeper into it”	81-82 306 167-169 87-88

	4	Barriers to gender affirming care	Perceive a non-binary identity as a preventing access to gender-affirming care	“So it was so when I spoke to the doctor. He basically said you won't get surgery because you don't identify as a binary trans female.”	306-307
				“all I'm asking from the NHS is a bit of support after I've worked really hard to get here and for them to say ohh the surgeon won't the surgeon won't won't accept you as a patient cause you don't identify it as trans female I think it's I think it's old fashioned”	313-317
				“But I think with me I'm just mildly anxious that because I haven't changed my name or because I'm yeah, I still pick and choose who I want to be out to. I think they are going to treat me with some thought or with some suspicion and I don't know how to feel more genuine or more have more conviction about my own gender identity”	362-365
				“It's not particularly fair if you withhold treatment just because I I'm being quite guarded around their transition and actually you know, my gender identity is fluid because that's just where I've got to in life”	270-273
				“I don't work in an environment that really allows me to be openly trans because of what we see in the world”	251-253
				“I don't think because I don't identify as something the NHS says that I should do, should stop me from having some support.”	684-686
				“Because there is obviously very entrenched process to get the support. But the problem or the the great thing, but what is probably quite. Uh. Counterproductive for the NHS is everyone's like gender identity is different. Yes, a lot of people will be either trans male or trans female, but there are a growing number of people who are. But I liken myself, and I'm not saying this is about anybody else, but I describe myself as neither here nor there. And I think that the NHS is probably not even the NHS, but surgical provision might be some way behind that because it cause is the GIC or is the surgeons saying that although we accept that the gender identity is different to a person’s sex are we just throwing that completely out the window for some support mechanisms”	653-663
				“the NHS as a whole seems to be flawed by the fact that. And I think they seem to be quite. Uh, not confused, but they don't really know how to manage people who have kind of a a non-binary identity”	218-221

				“Which kind of confuses me which makes it difficult for me to comprehend why they're being particularly funny about with me for lower surgery or this because I’m non or identify as non-binary” “I I have to had a real kind of negotiation with the with the GIC to actually get some support for like for lower surgery”	567-569 263-265
	4	How they attempted to access the Gender Clinic	Passive approach to care	“what I mean by that is, is that I had made no effort to actually mentally transition or you know all all I did was things that I thought made or did easy things and then said I was trans, but actually didn't grip it properly” “ultimately I did all the quick wins because that's what addicts do but didn't actually do anything” “So um the first time I went, and it was all I was, you know, I was, I was petrified of going because I think I'd be lying that I didn't kind of put my whole the whole idea of me waking up one morning and feeling better into the GIC because life was so rubbish” “I thought that I'll, I'll just go and have my first appointment and then I'll click the fingers and I'll wake up completely different and cured of all my ills and actually didn't put any of the work in to get myself prepped for first appointment” “I don't want to bother [GIC name] till they want to get in touch with me about the this is what the next steps with my sort of surgical sort of side of things.” “I don't really know what [GIC Name] are expecting of me” “if I have if I have this one session of speech therapy I’ll end up, I'll just wake up tomorrow completely different, completely sober, completely female, and completely amazing and often forget the last 10 years ever happened” “I'm gonna wait for tomorrow and everything's gonna be amazing, everything is going to be different” “I should have learned how to be who I think I should have learned who I was first before actually accessing the clinic potentially. And I'm not saying that [Location] wrong to put me on hormones and things like that, because	170-172 165-166 131-134 55-58 355-357 333 399-402 136-138 119-122

				then. No, I'm just kicking myself”	
	4	How they attempted to access the Gender Clinic	Motivation to access the Gender Clinic	“I did use the GIC initially as an excuse to not focus on the things that should have been focused on before.” “bizarrely, lower surgery has always been a thing like as ever since I've known like ever since I was about 9 years old” “I was really set on a binary male to female transition and in between not turning up to work and getting divorced and generally being an absolute horror of a human being, I ended up quite set on a binary male to female transition” “The one constant through all of this is my frustrations around how I am sort of anatomically” “The one constant in all of this is I'm assigned male at birth and I want to do something about that, which is why I'm at [Location] and I think they've lost sight of that a little bit.” “like I'm jacking it all in but don't discharge me from the services”	29-30 175-176 68-71 268-269 299-301 446-447
	5	Factors limiting or increasing access to gender affirming care	Adjusting to the impact of physical health on their gender affirmation	“I'm not in a situation to have surgery umm, you know” “ one of the doctors had suggested, you know well, "why are you not fully transitioning?" Well, that's my decision that I don't want to fully transition. Because fully transition part of it is it's, so I'm I'm not well enough really to be perfectly honest.” “I'm an open book. Umm unfortunately like when you get the diagnosis that I've got. But for me, blood and stuff. Yeah, you you don't. It's not. You don't care, but but like. I got. I've got nothing to lose” “It might have been a different path for me if I hadn't been diagnosed with with a cancer problem in my blood. Which I have to take chemo tablets for every day so it and it's it's the whole package of things you see. So you know these are all things that [Location]. So when I speak to the doctor at [Gender Clinic], it's not just umm I'm I'm not as medically fit straight away, medically I'm not straightforward case for them. But that's never been a problem”	339-340 335-338 424-426 16-22

1d. Factors perceived to facilitate access and disclosure	1	Motivators to sharing vs consequences of mental health difficulties	Factors facilitating disclosure	“I also trust them a lot, the gender clinic” “I I don't have a problem with talking about it because you know it's been that massive like cultural shift recently where everyone's talking about mental health now, so you know it feels fine to do it” “I think we might have talked about what it was like for me, what it felt like, what problems it caused me.” “ And that was kind of a result of a combination of my depression and the specific treatment I was having for my gender dysphoria.” “it was more just to make clear to them which they they're probably already like fully aware of umm the consequences of my gender dysphoria”	462-463 525-527 513-514 705-707 674-675
	4	Barriers to gender affirming care	Motivated to conceal alcoholism to access gendered care	“ When I lied about my alcoholism to try and get hormones because because they or because I was just petrified of not getting support” “that's why I lied, because I was petrified of not having support because there's still quite a lot of negativity around GICs” “There is the first time I went ultimately, I was um like the the alcoholism was just completely and utterly like there and I lied about it because I was absolutely terrified that I wasn't going to get any help because I knew I needed help” “But I think you know trans people because it until you get that support, you don't really know what to do with yourself and you don't really know how to support yourself. So when you actually finally get this appointment and you don't know what what's gonna happen, it just causes all these anxieties.” “I think the complete denial about alcohol being the problem, and that's just completely proven by the fact that I lied to the blooming very, very knowledgeable, very, very experienced um clinician at my first assessment” “I was petrified of going because I think I'd be lying that I didn't kind of put my whole the whole idea of me waking up one morning and feeling better into the GIC because life was so rubbish” “stopping transition was easier than drinking than stopping drinking.” “the problem is now that I'm in recovery, it's really hard to deal with	523-524 530-532 75-77 534-538 505-507 131-134 462

				depression also” “I got into a relationship and ultimately the drinking came back even worse and then I ended up with more counselling and then I ended up after about 12 months later, kind of quite contritely saying to [Gender Clinic]. OK, I need to really stop drinking now. And if I do stop drinking, can I come back and talk about me and actually taking myself serious now, seriously now? And they said yes. And here I am.” “ Because I was really unwell and because you know the grip of alcoholism had properly got got its claws into me” “I think in hindsight, maybe I should have been, or it should that should have been explored more, because I think if if I if I referred myself to gender identity clinic now with the knowledge that I now have about myself now I'm in recovery and to my knowledge, my feelings about kind of my own identity, maybe that first transition wouldn't have happened.” “I couldn't not because they were aware that I was being a prat with they were aware that I've been blooming been at the [Name of place] at the [Name of place] I've been twice I think [Name of Place] as well” “And then at the end, I mean, this is the madness of it all I was like I'm jacking it all in but don't discharge me from the services”	476-477 188-193 149-150 91-95 491-493 446-447
	5	Factors limiting or increasing access to gender affirming care	Facilitating access to the Gender Clinic	"you've gotta be open and honest. If you can't do that, you're not gonna get anywhere" "If you can't be open and honest with them, then why are you using the service? There's no, you. I was straight to the point with them. I addressed that I I see myself as nonbinary" “I'm sure I'm not a one off you just need to explain yourself when you go there what your goals are what you're thinking about and how that looks for you,” “ I think if your going to access the services for gender clinic and stuff, well is it's no good telling stories or making up stuff or lying or whatever. It is what it is. You answer the questions and the people are here to to help you and assist you. Umm. It's no good being quiet and keeping it all to yourself.” “that's the advantage possibly I've got over somebody else is that I was, I've I knew I	512-513 526-528 398-399 445-448

				wanted to see somebody I knew that was the right way to go.” “I'm a bit old fashioned on my views and something. If they're asking, they're asking you for a reason. So you, you'd answer”	96-98 522-523
	6	Obstacles and tactics to get gender care	Strategies used to increase access to gendered care.	"I feel like I have to be strategic and make sure that I'm presenting is like healthy…I feel like if I if I told them that I would was still like dieting or whatever, they would probably not let me get the surgery" “I'd make the whole trip out there to see the endocrinologist who would basically just like ask me some of the same questions again and and say, OK, yeah, this we we want, we are good to go ahead with this and then I'd have to wait another month to come and do the physical and then another month after that to like come and do the next step of it or whatever like get the prescription” “ And I was so used to like answering questions that that it was like very rehearsed for me. So I didn't think I came across as like umm. Like any warning signs or whatever” “I I I don't know if I'm really as far on with the recovery as as I put across, but I just I need to make sure that I'm I seem to kind of be. I feel like I have to be strategic and make sure that I'm presenting is like healthy and have like a healthy weight for my hysterectomy and that's that's about it. I feel like if I if I told them that I would was still like dieting or whatever, they would probably not let me get the surgery” “It's hard in general to be entirely honest about those things just because I'm worried that that will have some effect that” “So if it would influence my access to it, the hysterectomy and stuff on, I felt like it was relevant for that. But yeah, I've mostly tried to keep it like if it's not relevant to the treatment” “I didn't get the sense that I had this space to be fully honest just because, like if I said one wrong thing, it would, like, ruin all my progress in getting that far kind of thing because I already waited a long time and I wanted it to move it on as fast as possible. Kind of thing.” “I had a therapist when I first started going and then I stopped seeing that	312-315 104-109 119-121 310-315 267-268 292-294 158-160

				my NHS therapist because I've been transferred to the gender clinic and then I the the Gender Clinic didn't like give me any other like therapy”	122-124
1e. Anticipating future challenges to access	4	Barriers to gender affirming care	Anticipate future challenges for those with a non-binary identity.	"they all feel that they need to present in a way that gets them the results that they want” “So I I I think I think trans people probably feel that they have to say the right things and because I'm not saying the right things because I actually I'm not turning up to [Location] sort of as a ostensibly trans Female I think there” “I think it's it's quite damaging. And I think it's. Uh I don't think it's [GIC name] saying we agree, but I just think it's kind of what er what? What support is there out there for non-binary people who are struggling with their sex” “I think trans people probably will be in danger of making decisions because they don't want to lose that support”	665-666 322-324 370-372 241-243
	5	Concerns and improvements	Foreseeing service user experience	"“if you were younger and it was completely just says your first point of contact and then you see the waiting list, I could see that being a problem.” “I just worry about people that are don't do not have to support network that I have like my wife and stuff that I do worry about people that are on their own and stuff and how their minds might be playing you know playing tricks and they they they're they're looking to get help which is a massive that's the I mean the first step of even going to your GP and getting help and getting referral and the thing is you go through all of that and that is very very stressful and then it's like a two year could be longer wait I don't know what damage is waiting this is now I don't know some of the others are a lot, a lot bigger, you know, than [Gender Clinic]” “Yeah. I feel sorry for a lot of people. And they come out and tell the partners or to tell the wife or husband or whatever. And they they, you know, they all they do the off they don't understand. I don't have that I'm lucky I've gotta supportive partner.” “Yeah, the I think another another thing when another problem with it is is	42-44 637-645 543-546 75-78

				is with other things on the Internet now is so accessible, isn't it? So people like, even if you're waiting like if you go and REDDIT or or on the Internet or whatever and and look up say [Location] waiting times or whatever it comes up and then you got people moaning and moaning and moaning.”	
THEME 2: The journey to the true self: who have I been and who I am now?					
Subordinate Theme	Participant	PE Theme	PE Subtheme	Quote	Line Number
2a. Questioning self-identity	2	Who am I?	Questioning own identity	"are they gonna think I'm trans enough? Am I gonna be, you know? Or they gonna see that as because I'm not trans enough because I've got mental health problem and well, because I'm autistic, therefore I can't be trans and I don't know my own self. I don't know my own identity because a lot of times people struggle with a sense of self, but sometimes actually being autistic means that you don't see gender binaries either" "am I trans enough?" "So I was very worried about the effects of how they’ll perceive it, and how that relates to me being trans and whether or not that means that I am or am not trans. Or am I trans enough? Or is it for a different reasons and all that sort of thing?" "Did I? What is? What's the point of gender dysphoria? What's the point of this diagnosis of gender dysphoria? Really like it just doesn't make sense" "So I'm trying to express this to them and then they will go and speak to their colleagues and be like, oh yeah, we understand that this is an ingrained thing and you've been doing this for a long time. And I'm like, well, no, that's not, that's not the point that I'm trying to get. I'm trying to explain that this is not and he has any, it does not have any bearing on my mental stability. You can have someone who doesn't self-harm, who is very mentally unstable, but that's OK. And you know, so why is this? Why is this not OK, you know, and trying to prove why, how I'm sort of improving in one area of my life just to be able to receive the treatment that I feel I need shouldn't have to happen."	394-398 400 398-400 59-60 135-142 (shorter quote 140-142)

	4	Self-identity	Searching for self-identity	"because I'm not trans enough" "if I was to really drum down into me as a human being, I say well, identify as nonbinary, mostly because I still don't really understand where and what my place is in the world." "well, I'm obviously not feeling any better because I'm not trans and I didn't think that actually, it was the fact that I hadn't stopped drinking was making me feel really ropey" “my alcoholism is not gender identity specific in, but if I didn't have gender identity problems, I'd still be an alcoholic or alcoholic in recovery now” “the one thing that I don't particularly want to change about me, bizarrely, is my voice, but that's because I'm very idiosyncratic person anyway, and I think now that I've got to where I am in life, it's just I'm a human being and that's all I can say about it” “I still don't understand why I feel how I do about my own gender identity” “Because she just saw this woman rambling mess blooming, rambling on about how I'm trans and then wasn’t taking this seriously. But I wasn't taking my taking myself seriously” “I've always known that I'm trans to a point”	441 221-223 179-182 35-37 114-116 3 341-343 23-24
2b. Discovering self-identity and acceptance	1	Who am I?	Finding who they are	"I'm an open book" “I'm quite transparent” "I felt like I could really be myself. And they saw me for who I was and they didn't judge me for it." “I found it in general extremely traumatic, kind of growing up the wrong sex and then it took a lot for me to kind of go to the doctor, to the GP and talk to them about it and get referred and everything” “I felt like I could really be myself. And they saw me for who I was and they didn't judge me for it. Instead they just cared instead yeah so it was just. Yeah, it was really magical, magical thing” “the first time in my life I really just did feel like. I, you know uh, that I was a normal person”	432 523 130-131 29-31 130-132 264-265

	2	Who am I?	Discovering different parts of self	"once you start hormones, you start seeing yourself in the way that you you saw yourself before as such, like underneath then you feel a lot more confident in yourself and you fit in when you go to a bathroom or an area use of, you know, same-sex spaces" "she was very restricted to what she was able to support with and I know you can only support with gender related topics, but unfortunately gender is part of my identity and that unfortunately has a part to play in all aspects of my life and" "I don't felt like I didn't feel like she had quite had enough experience or quite enough knowledge to be able to sort of work with somebody who's quite got quite a lot of complex difficulties" "And I'm more than a diagnosis"	51-54 641-644 637-638 546
	4	Self-identity	Evolving identity	"I think where I am now is a lot of my transition now a lot of kind of my slow kind of umm move towards kind of a nongendered sort of identity of most, if as much as they were kind of what I do for living in this sort of sort of social networks". "I have incongruence in relation to my physical self, so I would like support around that, but I don't currently identify as female because one I don't feel it's right because that's not how I feel at the moment in my identity has completely kinda of now I'm in recovery it's it's kind of developed". "once I understood that I can get to or once I the actually I'm worth something, I can I can actually like myself. Um then that was brilliant" "I should have kicked the booze first. I should have got fit first or I should have learned how to be who I think I should have learned who I was first before actually accessing the clinic potentially" "I think um I'm very lucky to be where I am and very lucky to have, you know uh sort of learn again how to be uh a human or an adult, but also human being." "then start exploring who I am as a person"	85-88 225-228 565-567 118-120 125-127

					209-210
	4	Self-identity	Accepting themselves and the journey to get there	"I don't think that you should deny me what support I think need, because I know how I feel when I'm in the shower and I know how my life is and I'm I know that I'm lonely." "because I'm pretty alright with my gender identity at the moment" "I've learned actually how to like myself, or I've learned how to respect myself more. So although I look a bit rot rubbish at the moment because I've put a bit of weight on and stopped looking after myself because I've been stressed out actually it is really helped me get into recovery and then start exploring who I am as a person, you know, and as much as I hate the fact it's taken 7 years to get to this point. It couldn't have happened the other way." “because I know how I feel when I'm in the shower and I know how my life is and I'm I know that I'm lonely” “I've got to do something about my trans identity because I've got to do something about the fact that I feel really crappy all the time about me”	671-673 481-482 205-211 672-673 578-580
	5	This is me: "I live myself inside"	Self-discovery and knowing oneself.	"I live myself inside, if you know what I mean and I know what I'm feeling and how I am and how I act a certain things and behave in little different bits like that." "my myself and my gender" "You can't not. I've lived with myself. Fifty odd years, you know? So I know what I'm about" "When you go when you. I had my first appointment and then I got transferred to the doctor that I see now and he asked when I come to see you. could you write down. Now it's on A4 paper, I had to handwrite it. Uh, and it might have been about this. You you had to, you know, write it all. Write it all down. It's quite a good exercise. Then hand it in and then you talked about it during your consultation." “I'm bit complicated with me, blood and myself and everything like that, you know.” “Well, they might not wanna listen, but actually what goes on with me psychologically and gender wise is actually a big, massive part of my life”	416-418 319 197-198 496-499 179-180 608-610

				“my mind is different and works in a different way to maybe other people and how they live their lives” “Yeah I like to sit in the middle. I'm happy where I am. But I've needed some medical treatments from them or whatever to get my mind and myself in in the right space.” “he asked when I come to see you. could you write down. Now it's on A4 paper, I had to handwrite it. Uh, and it might have been about this. You you had to, you know, write it all. Write it all down. It's quite a good exercise.” “When it start from when you were a child all the way up. And it's got when you start thinking about that thing, right. Yeah. Yeah, yeah. Yeah. So yeah. It's quite a bit of what you call, like self-therapy” “I I could it sort of goes along depending on when I get up and how I feel or whatever. Like that's so sometimes like I went on one session I was fully dressed and that. And umm then the uh next session, I wasn't, whatever” “my mind is different and works in a different way to maybe other people and how they live their lives.” “gender dysphoria for me is is a. You know it's it's a I think that's that's linked is a mental in my mind is a mental condition.”	198-199 24-26 497-500 514-517 319-322 198-199 410-411
2c. The self as perceived by others	1	Who am I?	Responses to their transgender identity.	"Um other clinicians and also, also certainly, just the general public. Um were not understanding at all of like my condition or, or they just didn't care" "Ummm and reassured me for my future and also just generally reassured me that the way that I am now is okay" “or they were outright hostile and hateful about it. So, uh, it was just what was so positive about it was, the fact that they knew so much about the condition and conducted themselves so professionally” “But prior to accessing the gender clinic, other clinicians in the NHS certainly wouldn't, were nowhere near as understanding as that.” “the first time in my life I really just did feel like. I, you know uh, that I was a normal person”	251-252 255-256 253-255 89-90 264-265

	2	Who am I?	Others misunderstand me	"the sort of question that doesn't really get them to understand you as a person and and it's more about understanding again the diagnoses they're not, they're not looking at me as a person they're looking at a diagnosis."	544-546 546
				"I'm more than a diagnosis"	
				"by that time it's like Chinese whispers, and it's gonna be completely different to what the original meaning was"	342-344
				"And I understand you need to be stable, but they don't, also, they also misunderstand in my mind, like what mental stability is"	126-127
				"You can have someone who doesn't self-harm, who is very mentally unstable, but that's OK"	139
				"You know, they're not the ones who's having to deal with this. It's us, having to deal with this every single day."	121-122
				"And I said last thing I want is the gender clinic seeing that on my notes and thinking that I'm getting worse because my number of instances have increased and she turned around and said I'll speak to the gender clinic and he completely misunderstood the idea because he said ohh no, we go through stringent processes, [Name} knows we're here to support him and you know, will it when they ask, would it have an impact? He went ohh well, you know, as I said to Blake before it's something that we do, you know, is an ongoing process"	231-237
				"If there is a complex patient meeting, then why are we not invited to go and express our own views and express, you know, what is actually going on rather than me telling a Doctor who's gonna get their own perception of what I've said to then go to a group of people and then explain what they've perceived, what I've said to them, and then they're gonna get their own perceptions and by that time it's like Chinese whispers, and it's gonna be completely different to what the original meaning was. So one, I'm just going to let you tell him directly, and then they'll know exactly what's going on."	338-344
				"I'm sorry if somebody does have EUPD, let's say that's gonna mean different things to different people. And unfortunately, when I was like, they've already made an assumption as to what that was for me, without me	520-523

				even telling them"	
	5	This is me: "I live myself inside"	Expectation vs reality of being understood by others.	"To get a referral to your services, you go through your GP so I went to my doctor and spoke to him. He was so bad and appalling that I left that surgery that day" "They don't understand. They don't know what you're going through. They don't, you know? OK, their doctors and their GPS or whatever. They don't, they don't fully understand what you're going through." "Not that she wasn't any good at what she did is that she didn't understand my situation."	118-120 110-112 362-363
SUPERORDINATE THEME 3: The flow of power and creating personal agency					
Subordinate Theme	Participant	PE Theme	PE Subtheme	Quote	Line Number
3a. Noticing the power held by the gender clinic	2	Awareness of the difference between self and professionals	Gender Clinic holds the power	"And I said last thing I want is the gender clinic seeing that on my notes and thinking that I'm getting worse because my number of instances have increased and she turned around and said I'll speak to the gender clinic and he completely misunderstood the idea because he said ohh no, we go through stringent processes, [Name} knows we're here to support him and you know, will it when they ask, would it have an impact? He went ohh well, you know, as I said to Blake before it's something that we do, you know, is an ongoing process. And I just thought, see, haven't answered the question then you've just, you haven't. You haven't said whether or not you know this is gonna impact my, the risk of me having surgery or not, you've not actually stated that. So now it made me worried about accessing support." " The the fact that although they said, oh, you can receive psychology and whatnot umm I had to, I found that I was only I don't feel if this is how it's meant to have been done, but I was only seem to be able to request that once I'd already gotten got given appointment at the gender clinic. So I saw a doctor first and then they told me about the psychology. It wasn't like there	231-240 26-32

				was a psychology service from before you received like from from when you got referred to the appointment. So that I think would make more of a difference and having the psychology then and given more information about as to what it is they can provide."	
				" Because at the time I was nonbinary as well at like when I first came out, I came out as nonbinary, and I was worried that I wasn't gonna get taken seriously by the doctors because umm they're very much notoriously about, you know, you're going from, you know, if you're going there as a trans male, then this is what you're gonna go through. If you go in as a trans female, you are gonna go through this. And for if you're, if you're nonbinary, it's almost like you don't really fit in either sort of streamlined pathways as such. And I think that I was really worried about being denied access to treatments because they thought that I wasn't like male enough or female enough or whatever it is."	32-39
				"So for me, what's been frustrating is the fact that you always need two freaking doctors to sign off on everything because one doctor would say yes, and then you then have to wait another six months before you see somebody else"	70-72
				"Well, I was nervous, but I still disclosed it anyway. My mental health and the reason being is because I knew I couldn't lie because it they're gonna have all my my medical medical records in front of them. They've all got system one. So it doesn't really matter, you know the it'll be obvious if I lied if that makes sense."	73-76
				"That's invasive. I would say assessments are invasive and I think there's a lot of unnecessary questions and a lot of things to try and form an idea of where, whether or not you fit a certain stereotype of gender"	87-89
				"So the effects was that it had a massive effect on my mental health. Unfortunately, when they told me that I wasn't allowed to be referred for surgery, or when I found out that the referral was never sent and that did cause a decline in my moods and and I did get very depressed and my anxiety went through the roof, I was also really worried about, you know, whether or not I was even gonna get the surgery that I wanted"	567-571

				"He hadn't done it, he said that I had to go to this complex patient meeting, and they turned around and said actually they don't think I'm ready yet to have surgery. And so then I had to, so what they did is they got me an appointment with the doctor, who apparently was the most adverse. He said that to me personally, he said I'm not gonna, he goes I'm not supposed to he goes, but he's the one I think that you need to win over as such, if you can win him over then you'll be fine. So he put booked me an an appointment with him with this person and I went and actually and I've seen them before. Funnily enough. Umm and yeah, and then that's when he agreed to do it after I saw him then. But initially, yeah, they did. They did say no." "he said he was happy to do the referral. And it turns out actually later on, they said no so that's the bit that I would say has the biggest impact is when they say one thing and then it turns out there's something else going on entirely"	471-477 180-182
	3	Navigating the gender service	Gender Clinic holds ultimate power	"But then I just have to change my uh my medicine to make sure the gynaecology people uh feel good about me taking it" "he took like they took me back" “But then I just have to change my uh my medicine to make sure the gynaecology people uh feel good about me taking it” “nobody else in the entire country can help.” “I cannot have early morning appointments, but they always sent me those.” “second opinion letter for uh bottom surgery referral and stuff like that. Also like changing my name on my BRP. Although it took me a year for it to be approved with the government, but then those the letter was is there was really helpful” “all of those things where I might need their official, I don't know another letter of things” “because I already had an injection before I attended the initial assessment it there weren't many like gate keeping stuff given another Doctor who gave me the injection have already did their initial assessment.” “They just randomly delete my request brackets and so it was very	396-397 317 396-397 108 11 130-133 323-324 53-56

				unhelpful and appointments themselves were very short.”	72-73
	6	Awareness of who's in charge	Gender Clinic makes the decisions	"At that, at that age, I guess I felt like, intimidated by, like, their authority figure kind of thing and like, feeling like they were. Feeling like they were like like everything I said would have influenced the way that that, that they would next act or whatever." "I don't remember them saying telling me that it was like a safe place for me to be honest. I guess. Umm. And maybe they thought that was a given." “that part of it was like assess me and see if that I was like in the right mind to like, make the decision” “They didn't think that I was a risk or whatever, but I think if it was the case that like they kept it, it would have. Umm that it that it wouldn't make a difference if I like showed that I was like struggling mentally if they could have like told me that like umm like this is like” “And I had to talk a bit about, like my depression and and umm and stuff like early on and when they were just kind of like making sure I was like able to make the decision to go on hormones or whatever”	148-151 155-157 117-119 152-155 264-266
3b. Lack of personal power	1	Finding Power	Feelings of powerlessness and helplessness	"Well, just the overburdened NHS in general and not being employed to, not having money, not being able to do it privately and thinking this is an opportunity, so I better not waste it kind of things practical I guess, reasons." "It's just hell because your body is kind of going in the wrong direction and there's nothing you can do to stop it on your own. Yeah, it was, it was hell to go through. It really was.” “And hmm yeah, it was, yeah, just really difficult, emotionally painful and to the point where, you know, I couldn't, I couldn't take it. So I had to go private with the gender GP just to get started on hormones kind of in the meantime. Ummm until I finally was seen by the general clinic”	455-457 71-73 37-40
	2	Awareness of the difference between self	Disadvantaged by being trans	"I'm not saying you shouldn't ask questions. Of course, you need to understand whether or not someone stable, mentally stable and all that sort of thing. But. You know, to get to the gender clinic and you've waited that	500-509

		and professionals		long. And you've gone through all of that, you know what you want. You know what you need by that point. And I'm sorry you look at the success rates and what 99% success rates regret is like 1% of the trans community and you look at somebody who wants their cis-men who wants their you know taken off. I think it's something like you know like a rate of 40% like regret rate, you know or someone's nose job it's like 50% regret rate. You know it's like and they can just go and do this without you know any form of. Mental health like, is it being trans is not a mental health condition. That's what they say, right? Yet why are we constantly being asked about our mental health all the time?"	
				" One other person was like ohh you know, and when you have these surgeries, already making assumption as to what it is that I wanted when I hadn't actually explained what it is that I wanted"	275-277
				"Because at the time I was nonbinary as well at like when I first came out, I came out as nonbinary, and I was worried that I wasn't gonna get taken seriously by the doctors because umm they're very much notoriously about, you know, you're going from, you know, if you're going there as a trans male, then this is what you're gonna go through. If you go in as a trans female, you are gonna go through this. And for if you're, if you're nonbinary, it's almost like you don't really fit in either sort of streamlined pathways as such. And I think that I was really worried about being denied access to treatments because they thought that I wasn't like male enough or female enough or whatever it is."	32-39
				" Mental health like, is it being trans is not a mental health condition. That's what they say, right? Yet why are we constantly being asked about our mental health all the time? That's what is frustrating. Umm yeah. Whereas somebody else doesn't need to go and do that if they wanna have their nose shaved off a bit to make themselves look like anybody Voldemort or Danny Minogue. I don't know. You know they can. Whereas you know we can't do that umm, you know."	507-512
				"Which is weird because a woman can go and get a boob job and she doesn't need to have no psych assessment."	297-299

				"And I just think you wouldn't ask that to a cis-person if they had a different medical problem. So why are you asking that to a trans person? It just it doesn't make sense to me."	99-101
	2	Awareness of the difference between self and professionals	Lack of choice and control	“I knew I couldn't lie because it they're gonna have all my my medical medical records in front of them."	74-75
				"Information sharing well, I was told when I I had to sign a a letter when I first got referred, I had to tick a box to say that the doctors were happy to work with the gender clinic and so everyone shares my information with everyone"	369-371
				"The bit that I found the most difficult. Was when it was trying to access the referral for my top surgery. I had in the end, I think four or five appointments in order to get that referral and each of them was months apart and and that was really difficult and I almost gave up because I thought that it was never gonna happen and because they just kept saying no, no, no. And then when when I said, oh well, you've refused this they said oh, no, we're not refusing. We just don't think you're ready yet. And I'm like, well to me that's the same thing. And you know, if you're being told no, you you we don't think you're ready yet. Well, that's a no then, isn't it? That you're saying you're not gonna do it?"	105-112
				"The fact that I felt like I had no choice but to, and so I used it to my advantage and try to prove where I was stable rather than why I'm unstable and why it's because they're going by a load of notes that are probably inaccurate."	321-323
				"As far as I am aware I presumed they could see all of my notes, which is why I felt that I had no choice but to tell him about my mental health because I thought they're gonna find out anyway."	374-376
				"But yeah, I had to. Basically, I felt like I had no choice but to tell them. I felt like it wasn't really an option not to."	419-420
				"they're very much notoriously about, you know, you're going from, you know, if you're going there as a trans male, then this is what you're gonna go through. If you go in as a trans female, you are gonna go through this"	34-37

				"However, I found its when they've gone away and then it turns out that actually the outcome is very different to what you'd anticipated from how you felt the meeting had gone in the way that they've expressed how it had gone. So they sort of, you know, sort of says, not without not explicitly saying that, like, yeah, everythings fine we're gonna go forward. Although they did when it came to wonder referrals, he said he was happy to do the referral. And it turns out actually later on, they said no so that's the bit that I would say has the biggest impact is when they say one thing and then it turns out there's something else going on entirely" "They obviously got a gender dysphoria to a degree, but because otherwise they wouldn't wanna be transitioning, but they may not necessarily have like certain body dysphoria in different ways. Umm so they shouldn't have to be held into account that everyone should be going down a certain route and this is what you're gonna do. And before that person's even actually said anything about what it is they want"	176-182 355-359
	6	Awareness of who's in charge	Disclosure was not an active choice	"I think I wouldn't be able to like bring it up on my own accord." "And I had to talk a bit about, like my depression and and umm and stuff like early on and when they were just kind of like making sure I was like able to make the decision to go on hormones or whatever." “I mean mostly because they brought it up”	274-275 264-266 291
3c. Self as powerful	1	Finding Power	Recognition of their own authority	“I'm going to just be fully compliant with them because without a doubt, hands down, gender dysphoria was the number one priority in my life thing to address like without a shadow, shadow of a doubt. And umm I knew. I mean it made me suicidal, so, I knew that I had to take it seriously and so I just wanted to be fully cooperative and umm to to do it properly.” “I pushed for it quite early on in my process and I'm glad I did because I only had my surgery the month before COVID broke out.” “He's been insightful about it and umm just kind of approach it on equal terms with me and just been happy to openly discuss it and hear me out and hear my concerns and and again, just obliging”	485-488 304-306 352-354

	2	Awareness of the difference between self and professionals	Strategies to gain control	“The actual. Ohh, I haven't mentioned, although I haven't mentioned food and that is because yes, I'm worried about food. I'm worried about the fact that if I bring my food up that they will refuse to do the surgery because they've already agreed to do it. And I think that if I bring something else up now, then they are going to use that as a way of stopping me from having surgery. Because I think they're already on edge about it.”	240-245
				“Because I also wrote it down on the referral form because the doctors didn't know the doctors were the one who are meant to have done it, but they kept not doing it so I did it for them and then got them to stamp it and send”	385-387
				“I wasn't too keen on him at all and I tried to avoid it, but I'd already written my sort of script in my head so I'd already sort of, so I just went with it anyway”	415-416
				“I think it should be an option to disclose. Personally, unless it's so significant, you know where it's like you know you're in hospital and you're under section or something. That might be a bit different, but generally speaking, I think it should be a an option to disclose like with any other medical. Like anything else, you know, if I went to an appointment elsewhere, it's up to me to disclose. If I go to a job, it's up to me if I want to disclose my medical records that have to do that in the job. So why do I have to disclose that to a unless it's medication? If you're medication, I think it's different.”	555-561
				“The fact that I felt like I had no choice but to, and so I used it to my advantage and try to prove where I was stable rather than why I'm unstable and why it's because they're going by a load of notes that are probably inaccurate. So I thought if they're gonna see this on their system anyway, I might as well put the record straight and make sure that they know exactly what it is that is going on rather than using second hand information that's not actually correct”	321-325
				“The first time I did tell them, but I instantly was worried by the look on their face. So I then like tried to then over explain why I was stable and why	313-315

				everything was going well. In order to try and prevent a negative reaction” “But I was very mindful when I brought up my food and I don't know if they've really noticed it or not. But I did sort of mention that, you know, I have had a few struggles with, you know, worried about my chest and, you know, not therefore I worry about my weight. But that's sort of what I've mentioned, and they haven't really gone into any detail on that. So I was very sort of cautious, that they might. So I was quite surprised they didn't actually. I'm glad they didn't cause I wouldn't want that as another bloody thing to stop me from having surgery from wanted. I thought if I brought it cause this the thing if I did bring it up and then it became really bad, then they would say well, why didn't you tell us? We should’ve known about this. So I thought, well, I'll bring it up, but I'm not gonna make a big deal out of it. Because if you think it's a big deal, then you can bring it up yourself. So I did and they didn't ask about it. And I've been sort of quite thankful for it.”	591-601
	2	Awareness of the difference between self and professionals	Finding ways to manage own experience	"So I didn't understand why they couldn't still do the referral with the idea of then doing the whole keeping an eye on me thing and which means nothing. Umm and then if they really felt that there was a problem, then we could stop because actually my worry was that the longer I was waiting to get on the waiting list then I would have an even longer wait on the waiting list if they got me on the waiting list at least then I'd only be waiting in that amount of time and then you know if they wanna delay it's only a little bit" " And I think that if I bring something else up now, then they are going to use that as a way of stopping me from having surgery. Because I think they're already on edge about it." "I just hope that I can get through Christmas cause if I end up in hospital, I really don't want them to turn around and make me start from the beginning again. And I'm sure they won't. I'm sure it's just gonna be a delay, but I really don't want that to happen." "So yeah, I think that's where the negativity side comes from. It's and it's, it's it's restricted my access like I'm worried at the moment about becoming unwell between now and my surgery because if I end up in hospital and	448-453 243-245 404-406 200-206

				worried they are gonna delay my surgery again and then I'll have to go through another set of interviews for people to decide whether or not well enough to have this surgery. So I'm constantly worrying all the time about what is going to happen next and am I going to get the support I need when it's already a very, very long wait"	
				"I'm not saying you shouldn't ask questions. Of course, you need to understand whether or not someone stable, mentally stable and all that sort of thing. But. You know, to get to the gender clinic and you've waited that long. And you've gone through all of that, you know what you want. You know what you need by that point"	500-503
				"when I found out that the referral was never sent and that did cause a decline in my moods and and I did get very depressed and my anxiety went through the roof, I was also really worried about, you know, whether or not I was even gonna get the surgery that I wanted cause I felt like I've like pushing against barrier after barrier and jumping hoop through hoops. And I just couldn't get anywhere as I was going round in circles and. Hoops and circles, what is that what we say? And but yeah, so it's just. I just, yeah, I was just getting really frustrated with the system."	568-574
				"Me being mentally unstable is more likely to cause the self-harm but umm even still, my self-harm is because I'm autistic, it's a sensory seeking behavior, it's a routine thing and it's not connected to my mental stability. And I mean there is to a small amount like when I'm really on well then yes, OK myself harming me increase, but generally speaking it is a separate thing and uh they wouldn't understand that. So I'm trying to express this to them and then they will go and speak to their colleagues and be like, oh yeah, we understand that this is an ingrained thing and you've been doing this for a long time. And I'm like, well, no, that's not, that's not the point that I'm trying to get. I'm trying to explain that this is not and he has any, it does not have any bearing on my mental stability. You can have someone who doesn't self-harm, who is very mentally unstable, but that's OK"	131-139
				"Which I find just leaves me with more anxiety than if they just said, you know what, yes, this could have an impact or no, this wouldn't have an	221-226

				impact. Umm and my last appointment, the doctor was very clear to say to me mental health will not stop you having surgery. However, it's how sort of basically what he was trying to say is it depends on how stable you are it's not the mental health itself that's the problem. You can have mental health issues that's fine, it's whether or not you're stable and" " But I'm just saying it didn't sound great to me. And and then and that there was one particular Doctor who was particularly concerned umm and so I've now been going to see him and he's very nice. Don't get me wrong he's a lovely doctor. And I've been seeing him since. And. Yeah, he's always been trying to be as helpful as possible, but that really has significant impact because you know, it affected my day-to-day life." "So I just want, sorry, there's one point that I noticed I didn't quite make on the last question and that was the doctors themselves seemed to do try their best and I don't wanna say that they don't because the ones that I have personally encountered have been very helpful in the best way possible and done their best" "don't think it's anything helpful about disclosing mental health, if I'm honest. I'd love to say that it makes them more understanding of you, but it doesn't really. Umm. Because diagnosis only shows a deficit of a person. It doesn't show a positive out of person, just a deficit. It's always a something wrong with you on your inability to cope with the world. That's what the DSM does unfortunately. It's how. It's how you know, something wrong with me? It creates a them and us sort of situation"	117-121 – doctor nice 173-176 489-493
	2	Awareness of the difference between self and professionals	Attempts to get others to hear own experience	"And so then I had to, so what they did is they got me an appointment with the doctor, who apparently was the most adverse. He said that to me personally, he said I'm not gonna, he goes I'm not supposed to he goes, but he's the one I think that you need to win over as such, if you can win him over then you'll be fine. So he put booked me an an appointment with him with this person and I went and actually and I've seen them before. Funnily enough. Umm and yeah, and then that's when he agreed to do it after I saw him then. But initially, yeah, they did. They did say no."	471-477

				"And I think that I was really worried about being denied access to treatments because they thought that I wasn't like male enough or female enough or whatever it is." " You can have someone who doesn't self-harm, who is very mentally unstable, but that's OK. And you know, so why is this? Why is this not OK, you know, and trying to prove why, how I'm sort of improving in one area of my life just to be able to receive the treatment that I feel I need shouldn't have to happen." "So I think it is a bit of a balancing act. If I'm honest so for me personally, the disclosure itself wasn't the negative problem that the problem wasn't the negative part in itself, because they are gonna be aware of that anyway from the umm the notes, as I said earlier. The problem I had is what they're perceived idea of that diagnosis in relation to myself is the problem" "When out of hospital and I've been out of hospital for a few months I went to that, did an arrange to do another appointment. I'd shown I've been, I've stable, got, become more stable. And answered the questions about my mental health, I explained how it's been, how I've got support in place, blah blah, blah. And he agreed to do the surgery and he's to do that, to do the referral. He agreed to do the referral and I walked out there so happy it was ridiculous"	37-39 139-142 193-196 463-467
	4	How they managed accessing the GC	Advocating for themselves	"It was at that point I put my hands up and said actually I really need help and then that's when they said, right, come and have some counselling" "I'm taking quite, I'm quite taking quite a stubborn approach and just saying this exactly who I am" "So like I had eight or nine sessions. Didn't stop drinking. Disappeared for a bit, stayed kind of on the books, then came back with her tail between my legs and said gotta stop drinking."	613-615 670-671 576-578
	6	Awareness of who's in charge	Ways to manage impact of accessing	"I think every every stage of like my process has been the assessment has always been the same like it's always the same questions and I kind of which is a little like frustrating, but I get it because like it's a new place they	80-83

			gender services	need to, like, learn about you again, I guess” “I haven't talked to him about my ADHD but I don't think it's relevant to the treatment. So that's fine.” “I think there's a lot of improvement that needs to be made, so yeah” “I felt pretty distanced too” “I think they just need like multiple like multiple opinions and make sure that it's all good to go”	 247-248 4-5 84 205-206
SUPERORDINATE THEME 4: The true lived experience of the Gender Clinic					
Subordinate Theme	Participant	PE Theme	PE Subtheme	Quote	Line Number
4a. Limits to provision of care	1	How the Gender Clinic is experienced	Limits to accessing the Gender Clinic	“Umm, I feel awkward it’s having two faces on the screen and the lag as well and like if you talk at the same time it kind of like could go over each other. Ummm I hate it, but. it's also not felt, yeah, I haven't felt that kind of magical spark that I had when I was in the room. Ummm it feels impersonal. Uh over zoom.” “nowadays people are pretty quick to respond to my emails, so maybe maybe that wasn't my fault, but, I don't remember receiving any help, but maybe it was because I didn't really ask for it.” “it was kind of already. It was someone else's uh remit to, to deal with those problems. Really. I was there to deal with my gender dysphoria and the gender dysphoria was the stem of all my other mental health problems generally anyway.” “seven gender clinics. So, you know, they're oversubscribed.” “One conversation with the psychiatrist over a screen wasn't going to, you know, that's just that was way too much to, to deal with that there. Um. You know, it would have been impossible for anyone to, to really reach me properly, you know, he had one appointment with me. It's not possible to that wasn't. And that's not even what the appointment was about” “maybe I didn't send enough emails or maybe, you know, maybe I was just	198-201 53-55 510-513 112-113 573-576

				trying to call instead of e-mail. // so maybe maybe that wasn't my fault, but, I don't remember receiving any help, but maybe it was because I didn't really ask for it” “maybe I didn't send enough emails or maybe, you know, maybe I was just trying to call instead of e-mail.”	 51-52
	1	How the Gender Clinic is experienced	Gender Clinic provided a person-centred approach	“it felt like he took it seriously. It always felt like they took everything seriously” “I was saying made it reassured me about my care and my how my transition would be” “And, and he was just very obliging, you know, he said, yeah, sure, there's no problem. Ohh I’ll arrange an appointment to start processing it and” “But then the nurse spotted me do that and said ohh, I think [Participant Name] has something else that she wants to talk about. And then he whipped right back around in his chair immediately and sort of lent forward and he was like ohh yeah what is it” “they were great cos they would print it out and what the called like a discharge summary like from the hospital but just like a summary for the appointment and what’s discussed” “So its good, and they work well with my GP, getting me the care that I need. The information sharing is good, huh, I guess.” “We're not going to talk about that at all, but we're going to focus on the other mental health problems that you're experiencing because that's what's sort of eminent.” “the fact that there were people that were understanding there in the clinic made me think that you know, other people can understand as well” “they just showed that they really kind of understood” “Umm this has been life changing, truly, and so for the better” “ It's done so much for me, really, that service I can't like, I can't. I just can't say enough about it to be honest.” “there was like an afterglow that I had, but I was generally just from the appointment anyway. I felt that I had hope again and that things were going	519-520 181-182 306-308 299-302 633-635 640-641 425-427 169-171 86-87 5-6 132-133 585-587

				to get better, and uh so it made life more manageable” “ it all sounds like things that will have uh therapeutic benefit for me. So you know, I'm looking forward to seeing what that will be like.” “Any uhh anxiety or, you know, anxious feelings or uh depressive symptoms. Just weren’t there and yeah”	 237-238 162-163
	2	Differences between the expectations and reality of accessing the gender service	Desire for change: how can the service hear me?	"And actually it's because I'm autistic, not because of EUPD. So and that's not an uncommon, uncommon misdiagnosis. And actually, a lot of gender clinics need to start being more aware that there is a link between trans people and autistic people, and that actually EUPD is often misdiagnosed in women and therefore transmen are more likely to be misdiagnosed as autistic as well, and are probably more like to have an EUPD diagnosis. So they need to be taken into consideration really" "I think it should be an option to disclose. Personally, unless it's so significant, you know where it's like you know you're in hospital and you're under section or something. That might be a bit different, but generally speaking, I think it should be a an option to disclose like with any other medical. Like anything else, you know, if I went to an appointment elsewhere, it's up to me to disclose." "Umm I think we need to be more involved in our care. We need to be more involved in, like, meeting in these multidisciplinary teams, for example, like, there's no reason why I can't go at the beginning or at the very end of their general discussions, you know, where I go in, do my talk, I leave. And if they wanna discuss other people, they can. You know, I'm not gonna interfere in any confidentiality or whatever it is. That's what the the usual excuse they use, not gender clinic but other services have tried to do this before and they say ohh confidentiality you can't. I said well I can and if you just don't talk about them until I've left umm obvious one really. Umm but yeah, so I think things like that, that's what needs to improve" "That's what the DSM does unfortunately. It's how. It's how you know, something wrong with me? It creates a them and us sort of situation. So disclosing mental health never makes you feel any good, because all it does	523-528 555-559 344-351 492-499

				is it makes you feel even further, like more different than you can imagine from that, that from the professional I think it creates more distance not less. Whereas if they asked, you know, maybe where your struggles were in like with what's going on in your life, I think that'd create a bit more of an empathetic and more of a patient led or a better way of working with working with people. Umm. Rather than just intrusive questioning, which I don't think is really helpful in any way" " Umm because I feel that there's not enough education in the services" "Nothing about me disclosing my mental health has made any benefit whatsoever. I'd like to say they supported me with it or whatever, but they haven't really. All they do is they monitor you and all this monitor. I don't. I was like so like all this monitoring is basically a case of having a look at your notes now and then on appointments and seeing whether or not you've improved or like gotten better or gotten worse. That's their reviewing. It's not really checking up and seeing how you're doing. There's no like, they don't do anything with this, you know, we'll keep an eye on you process. I'm not in, I'm not involved in that in any way, shape or form. And I feel like we could be more involved, we could go to these meetings, you know" " So I saw a doctor first and then they told me about the psychology. It wasn't like there was a psychology service from before you received like from from when you got referred to the appointment. So that I think would make more of a difference and having the psychology then and given more information about as to what it is they can provide." "So for me, what's been frustrating is the fact that you always need two freaking doctors to sign off on everything because one doctor would say yes, and then you then have to wait another six months before you see somebody else. Umm. So I think that could be streamlined a lot better as well"	3 331-338 28-32 70-72
	2	Differences between the expectations	Questioning the Gender Clinic	“And also what's unhelpful is just I don't know; they all are asked the same questions that. That doesn't. I don't really find that it makes someone want to understand me as a person, really, it makes someone want. I don't. It's	534-536

		and reality of accessing the gender service	processes	whether or not I tick the box of the criteria” “And yeah. And it's just like that, it's like, question, some questions become quite invasive. And I just think you wouldn't ask that to a cis-person if they had a different medical problem. So why are you asking that to a trans person? It just it doesn't make sense to me.” “Well, the first thing they did was start asking me questions about the mental health, the mental health condition, and and how it affects me and and they asked quite a lot of in-depth questions and like, how regularly are you self-harming or you know. I can't remember some of the other things. It's always just about like. How serious are you working with any like medical professionals? Are you into therapy? And it's always very quite like I say quite invasive questioning. Umm. Not aggressive, but definitely quite, but like definitely quite a lot of questions after another. And so yeah, that gets quite tiring to deal with all the time I have to admit. That's that's. That's the repercussions of the first time I opened up about it.” “That's invasive. I would say assessments are invasive and I think there's a lot of unnecessary questions and a lot of things to try and form an idea of where, whether or not you fit a certain stereotype of gender. And I didn't like that at all” “The bit that I found the most difficult. Was when it was trying to access the referral for my top surgery. I had in the end, I think four or five appointments in order to get that referral and each of them was months apart and and that was really difficult and I almost gave up because I thought that it was never gonna happen and because they just kept saying no, no, no” “Umm that wasn’t an easy umm the thing is, by law, under the NHS, you have the right to receive treatment within 16, 18 weeks of referral and unfortunately, they are unable to provide that” “so why is this? Why is this not OK, you know, and trying to prove why, how I'm sort of improving in one area of my life just to be able to receive the treatment that I feel I need shouldn't have to happen”	98-101 434-441 87-89 105-108 16-18 140-142
	3	The Gender	Multiple needs	“ I don't have official diagnosis of depression, but then I had counsellors	113-114

		Clinic is not all knowing	mean multiple services	myself privately” “ So having a third party or like a second healthcare professional involved or helped me too, you know, just discuss every single other issues I have” “I was pretty bad and I have tried to access all the NHS systems and I have tried to find a suitable counsellor” “I don't think they are aware that gamete storage can actually be this time consuming and I and and the fact that I need to travel so frequently to there and also they are not very aware of um where the um the acne treatment might interfere with the gamete storage process because the most common drug is advised to not to be given to pregnant and breastfeeding people. And obviously the I think gynaecology doctors are not specialists in skin care stuff as well” “Because I'm not accessing any sort of help from uh the clinic itself for my psychology or mental health problems. Because I'm also saying it to my own counsellor”	117-119 314-315 382-385 402-403
	3	The Gender Clinic is not all knowing	There are limits to expert knowledge	“And so people seem to not know not have information about what other departments or specialities are even they kind of need to give that information initially” “ the fact that they don't really know how long those referrals might take and they themselves are not really familiar with the procedures they are referring to us too” “He's just a gender specialist not a psychologist or therapist or whoever does the actual therapy things that what I've been told was usually just need referrals or, like, go to my own counsellor and stuff like that too, actually deal with all tackle the problem themselves” “I don't think they are aware that gamete storage can actually be this time consuming” “I just have to change my uh my medicine to make sure the gynaecology people uh feel good about me taking it” “I don't feel like there's any barriers for me to discuss it with my current Doctor in the clinic and umm although he cannot really help me, given, as	390-392 371-372 282-285 382-383 396-397 247-250

				you know, the psychologist has just resigned and they have trouble finding one”	
	4	Boundaries to Gender Clinic's provision of care	Limits to Gender Clinic's abilities	“because I wasn't focusing on the thing that was staring me in the face and I wasn't giving enough information to [Gender Clinic] to say. This is actually a much bigger problem than we're both took the than we're both saying and I think that they, you know, can only probe so much” “um she just sat there and let me prattle on and on and on and on and on, uh saying that I'm jacking it all in” “"Hello, this is doctor". Ohh. What was his name? "[Doctor Name] from the gender clinic here for your appointment." Well I was like, "I'm terribly sorry. I don't, I've you've not written to me and I'm I'm at work and I can't talk." And he said "right quickly. Do you want bottom surgery?" I was like, "whoa, hold on a minute I'm at work, you know, I'm not aware of this appointment". And he's like, "yeah, but do you want do you want bottom surgery? Is that what you're after?"” “So I did e-mail and say I wouldn't mind actually just touching bases with somebody just to talk through some things because I'm kind of struggling at the moment and that wasn't responded to or that wasn't. Er apparently they had lost some staff and they would get back in touch me, but they never did so” “I was aware that there was about an 8 month wait at the time, which now seemed just incomparable to what's going on in the world.” “Gender Clinic], to be fair was better at communicating than potentially they are now” “[Gender Clinic] only know as much as I tell them I guess”	198-202 444-446 233-239 351-354 25-27 50-51 98
	4	Boundaries to Gender Clinic's provision of care	Gender Clinic seen as letting them down.	“I think they're scared of making quite decisive decisions about things because they don't want me to change my mind” “all I'm asking from the NHS is a bit of support after I've worked really hard to get here and for them to say ohh the surgeon won't the surgeon won't won't accept you as a patient cause you don't identify it as trans female I	296-297 313-317

				think it's I think it's old fashioned.” “can't really do much about that at the moment because I'm kind of neither here nor there on the treat treatment pathway” “I think it's fairly discriminatory potentially. Umm and I think it’s also a little bit defeatist, defeatist as well, because ultimately I I can say to them that this is my identity. This is what I want and actually I can evidence kind of how I'm feeling about things, and I don't feel like I should have to negotiate for it. Which is ultimately what I think I'm doing at the moment. I think I'm having to play a bit of a game.”	292-293 317-322
	5	How I experienced the service	Service experience as a non-binary individual	“I will not be pushed or forced to go in one direction or the other.” “I addressed that I I see myself as nonbinary. I'm not in a situation. I wanna go 100% female. I don't wanna be 100% male. I was very open with that, and I was actually waiting to see what way they would respond with that, you know, which could have been. Well, we can't help you on this occasion, but it wasn't wasn't at all you see” “ It's not an easy subject, and it's definitely not an easy subject for me because it is so it's so not black and white for me.”	334-335 528-531 15-16
	6	How I experienced the Gender Clinic	Lack of a person-centred approach	“ it's been mostly accurate. Umm I did, umm there was there was a letter one time where they they told my GP that I was gay, which I did, never said. Which was weird, but other than that I don't think I think everything should be accurate” “like healthcare professionals kind of tend to be a little insensitive, about eating disorders in that way, they don't know what the right thing to say is” “Very like transactional” “Passed around” “It would, I think it would have been nice to have like the same, umm, the same consultant every time. I did have a while where I was with the same person. Umm, but now every time I've got an appointment, it's been different person and I feel like I have to like get to know them again and uh and I don't understand why”	227-230 372-373 204 44 44-48

				“I remember also being very just like transactional kind of like how you doing. Are you the risk of this? Yes, no kind of thing rather than. I don't remember like feeling like they're very empathetic about it” “so I think it would have been nice if they because I'm pretty sure like on my record they can see that I that I have an eating disorder and it would be nice if they had like been aware of that and not I mean I get they have to weigh me but like not discuss it I guess I don't know” “I think if they had been more sensitive to to, umm like not assuming that because I was physically recovered that I would be able to take that information well. I guess maybe like like asking, do you wanna hear it to or is it OK if like they could have done a blind weigh, they didn't have to tell me kind of thing and kind of being sensitive to the what I may or may not be comfortable with” “think the the this process could have been sped up to me getting hormones if they had just, like been like, hey, is this information correct? And I'm like, yes. And then that's it. They don't have to like see me like two or three times to ask about it, you know.” “And I guess I think that's probably I think eating disorders ia quite common in people and people with gender dysphoria. So that's probably something that needs like the, I guess, like the sensitivities around that kind of stuff needs to be improved. I think just in umm all of health care, mostly NHS, I guess” “So yeah, that that was that was also frustrating and kind of felt like I could make that whole trip and do do a little more at a time, like maybe see the endocrinologist and then do the physical straight away if that was like a that was a green light from the endocrinologist”	280-283 185-188 383-387 97-99 373-377 109-112
4b. Valued aspects of experience	1	How the Gender Clinic is experienced	Found acceptance and safety within the Gender Clinic	“I felt safe to do so” “They've got sensibilities towards trans people and um like they just they seem like everyone, everyone at the gender clinic just seems to be an expert in it and umm expert at handling the, the situation and just, at least in my case, making me feel like a normal human being.”	482 23-233

				“ one of the first times in my life, I think when I was getting umm assessed. I think it was, doctor. Uhh there's a doctor or Doctor. Sorry, Dr. Is that right? I don't know if there was a doctor there, I can't remember maybe it was somewhere else. Doctor though, he was there, right? I think he was on that assessed me and when he did it, it was the first time where I really felt like I could talk about it with someone who understood, and he really did get it and he just made me feel like a normal person.” “It always felt like at any point I could ask whatever I wanted” “ just the fact that they showed that they cared and were compassionate. Umm. And there's there's something about that almost makes me regain some self-worth from that” “It made me feel like that there was someone that would listen and although it's his job. Uhh genuine like compassion and care came across even through the screen.” “Just made me feel heard”	118-124 331 540-542 443-445 446
	3	Navigating the gender service	Personal values in their experience	“the fact that I can continue with my injection was very helpful” “ every issue mentioned had a response to it uh whether there were solutions or not, um there were always some, at least they noted it” “But my umm what I'm more concerned of is actually the government. And I actually saw this Parliament discussion back in 2013 or sometime where they decided to not to disclose how many trans people are there in the UK. And that's really is for me is associated with the lack of resources and lack of public awareness, because if there is no public information, then nobody know how many resources we need to allocate.” “Just somebody might take it. While there is always a chance, so it is not very private as much as they might think paper are when compared to emails.” “I was very secured that I will continue getting my hormone whenever I needed because of the agreement” “And not enough, there is just not enough data for maybe people to find out. Umm how often they might need to be aware of these are kind of like	33 364-365 219-224 47-49 116-117 224-227

				encounters. So for me, that's what I'm more concerned about rather than what the NHS is doing about it, of handling my data”	
	4	Boundaries to Gender Clinic's provision of care	Gender clinic support led to positive change	“I think I'm only here now because she understood what I needed.” “Once we identified that the that group might be or once they put that group to do would be good for me it kind of opened up new possibilities. And it was hard because they are because those groups are designed to kind of break you down and build you back up. Um. But I think. Because I've got enough time in recovery behind me or I was starting to get into recovery prop cemented that recovery properly” “since getting into recovery recovery and [Gender Clinic]. Uh suggested that I could might be receptive to group self-compassion therapy and that has and that within 20. So during mega lock down part one, so what 2020? That has been massively important because I've learned actually how to like myself, or I've learned how to respect myself more” “I think she I think she understood me more than I understood myself at the time because she could see me” “ They there was always support that when I needed it” “ And plenty of other people gave up on me, but [GIC Name] didn't”	389-390 511-514 202-206 381-383 581 588-589
	5	How I experienced the service	What was important to me	“I've had him for quite a while so. For the first year and a half, maybe two years, I was, I was visiting” “But with a psychologist, I think they delve a little bit further.” “that's the difference between I think the difference between doctors, psychologists and stuff you see.” “Whereas when you speak to a psychologist, which is a very important part of this because it's a lot wider picture because a lot of the things that go on with this, I think with gender dysphoria and stuff” “having somebody outside of that thing that's an important that's the key part of it, which is is what like for arguments sake [Name] was, is outside of that. That piece is somebody sort of like, totally independent like yourself. You know, it makes it a bit easier. You know, you can you can talk. I think	173-175 276 302-303 271-273 588-592

				you can talk and probably be a bit more honest with somebody because you don't live with them.” “so having somebody like [Name] was in was important. And the right question, the right questions as well, you know. Now you're building relationship with the person you're talking to is, I think is crucial” “So I can't think who it was, but somebody at [Gender Clinic] said right we'll do this chat thing every uh once a month and that that could be a bit of a problem. It was alright” “I didn't have this issue because I've got got my wife and stuff” “Yes. So that would be my, my wife, yeah. I'm lucky I've got her to support me on this because it's umm having that person there when you're talking about this with a doctor or whatever, I mean, you know, it's it, you know, she supports it.” “I've got nothing to lose” “So when you talking to the doctor, he's obviously focused, focused all completely on the medical issues” “I was on a little waiting list and then all of a sudden I think I got a note saying, right, we got [Name], that it would like to would, would you be interested in having a session with [Name]? And I thought, yeah, that would be good. And that's where that's started and that that was brilliant”	610-612 308-310 73-74 537-539 426 269-270 575-578
	5	How I experienced the service	Things that improved their experience of the Gender Clinic	“You know, it's a nice hospital and I think it's a nice. It's hospitals go. Obviously not nice places, but you know it's nice and nice. Cafeteria, it's friendly.” “I've never been worried if I've if they say, could you come to the hospital well never been worried to go or or whatever?” “So he was actually very, very knowledgeable and it was actually I found that quite uh quite reassuring you know.” “because I had already sort of access to service and was getting some help around that. I think that you know that helped”	137-139 285-286 147-148 40-41
	6	How I	Positive parts	“And for the most part, they've been like they've been sensitive”	254-255

		experienced the Gender Clinic	of my journey	“the consultant like brought it up and like asked how I was doing with it, which was nice” “I think they always brought it up first because it would be on like my record or something. Umm which is good” “Umm yeah, they've you know they they always send me like a letter. Like a copy of whatever they sent to my GP” “ I don't remember them saying telling me that it was like a safe place for me to be honest”	243-244 273-274 226-227 155-156
4c. Differences in expectations and reality	3	Navigating the gender service	Expectations vs reality	“there weren't many like gate keeping stuff” “it is much shorter than people expect from the NHS” “my situation is a bit different” “ So my referral was an emergency referral in in some way, so I didn't really wait till long thing he was for. Maybe two or three months only.” “ I believe it's speed up the process of producing whatever paper thing they need to produce for that uh discussion afterwards. So their resources were pretty quick. So for instance via e-mail, sometimes you're just respond to my questions there and only when they feel like there is a ton of things that we need to discuss then he will have an appointment with me.”	54 178 25 27-28 340-342
	4	Boundaries to Gender Clinic's provision of care	Believe the GC could infer their MH needs	“But I don't know. I think. When I did the referral through the GP, they filled the GP fill that form so they would have known some background. And they will have seen that” “I think it was at a point where I I don't think they could have. Well, they it was. It was just obvious cos most Alcoholics look the same don't they so you know, like when they're when they're really struggling” “Um no cos I think it was obvious right from beginning that there was more going on than gender incongruence” “So they would have had an idea and you know, but I think that would have been the purpose of those two assessments as well potentially. But I don't know what I don't know if it reasons, you know the GP was not great and I don't really know what they put in their referral so.”	426-428 493-496 606-607 430-433

	5	How I experienced the service	Expectations vs reality of Gender Clinic service experience	“I can't imagine how difficult it is for some people when you you read about some terrible stories of people that do things to themselves and things acts because they can't always help”	105-107
				“And you read it online and people ohh, you know, they're not interested in people like like myself. And that they only want to deal what I said like male, female, female to male and I er man, they are so wrong”	388-390
				“My opinion, the people at the gender clinic like doctors and that they're there to help you”	525-526
				“I didn't feel embarrassed. We had a good open chat. My ember, at my times of embarrassment and stuff are long gone”	152-154
				“I don't fit in the traditional mold, but I've been treated extremely well, but there's people that were like quite happy to go online and and write, you know, are like they don't help nonbinary people, you're wasting your time and blah, blah, blah. That's wrong. And that that made me quite angry that did”	81-84
				“always been very good and very consistent”	627
				“it's very similar process with with this is that you go through the clinic”	229-230
				“I sort of almost self-sufficient, you know. It is what it is. So you go to the doctors or the hospital when you got a medical problem, or you got an issue or whatever.”	224-226
				“You know, he's absolutely brilliant. So I I I know I don't, I don't have any sessions with [Psychologist] now, but also know that if I ever need anything I need to get in touch somebody. I could get in touch with him, and I know he'll reply, and that's that's quite an important thing.”	249-252
				“that's the difference between I think the difference between doctors, psychologists and stuff you see.”	302-303
				“more important that the one that I had at [Location] on my self-referral was alright, but it weren't really. Weren't right, but when I had somebody from the clinic you guys and it was like [Name], that that was that was that's what it was about.”	597-600
				“I will not be pushed or forced to go in one direction or the other. And I	334-337

				think one guy, one of the doctors had suggested, you know well, "why are you not fully transitioning?" Well, that's my decision that I don't want to fully transition”	

Theory Driven Research Project Appendix 3.1

Author Submission Guidelines

Author Guidelines

Sections

1. SUBMISSION
2. AIMS AND SCOPE
3. MANUSCRIPT CATEGORIES AND REQUIREMENTS
4. PREPARING THE SUBMISSION
5. EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS
6. AUTHOR LICENSING
7. PUBLICATION PROCESS AFTER ACCEPTANCE
8. POST PUBLICATION

1. SUBMISSION

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

The *International Journal of Mental Health Nursing* now offers **Free Format submission** for a simplified and streamlined submission process allowing researchers to submit their manuscript in their preferred formatting style at original submission. See details in SECTION 4. PREPARING THE SUBMISSION.

New submissions should be made via the Research Exchange submission portal https://wiley.atyponrex.com/dashboard/?journalCode=INM Should your manuscript proceed to the revision stage, you will be directed to make your revisions via the same submission portal. You may check the status of your submission at any time by logging on to submission.wiley.com and clicking the “My Submissions” button. For technical help with the submission system, please review our FAQs or contact submissionhelp@wiley.com.

The submission system will prompt you to use an ORCiD (a unique author identifier) to help distinguish your work from that of other researchers. Click here to find out more.

We look forward to your submission.

2. AIMS AND SCOPE

The *International Journal of Mental Health Nursing* (IJMHN) is the official English journal of the Australian College of Mental Health Nurses Inc. The Editors welcome original articles dealing with current trends and developments in mental health nursing. The Editors are also looking for papers that will be widely read and cited, thereby having an international impact on mental health nursing education, practice and research. Papers submitted should be relevant to the Aims and Scope of the IJMHN and written in a manner that makes the relevance of content clear for IJMHN's international readership.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Note that word counts should include abstract and acknowledgements, but not table or figure legends and references. Longer manuscripts may be negotiated by the Editor-in-Chief in exceptional circumstances.

Original Articles: Original Articles should not exceed 5,000 words. The main text should be structured as follows: Introduction (putting the paper in context - policy, practice or research); Background (literature); Methods (design, data collection and analysis); Results; Discussion; Conclusion; Relevance for clinical practice. The number of words used, excluding abstract, references, tables and figures, should be specified. Pilot studies are not suitable for publication as original articles. We also ask that authors limit their references to 50 in total and all references must be available in English. We ask that you include all information required by the reporting guidelines relevant to your study. For example, use the CONSORT checklist for RCTs.

Review Articles: Qualitative and quantitative literature reviews on any area of research relevant to clinical nursing are welcomed. Submissions should not exceed 8,000 words. Quotes are included in the overall word count of the main text. Authors are advised to explain their methodology clearly (e.g., overall approach, literature search strategies, data analysis). The PRISMA checklist and flow diagram should be used to guide manuscript development. Systematic review methods are evolving and authors are urged to cite supporting references. The main text should be structured as follows: Introduction; Aims; Methods; Results; Discussion; Conclusion; Relevance for clinical practice. We encourage authors to prospectively register their reviews with a registry such as PROSPERO (https://www.crd.york.ac.uk/prospero/). We also ask that authors limit their references to 50 in total and all references must be available in English.

Commentary: Expert opinion from one or more people (who may agree or disagree) on a current understanding/status of a specific nursing or related area, or how practice should be undertaken. No abstract; limit references to 5 or less; 2,000 words maximum.

Perspective: including position papers and critical reviews of particular bodies of work which do not contain empirical data or use systematic review methods are also welcomed. Submissions should not exceed 5,000 words. These should be structured as follows: Aims; Background; Design (stating that it is a position paper or critical review, for example); Method (how the issues were approached); Conclusions; Relevance for clinical practice.
Editorial: Opinion on timely or general interest topics, or to provide an overview of an issue. Usually by the Editors or someone invited by the Editors, but suggestions can be submitted to the editorial office for consideration **ijmhn.eo@wiley.com** . No abstract; limit references to 5 or less; 1,500 words maximum.

Letter to the Editor

- **a.** Reserved for discussion about published papers.
- **b.** No abstract; 5 or less references.
- **c.** 1,500 word maximum.
- **d.** The Editorial Board reserves the right to accept or reject, edit, and condense letters for publication and to publish an author or editor response to letters.
- **e.** If a Letter to the Editor is accepted for publication, the authors of the article you are writing about will have an opportunity to review their Letter and respond with a Letter to the Editor of their own in response if they wish. You will not be given another opportunity to respond to the author's response to you.
- **f.** Letters to the Editor undergo review, but they do not need to have a full standard peer review. The Editor-in-Chief might choose to accept or reject the Letter themselves, or consult with board members, or send the letter out for full peer review.
- **g.** Letters by article authors in response to Letters to the Editor disputing their articles are usually accepted for publication after the same type of review described above.
- **h.** If a Letter to the Editor is accepted for publication, the Editor-in-Chief will decide when and how it will be published.

Relevance to Clinical Practice: appears after the Conclusion in all article types except Commentaries/Responses to Commentaries. In this section, explain to practitioners what your research adds to the current body of knowledge (around 80 words).

For RCTs, please refer to:

Research Reporting Guidelines

Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it. We expect authors to adhere to an EQUATOR research reporting checklist, and to both

declare this adherence in the Abstract and Methods sections of their submission and upload their completed checklist as a supplementary file with their submitted manuscript.
EQUATOR checklists include:

• CONSORT checklist for reports of randomised trials and cluster randomised trials
• TREND checklist for non-randomised controlled trials
• PRISMA guidelines for systematic reviews and meta-analyses
• STROBE checklist for observational research
• COREQ checklist for qualitative studies
• SQUIRE checklist for quality improvement
• TRIPOD checklist for prediction model development and/or validation
• CHEERS guidelines for economic evaluations
• SPIRIT checklist for study protocols
• AGREE checklist for clinical practice guidelines

Please ensure that you have completed and uploaded an EQUATOR checklist with your manuscript submission.
These guidelines have been adapted from the Journal of Clinical Nursing.

Clinical Trial Registration

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

Statistics

The advice of a statistician should always be sought for quantitative studies, and this person should be acknowledged in the acknowledgement section if the paper is accepted for publication. Where other than simple descriptive statistics are used, a statistician should be included as one of the authors and identified as such when submitting the paper.
These guidelines have been adapted from the Journal of Advanced Nursing.

4. PREPARATION OF THE MANUSCRIPT

4.1 Original submissions

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Journals

Meehan, T. (1994). Questionnaire construction and design for surveys in mental health. *Australian and New Zealand Journal of Mental Health Nursing*, 3, 59–62.

Books

Taylor, J. & Muller, D. (1994). *Nursing adolescents: Research and psychological perspectives*. Oxford: Blackwell Science.

Chapter in a book

Bergen, A. & Labute, L. (1993). Promoting mental health. In: A. Dines & A. Cribb (Eds), *Health promotion: Concepts and practice* (pp. 93–109). Oxford: Blackwell Science.

Electronic material

World Health Organisation (3 July 2003). Update 94: Preparing for the Next Influenza Season in a World Altered by SARS. http://www.international/csr/disease/influenza/sars. Accessed: 15 September 2003.

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Appendix 3.2

Ethical approval for study, and additional amendments

CONFIDENTIAL

Dr Clare Borsay and Jodie Collins
Oxford Institute for Clinical Psychology Training
(OxICPTR)
Isis Education Centre
Warneford Hospital
Oxford

27 June 2024

Dear Dr Borsay and Jodie,

Research Ethics Approval - CUREC 1

Ethics Approval Reference: R89110/RE001

Study title: The Influence of Stigma on PTSD Symptom Severity and Help-Seeking Intentions in Forensic Mental Health Staff Experiencing Workplace Trauma

Short title: Investigating Stigma, Trauma and Help-Seeking Intentions in Forensic Mental Health Staff

The above application has been considered on behalf of the Medical Sciences Interdivisional Research Ethics Committee (MS IDREC) in accordance with the University's procedures for ethical approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and approval has been granted from **27th June 2024** until **26th December 2025.**

Insurance-provided indemnity arrangements are in place for the duration of the approval stated above. It is your responsibility to ensure that you request an extension to the end date for indemnity to remain in place should you continue the research beyond the dates covered.

Amendments

Should there be any subsequent changes to the study, you should submit details to the MS IDREC for consideration and approval. Details of changes must be listed on an amendment form.

Yours Sincerely

DocuSigned by:
Leah Butts
9F14889D2BC549A...

Mrs Leah Butts
Research Ethics Administrator

for
Dr Helen Barnby-Porritt
Research Ethics Manager

From: MSD Ethics <ethics@medsci.ox.ac.uk>
Sent: Friday, October 11, 2024 8:21 AM
To: Jodie Collins <jodie.collins@hmc.ox.ac.uk>
Cc: Danielle Shore <danielle.shore@psy.ox.ac.uk>; Claudia.Koch@oxfordhealth.nhs.uk <Claudia.Koch@oxfordhealth.nhs.uk>
Subject: R89110/RE002: The Influence of Stigma on PTSD Symptom Severity and Help-Seeking Intentions in Mental Health Staff Experiencing Workplace Trauma - Amendment Approval

Dear Jodie,

Thank you for submitting a request for an amendment to project R89110, which has been reviewed on behalf of the Medical Sciences Interdivisional Research Ethics Committee (IDREC).

I am pleased to inform you that your requests to:

- expand the recruitment eligibility criteria, to include therapists, psychologists and counsellors
- update the project title to reflect the expansion of participants

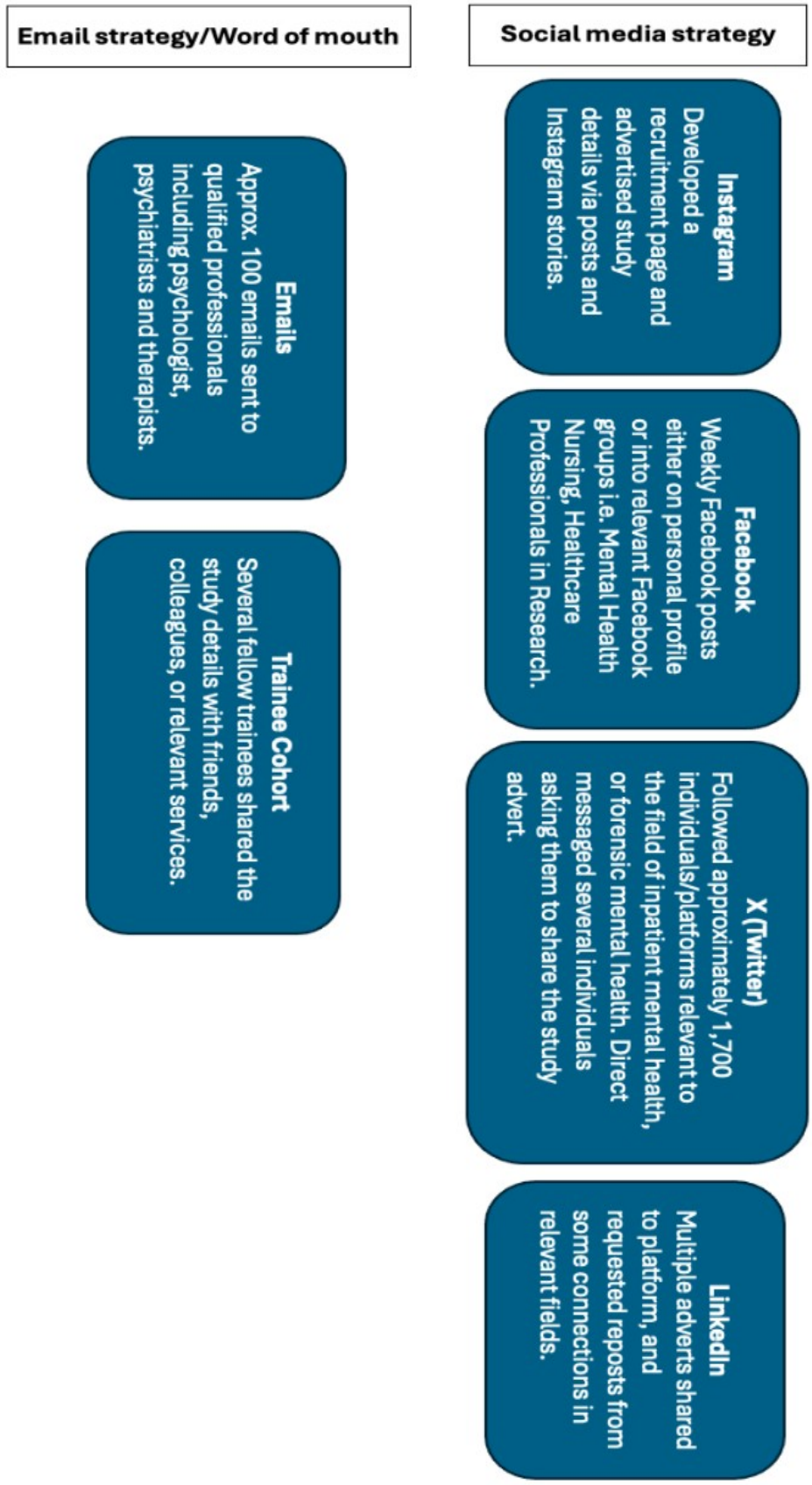
have been judged as meeting appropriate ethical standards, on the basis of the information provided to the IDREC, and approval has been granted, under reference R89110/RE002.

Please note that this email is your sole approval.

Best wishes
Leah

Appendix 3.3

Recruitment Strategy



Appendix 3.4

Study advertisement details – shared on social media sites and via email to known professionals.

TDRP Appendix 3.53

Internal reliabilities of the scales used

PTCI

Reliability Statistics

Cronbach's Alpha	N of Items
.944	36

EASI

Reliability Statistics

Cronbach's Alpha	N of Items
.897	8

ISMI-9

Reliability Statistics

Cronbach's Alpha	N of Items
.806	9

PLC-5

Reliability Statistics

Cronbach's Alpha	N of Items
.943	20

Adapted GHSQ-9

Reliability Statistics

Cronbach's Alpha	N of Items
.724	5

Appendix 3.64

Demographic and Workplace Trauma History Questions

Demographic questions

1. What is your age in years?
2. What is your gender identity? (as specified on Qualtrics)
    a. Male
    b. Female
    c. Non-binary/Third Gender
    d. Prefer to self-describe
    e. Prefer not to say
3. How would you describe your ethnicity? (as specified on Qualtrics)
    a. White
    b. Black/African/Caribbean
    c. Asian (Indian, Pakistani, Bangladeshi, Chinese, any other Asian background)
    d. Mixed (two or more ethnic groups)
    e. Other (Arab or any others)
    f. Prefer not to say
4. Do you currently work in an inpatient forensic and/or mental health service?
    a. Yes, I work in a Forensic Inpatient Mental Health Service
    b. Yes, I work in an Inpatient Mental Health Service
    c. No, but I have worked in either in the past 6 months

If yes:

1. What is your current job title?
2. How long have you worked in your current job role?
3. How long have you worked in psychiatric services? (years and months)

4. Are you PEACE trained or equivalent? Yes/No

If no:

1. What was your job role when you worked in psychiatric services?
2. How long did you work in psychiatric services?
3. Were you PEACE trained or equivalent? Yes/No

Workplace Trauma History

1. In the last 6 months, how many times have you experienced incidents of workplace trauma?

(This includes both direct, indirect, and witnessed incidents that were of a physical/psychologically violent nature including death, threatened death, actual or threatened serious injury or actual or threatened sexual violence)

Response options: 0, 1-10, 11-20, 21-30, 31-40, 41-50, 50+

If over 50 please specify approximate amount:

2. What type of incidents have you experienced directly, indirectly or witnessed? (tick all that apply)
    a. Death/threat of death
    b. Actual or threatened serious injury
    c. Actual or threatened sexual violence
    d. Actual or threatened racial violence
    e. Other (please specify)
3. We would like you to think about the most recent workplace incident you experienced or witnessed. How great do you think the danger was that you/others could actually be harmed?'

Scored on a five-point scale (1, none; 2, small; 3, moderate; 4, great; 5, overwhelming).

For survey two the following questions were asked in relation to workplace trauma:

1. Since completing the first questionnaire in this study, have you been exposed to further incidents of workplace violence? (this included direct or indirect experiences such as death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence within the work context)
    a. Yes
    b. No
2. If yes, how many incidents of workplace violence have you been exposed to since the completion of the first part of this study?

    Response options: 0, 1-10, 11-20, 21-30, 31-40, 41-50, 50+

    If over 50 please specify approximate amount:
3. What type of incidents have you experienced directly, indirectly or witnessed? (tick all that apply)
    a. Death/threat of death
    b. Actual or threatened serious injury
    c. Actual or threatened sexual violence
    d. Actual or threatened racial violence
    e. Other (please specify)
4. We would like you to think about the most recent workplace incident you experienced or witnessed. How great do you think the danger was that you/others could actually be harmed?’

Scored on a five-point scale (1, none; 2, small; 3, moderate; 4, great; 5, overwhelming).

Appendix 3.75

Other types of incidents reported by participants.

Participants qualitative responses to the types of other incidents they experienced: Verbal threats, aggression, severe self-harm, psychological abuse, spitting with the intent of spreading disease to staff, threats to family, NG-feeding with resistive patients, actual and threatened minor injuries (hitting, kicking, punching, slapping, spitting, tripping up, intimidation), actual and threatened use of weapons, false allegations (calling up people outside the trust and passing over staff detail and making allegations), criminal damage, and patients trapping staff in closed environments with threat of violence if they try to escape.