

How is the Power Threat Meaning Framework being used by Clinical Psychologists in Clinical Practice?

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ABSTRACT

Background: The Power Threat Meaning Framework (PTMF) was published in 2018 as an alternative to psychiatric diagnosis, a way of conceptualising psychological distress through a contextual framework.

Objective: This study seeks to explore how the PTMF is being used by Clinical Psychologists in clinical practice, what factors may be facilitating or hindering its use and what theoretical implications this may have for the profession.

Methods: A qualitative methodological approach was taken. The study involved individual semi-structured interviews with 10 UK Clinical Psychologists working clinically with the PTMF. Data was analysed using thematic analysis, from a critical realist epistemological position.

Results: Three superordinate themes were identified from the analysis, Supporting Conceptual Change, Clinical Usefulness of the Framework and Facilitating Institutional Change. Subordinate themes are expanded on within these.

Conclusions: The study demonstrates that the PTMF was felt to be conceptually and clinically useful to the practitioners making use of it. The PTMF was described by the participants as being applicable to numerous clinical activities, supporting the multi-faceted nature of their roles and allowing for an integrative clinical approach as it was seen to both supplement and complement existing ways of working. Limitations to the PTMF, such as its potentially confusing terms and concepts, and challenges in applying it in clinical contexts are also highlighted. Implications and recommendations for widening the PTMF's use clinically and for future research on the topic are discussed.

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1. INTRODUCTION

The Power Threat Meaning Framework (PTMF) was published in 2018 as an alternative to psychiatric diagnosis, a way of conceptualising psychological distress through a contextual framework (Johnstone & Boyle, 2018). Given the framework's recent publication and broad possible applications this study sought to explore whether the PTMF is being used by Clinical Psychologists in their clinical practice and the nature of its applications. The study also sought to explore the contextual factors that may be facilitating or hindering the application of the framework in clinical practice.

1.1. Chapter Overview

This chapter will start by outlining the longstanding debates surrounding the medicalisation of mental distress, including concerns regarding the validity, reliability and ineffectiveness of psychiatric diagnosis and psychiatric treatments. It will go on to consider the role of psychology in perpetuating medicalised understandings of distress, and the growing concerns of clinicians in relation to this way of working. It briefly outlines a changing context in which government policy, the NHS and practising psychologists are prioritising trauma informed and individualised approaches to care. The chapter will then introduce the PTMF, a research project funded by the Division of Clinical Psychology as a result of these debates and concerns leading to the publication of the PTMF as an alternative framework for conceptualising mental distress through a non-medicalised lens.

The chapter then provides a review of the literature on the PTMF to date, exploring the response of clinicians and academics to the framework's publication. A review of the literature demonstrates that much of the peer reviewed work focuses on the framework's theoretical and conceptual benefits to the field, with very few pieces detailing the PTMF's application or utility in clinical practice. The review of the literature also considers criticisms and limitations of the PTMF.

Consideration is then given to Clinical Psychologist's theoretical orientations, how frameworks and models are applied by psychologists in practice and the nature of their

professional role in the NHS. Clinical Psychologists train in numerous theoretical approaches and several clinical competencies such as assessment, intervention, formulation and evaluation. This is explored for its relevance in understanding how the PTMF may be taken up and used by Clinical Psychologists in clinical practice, and to consider if there may be opportunities for psychologists to integrate trans-theoretical approaches in their work.

The chapter culminates by presenting the rationale for this research project, to fill a gap in the existing literature by examining how and why the PTMF is being applied in clinical practice by Clinical Psychologists in the UK and the contextual factors that may be facilitating or hindering this process.

1.2. Medicalisation of Mental Distress

Medicalised understandings of mental distress have come to dominate the fields of psychiatry and psychology in the UK. The medical model of mental health describes people's distress in the medical language of symptoms, disorders and illnesses, leading to medical practices such as diagnosis, hospitalisation and administration of psychotropic medications. The medical approach also creates a research agenda focusing on attempts to uncover the genetic and biological causes of mental illnesses such as chemical imbalances, brain disease and heredity genetics (Read et al., 2006).

Despite its dominance, there have been long-standing concerns regarding the legitimacy and effectiveness of a medicalised approach in treating psychological distress. Concerns are particularly raised in relation to the reliability and validity of diagnostic categories. Several decades after the first publication of the Diagnostic Statistical Manual of Mental Disorders (DSM) there are still no objective measures for psychiatric diagnoses and the clustering of symptoms for psychiatric disorders in subsequent editions of the DSM continue to differ (Harper, 2020; Kinderman et al., 2013; McWilliams, 2020). Furthermore, despite extensive efforts over the past six decades, research has failed to uncover biological causes of mental disorders, or to prescribe effective treatments (Johnstone & Boyle, 2018; Kinderman et al., 2013; Moncrieff, 2014; Moncrieff & Middleton, 2015).

The lack of scientific evidence and biological markers for psychiatric disorder categories has led to difficulties in clinical practice. Concerns regarding the validity and reliability of diagnostic categories are further demonstrated by the low levels of agreement amongst practitioners making diagnoses. A study showed US psychiatrists held broader definitions of Schizophrenia than UK psychiatrists and therefore were more likely to diagnose it, highlighting the extent to which diagnosis depends on the subjective judgements of individual professionals and that this can lead to highly different outcomes for patients (Harper, 2020). Attention has also been drawn to the high rates of comorbidity amongst those with psychiatric diagnoses, a phenomenon in which people fit several disorder categories simultaneously (Johnstone & Boyle, 2018; Kinderman et al., 2013). This may raise questions about how accurate or useful these disorder categories are. As mental health services are organised by diagnostic categories, such is the prevalence of the medicalised approach to mental health, the high rates of comorbidity create further difficulties as it raises questions about which service a person should access when they have more than a single psychiatric diagnosis (Harper, 2020). In this respect, the medicalised approach creates conceptual and structural inconsistencies for both mental health staff and service users.

Concern for the validity of psychiatric diagnosis has also been raised in the context of high diagnostic rates of schizophrenia amongst black and minoritized groups, with some clinicians and academics arguing it is possible to understand higher rates of paranoia amongst minoritized groups as being understandable responses to experiences of racism rather than signs of psychiatric disorder (Cromby et al., 2013). The medical model may, in fact, obscure the reality of the causes of people's distress in this respect. McWilliams shares this concern in her writing stating that the deemphasis on clients' subjective experiences has led to flat, distant understandings of peoples' mental health (McWilliams, 2020). While there has been no biological pathology identified in connection to psychiatric disorders there has been considerable evidence that lived experiences contribute significantly to individuals' emotional distress and behavioural problems (Rapley et al., 2011). Some argue the medicalised approach contributes to fear and stigma surrounding mental illness as it makes distress unintelligible and incomprehensible as the causes of these illnesses are never found or understood within a medical model (Johnstone & Boyle, 2018; Rössler, 2016).

McWilliams (2020) refers to how all clinicians have observed the misuse of diagnostic formulations in which the complexities of a person are oversimplified for the convenience of the interviewer, the anguish of a person is distanced by linguistics for the interviewer who cannot bear to feel the pain and troublesome persons are punished with pathologising labels.

Despite these concerns many psychiatric and psychological professionals continue to defend medicalised approaches to mental health. They argue any medical population may include extreme variations in presentations, and that classification of some form is needed to guide possible treatments and logical next steps (Craddock & Mynors-Wallis, 2014). This may be particularly true during professional training when it is helpful to have language that generalises presentations into diagnoses and provides subsequent treatment recommendations (McWilliams, 2020). Diagnosis, it is argued, may also serve to reassure individuals that their situation is not inexplicable or unique and that this is supported by existing bodies of knowledge and experience and may also connect patients or carers with similar problems (Craddock & Mynors-Wallis, 2014). Furthermore, some professionals argue the medicalised approach helps to organise services and serves as a communicative aid between professionals as well as the public (Craddock & Mynors-Wallis, 2014).

1.2.1. Psychology's Role

It could be easy to see the medicalisation of mental illness as a problem within the psychiatric field, however, the field of psychology has also adopted the medical model despite a psycho-social understanding of distress seemingly being core to the field's foundations. The adoption of a medicalised approach in psychology was likely due to the field's insecurity over its acceptance as a science and concern with engaging in research which appeared scientifically objective and whose results could be presented as fact rather than opinions (Rapley et al., 2011). Pilgrim (2010) has similarly argued that Clinical Psychologists collude with the medical model to gain professional status. Rapley et al. (2011) argue that it is for these reasons that psychologists may prefer to speak about brains and illnesses rather than poverty and oppression. This may also explain why alternative approaches can be met with much hostility within the field (Rapley et al., 2011).

Another aspect of note is that the use of medical and scientific language confers a level of credibility onto the psychological and psychiatric fields which ensures it is difficult for others to question or criticise, this may preserve the medical approach from legitimate questions regarding its utility and effectiveness. In tandem with this professionals are socialised through their training into certain ways of thinking which may then be challenging to re-dress or alter, especially if there is minimal exposure to alternatives, or if change is associated with a loss of professional credibility (Grant & Gadsby, 2018; Johnstone & Boyle, 2018).

Nonetheless, many psychologists have shared concerns regarding the DSM and the medicalisation of distress. Raskin et al.'s (2022) poll of US psychologists found dissatisfaction with several aspects of the DSM-5, mainly that it obscured individual differences, medicalised psycho-social problems and relied heavily on medical semantics when it remains unclear if mental disorders should even be understood as a subset of medical disorders. They found that psychologists have continually supported the creation of alternatives to the DSM over the past 30 years (Raskin et al., 2022; Raskin & Gayle, 2016). Their findings have also shown that psychologists use the DSM despite their apprehensions about it, for practical reasons over scientific ones, which raises further professional and ethical concerns (Raskin et al., 2022; Raskin & Gayle, 2016). Raskin concludes by warning that until alternative approaches can provide the same practical advantages and become better known psychologists are likely to continue to use the DSM out of convenience and necessity, despite mixed feelings about it (Raskin et al., 2022). It is worth noting that expectations to provide a diagnostic classification for clients are considerably more prevalent in the US due to the intersection of healthcare and insurance provisions. This expectation may not be as prevalent in the UK; however, UK psychologists are also professionally mandated to provide diagnostic classifications and work within a context in which the medical model dominates.

Further studies found other mental health professionals such as counsellors and psychotherapists similarly held concerns regarding the DSM and supported the generation of alternatives (Gayle & Raskin, 2017; Raskin, 2019). Despite this wide ranging support for the development of alternatives when participating psychologists were asked about existing alternatives such as the Operationalized Psychodynamic

Diagnosis (OPD) and the PTMF they were unfamiliar with these (Raskin et al., 2022). Raskin's work demonstrates a call within the profession for alternatives to the medicalised approach to mental health but also raises questions about whether alternatives are known about and taken up by clinicians.

1.2.2. A Changing Context

'Theory influences practice and it is also influenced by it. When enough therapists come up against aspects of psychology that do not seem to be adequately addressed by prevailing models, the time is ripe for a paradigm shift' (McWilliams, 2020, p.36). The concerns surrounding the legitimacy and effectiveness of medicalised approaches have led many to ask if there may be better ways of making sense of human distress which does not involve psychiatric disorders. The United Nations Human Rights Council has highlighted its concerns that 'the concepts supporting the biomedical model have failed to be confirmed by research and...we have been sold a myth that the best solutions for addressing mental health challenges are medications and other biomedical interventions' (UN General Assembly, 2017, p.5). The Division of Clinical Psychology (DCP) were of a similar opinion, stating that 'psychiatric diagnoses have significant conceptual and empirical limitations...there is a need for a paradigm shift in relation to the experiences that these diagnoses refer to, towards a conceptual system not based on a 'disease' model' (Division of Clinical Psychology, 2013, p.1). Professionals and those with lived experience of mental health services have similarly been expressing concerns regarding existing mental health practices for decades, for instance, groups such as 'Recovery in the Bin' are calling for a 'robust social model of madness, distress and confusion, which places mental health within the context of social justice and the wider class struggle' (Recovery in the Bin, 2016, p1.). These concerns relating to the limitations of the medicalised approach have developed into a wider, public discussion about dissatisfaction and disillusionment with prevalent existing practices and appear to have contributed to interest in alternative approaches. It is within this context that the DCP provided funding for a new project with the aim of developing an alternative contextual approach to mental health from which the Power Threat Meaning Framework was born.

Recent examination of the role of psychologists in the NHS has demonstrated that by having a visible and active presence in team decision making psychologists are increasingly promoting the significance of psychological processes in mental distress, and offering a different perspective to the medical model in multidisciplinary teams which has been valued by colleagues and service users (Christofides et al., 2012). Psychologist's use of team formulation, a way of making sense of a client's presentation and history typically without using diagnostic terms, is reported to have been effective in shifting the culture toward a more psychosocial perspective, and the Department of Health has long advised on creating shared formulations to guide client's care within teams to promote communication, transparency and agreement on objectives amongst professionals (Christofides et al., 2012; Department of Health, 1999). Clinical Psychologist's may be more interested in non-medicalised approaches compared to their psychiatric colleagues in this respect, especially in the UK where diagnosis is not closely related to insurance requirements and third party payment arrangements, as a result US psychologist's may have less organised opposition to diagnosis because of the practicalities surrounding pay.

Another aspect of the changing context surrounding mental health services is the move to trauma informed approaches. Trauma informed approaches emerged in the US in 2005 and have been the source of international interest. A trauma informed approach emphasises the adverse and persistent impact traumatic experiences can have on individuals, their social development and their relationships (Sweeney et al., 2016), and are also often referred to as an organisational change process (Sweeney & Taggart, 2018). This increased interest in and shift towards trauma informed approaches over the past two decades, including in the UK, is understood to have developed out of frustration and disillusionment with traditional models which were felt to be insufficient, as well as due to research highlighting the widespread nature of trauma and its high correlation with mental health difficulties (Sweeney et al., 2018). Despite interest in this approach, it has also been criticised for being complex and difficult to apply, and attention has been drawn to the limitations of its implementation in UK mental health services (Sweeney et al., 2016, 2018). The PTMF may be comparable to trauma informed approaches in that it similarly focuses on contextual and adversarial experiences and seeks to understand service users holistically in non-diagnostic terms, asking what has happened to people opposed to

what is wrong with them. However, the PTMF distinguishes itself from trauma informed approaches by using distinct language, such as referring to adversity opposed to trauma, and seeking to highlight it's more practical and concrete possible applications as a framework. Nonetheless, the PTMF's emergence and interest in its publication is likely best understood within this changing context in which there has been a move to trauma informed approaches.

The NHS Long Term Plan published in 2019 also exemplified a change in direction for the government and health services. The plan outlines a 10 year strategy for improving and reforming the NHS in England and formally introduced a move towards trauma informed approaches, intending to facilitate a shift in the nature of mental health service delivery towards increasingly personalised care (NHS Long Term Plan, 2019). This policy may demonstrate a shift away from the dominant medicalised approach to a more contextualised lived experience understanding of mental distress.

These developments seem to demonstrate a significant shift in which professional bodies, practitioners, service users and government health policy are acknowledging the shortcomings of the medical model and are actively seeking to redress these shortcomings. This context of change is likely to affect the reception of a recently published alternative approach such as the PTMF in the fields of psychology, psychiatry and mental health services broadly.

1.3. An Alternative: The Power Threat Meaning Framework

The PTMF details the conceptual and empirical deficiencies associated with psychiatric diagnoses and provides an alternative framework for working with psychological distress. Its central assumption being that troubling behaviour and emotional distress are intelligible responses to social and relational adversities (Johnstone & Boyle, 2018). Opposed to assuming pathology or identifying symptoms, the PTMF uses the language of coping and survival mechanisms and describes these as adaptations to adversities, provides a structure for identifying patterns in distress, troubling behaviour or unusual experiences and suggests alternative language to that of diagnostic terms (Johnstone & Boyle, 2018). The authors claim it also offers an alternative way of fulfilling the research functions of diagnosis and service-related

administration (Johnstone & Boyle, 2018).

'It can no longer be considered professionally, scientifically or ethically justifiable to present psychiatric diagnoses as if they were valid statements about people and their difficulties' (Johnstone & Boyle, 2018, p.314). The authors draw attention to the fact that the field is unlikely to make progress and improve clients' outcomes within a biomedical approach and ask why an invalid system of understanding should continue to dominate psychological research, theory and clinical practice (Johnstone & Boyle, 2018). They raise the professional and ethical issue of the potential harm caused to individuals by invalid diagnoses and ineffective treatments.

They recognise that while alternatives to medical understandings of distress have always existed, such as formulations and problem descriptors, they argue what has not been available is an alternative conceptual framework which allows for broader clustering and pattern identification (Johnstone & Boyle, 2018). They argue that existing alternatives have till now continued to position socio-political and relational factors as secondary to biological deficiencies in the individual, meaning medicalised understandings have continued to dominate and human distress has been prevented from being theorised as a meaningful and understandable response to lived experiences in psychiatric and psychological fields. In contrast, the PTMF conceptualises individuals as having agency in their lives, while simultaneously being subject to wider bodily, material, financial, social and ideological power and influence (Johnstone & Boyle, 2018). A central aim of the framework is to demonstrate the links between wider social threats and power on individual people's threat responses. As opposed to being classified as 'symptoms' they argue people's threat responses should be understood in terms of the functions they serve, that humans are adaptive and create strategies to ensure their core needs are protected, consciously or otherwise, in the face of the negative impacts of power that can affect their daily lives (Johnstone & Boyle, 2018). In this respect, the framework also intends to have implications for wider social and political action by drawing attention to these broader influencing factors.

The framework intends to restore meaning and understanding to mental disorders, meaning and understanding which has been obscured by psychiatric processes and

allows for the emergence of non-blaming and de-mystifying stories about strength and survival, and for behaviours or experiences which are currently considered signs of psychiatric disorders to be re-integrated back into the spectrum of universal human experience (Johnstone & Boyle, 2018). The project was co-produced with service users, who made up the core team as well as consulting on the project. The framework was the first of its kind to be co-produced in this way and aimed to create resources for diverse demographics, including clients, carers, professionals and commissioners, researchers, policy makers and the public broadly (Johnstone & Boyle, 2018).

The framework's aims are both broad and ambitious. The authors suggest the PTMF could be used as it is but could also be used as a meta-framework within which existing models could be accommodated or integrated (Johnstone & Boyle, 2018). The hope is that the framework may produce a shift in policy, practice, thinking and even research focus within the field. The authors have emphasised that, unlike the dominant medical model, the PTMF is an optional resource, an approach which people may or may not choose to engage with or translate into their practice (Johnstone et al., 2019). This raises the question: given the optional nature of the PTMF and its broad potential applications, have clinicians opted to engage with it, and if so in what ways?

1.4. Literature Review on the PTMF

Literature on the topic of the PTMF has been growing since its publication in 2018. There is no systematic review of this literature at present. This literature review intends to provide a scholarly summary of the overall number and nature of publications on the PTMF, but ultimately to provide a more detailed review of the PTMF's theoretical and clinical implications for the field of Clinical Psychology and mental health work. For this reason, a narrative review approach is proposed, as it may be more conducive to interpretation, insight and critique, whereas systematic reviews may tend to address a more problem-focused question and seek primarily to summarise data (Greenhalgh et al., 2018). Narrative reviews may also be more suitable in seeking new areas of study that have not yet been addressed in the literature (Ferrari, 2015), and by enabling the inclusion of a range of publications – such as those that are theoretical opposed to empirical in design.

1.4.1. Literature Search Strategy

Literature searches for the terms “Power Threat Meaning Framework”, “Power Threat Meaning Framework: Overview”, and “PTMF” were completed on the EBSCO (EBSCOHost, CINAHL, APA PsycINFO, Academic Search Ultimate) and SCOPUS databases, and supplemented by a Google Scholar database search. An initial summary of the database search findings is provided, before presenting the criteria for inclusion within the main literature review.

All three databases were searched from 2018, in line with the publication of the PTMF, to January 2023. The EBSCO and SCOPUS databases yielded a conservative finding of 40-52 results depending on the search term, of which most findings were relevant, and several findings used the ‘PTMF’ acronym but not in relation to the Power Threat Meaning Framework and were excluded. Searches of the Google Scholar database yielded a considerably higher number of results, ranging from 113-992 depending on the search term, however, most of these findings made minimal reference to or simply cited, the PTMF. Consequently, the criteria for inclusion within the main body of the literature review was for peer reviewed publications that engaged with the PTMF in a substantial way, such as in the title or within the main body of the article. This literature review focuses on search results written in English due to the limitation of resources.

1.4.2. Literature Summary

The database findings can be summarised in three main categories:

The largest portion of the search results were peer reviewed publications such as journal articles and books that made very brief reference to the PTMF or simply cited it as a source. This literature typically referred to the PTMF for its possible use as an alternative approach, or as a way of focusing on the roles of trauma, power and social adversity to understand people’s distress but did not explore or apply the concepts (Beshara, 2020; Dawson, 2018; Downs & Rayner-Smith, 2022; Faulconbridge et al., 2019; Howard & Adan, 2022; Khan & Haque, 2021; Phillips & Raskin, 2021; Read & Moncrieff, 2022; Sowers et al., 2021).

A secondary portion of the findings, particularly in the Google Scholar search results

were grey literature, such as unpublished dissertations, teaching materials, blog posts, magazine articles or internet reports which made reference to or engaged with the PTMF. This portion of the literature typically applied the PTMF to a case study in order to provide a framework for conceptualising distress or a certain lived experience such as bullying in the workplace or refugee women's experiences of war (Brown, 2020; Schweitzer et al., 2018). The PTMF was also often referred to in order to provide an overview of, personal reflections on, or critiques of the framework and its concepts in blogs or magazines (Priest, 2018; Salkovskis & Edge, 2018).

A third, smaller portion of search results and particularly the findings of the academic EBSCO and SCOPUS databases were peer reviewed publications such as journal articles and books that engaged with the PTMF in a substantial and detailed way. This third category of peer reviewed journal articles or books which engage with the PTMF more substantially is the focus of the following literature review, within which 45 items are discussed. This literature on the PTMF can be thought of in two main sections: literature detailing the theoretical and conceptual contributions of the framework and literature detailing the clinical applications and clinical contributions of the framework.

1.4.3. Theoretical and Conceptual Contributions

The majority of peer-reviewed literature on the PTMF focuses on the theoretical and conceptual benefits and contributions of the framework. For instance, Boyle (2022) highlights that discussions of power and social context are absent from mainstream psychological and psychiatric accounts of emotional distress and that the PTMF now allows for considerations of power in people's lives to be incorporated into their therapeutic work. She argues this could shift the locus of change from individuals to the wider social world and provide a more realistic assessment of what change is possible (Boyle, 2022). Similarly, Harper (2020) discusses the importance of the narrative elements of the PTMF in drawing attention to the ideological power of medicalised approaches to frame public conversations about mental health, highlighting the hermeneutic injustice which has been enacted by the dominant medical approach in limiting understanding and expression of peoples experiences. He argues the PTMF is providing alternative ways in which to story lived experiences that bridge this hermeneutic gap and differs from existing narrative therapeutic

traditions.

The PTMF's core tenet of personal meaning has been highlighted for its importance theoretically in helping to explain the highly varied responses different people can have to adversities (Cromby, 2022). Ramsden (2019) a Clinical Psychologist working in forensic mental health settings reflects that professionals have been limited by services and therapies that have been designed on biomedical assumptions, and that the PTMF now offers services a better articulated, explicit and radical framework from which to recognise the importance different types of power play in mental distress. In a similar forensic context, Willmot and Evershed (2018) consider the potential use of the PTMF, alongside other approaches, to help think about and formulate client's challenging and offending behaviours as learned survival responses to perceived threats and that this could be applied when interacting with or interviewing forensic demographics to avoid perpetuating problematic patterns between forensic clients and people in authority. The possible utility of the PTMF in the criminal justice system is expanded on in Ramsden and Beckley's (2022) book chapter, the authors argue that the criminal justice system typically fails to consider context and trauma when attempting to understand and work with those who offend and that the justice system itself can be threatening and exacerbate presentations. Consequently, they argue the PTMF should be integrated into practice, to allow for explicit conversations about power and to notice the presence and impact of threats in these systems and relationships. Much of the existing literature echoes this potential of the PTMF to inform service developments and influence policy change (Albanese et al., 2021; Henrich, 2022; Pilgrim, 2022; Read & Harper, 2022; Stupak & Dobroczyński, 2021). This literature highlights the potential utility of the PTMF for clinical services and the profession but raises questions about how and in what ways the framework may be applied in practice.

Several articles consider the PTMF's contributions in critiquing the assumptions of the biomedical approach and psychiatric positivism, and the need for professionals to reflect on their philosophical assumptions in the context of their professional authority over the lives of others (Harper & Cromby, 2022; Pilgrim, 2022; Pilgrim & Cromby, 2020; Read & Harper, 2022; Strong, 2019). Whether the PTMF is able to facilitate such reflections in professionals is yet to be determined. Johnstone (2022) has also

drawn attention to the conceptual structure the PTMF now offers to identify patterns of emotional distress, which can replace unsuccessful attempts to identify patterns of bodily dysfunction for psychiatric diagnoses. One experimental study uses the PTMF to create a psychological formulation for a fictional person and a corresponding psychiatric diagnosis for the same fictional person to assess participants' attitudes towards a schizophrenia diagnosis v a formulation and its effects on stigma and treatment attitudes (Seery et al., 2021). The findings suggested psychological formulation guided by the PTMF lessened stigma-related attitudes compared to traditional diagnosis, and that the formulation model did not negatively affect the perceived helpfulness of specialist care or help-seeking behaviours, but did lead to a preference for less medicalised treatment options (Seery et al., 2021). In these respects, the PTMF is described in the literature both as a potential alternative to the medical model and as a possible replacement for its clinical functions. How this translates to practice and whether the PTMF is seen as an alternative or replacement is still to be seen.

Numerous articles have applied the PTMF to research, audits or case studies as a framework for conceptualising distress. One article applies the PTMF to conceptualise stress in footballers in non-diagnostic terms (James et al., 2022), while another utilised the framework to offer insights into mental health carers' experiences (Paradiso & Quinlan, 2021). NHS audit of a community psychosis team's caseload found histories of trauma for every client using the PTMF as a guiding and contextual framework (Colbert et al., 2022). The PTMF has been used to interpret qualitative data of people's experiences of lockdown and accessing services remotely, and was found to be useful in recognising participant's experiences of threats to their wellbeing which were heightened by inequality and powerlessness (Leeming et al., 2022; Newton et al., 2022). The PTMF has also been applied to other analyses of lived experiences and resultant distress (Darcy, 2022; Enlander et al., 2022; Jagasia et al., 2022; Willmot & Siddall, 2022). This literature suggests the PTMF's application was conceptually beneficial in this way.

Literature has also highlighted the use of the PTMF being applied personally by psychologists, including Counselling Psychologists, to make sense of their own experiences in a practice of self-formulation (Amari, 2023; Randall et al., 2020). This

suggests that the framework could also be applied by staff themselves as a tool for self-understanding and exploration and supports the PTMF's claim that it is a tool accessible to everyone, not just service user demographics.

The literature demonstrates that the conceptual benefits of the PTMF go beyond that of the psychological field as it provides a framework to conceptualise distress for other professionals in a wide array of contexts. For instance, mental health nurses have described the possible benefits of the framework being applied to mental health nursing training and clinical practice as a way of according dignity and respect to clients around meaning making and the potential to support clients in re-storying their experiences free from stigmatising and pathologizing narratives and thereby challenging epistemic injustices (Grant & Gadsby, 2018). The authors suggest the PTMF should be applied to mental health nurse training, but acknowledges its implementation may not be successful due to the contradictions between the PTMF and existing frameworks services currently rely on (Grant & Gadsby, 2018). This suggests that while the PTMF may be a useful tool its incompatibility with existing ways of working may limit its application or effectiveness in clinical contexts. This raises the question of if professionals would be able to engage with a framework that is at odds with their established ways of thinking and working. On the other hand, it being taken up by mental health nursing colleagues may also raise questions about whether the PTMF could be useful to other professionals and colleagues.

The PTMF has even been used in case studies of climate distress in South Africa and is described as having helped to illustrate the importance of unequal power dynamics and the socially rooted nature of climate distress and to critique the current conceptualisations of 'climate anxieties' for their perceived medicalisation and decontextualization (Morgan et al., 2022; Watson et al., 2020). In another article one of the PTMF authors reflects on the training she was invited to provide on the PTMF to mental health professionals in New Zealand and Australia. She reflects on the experience as having been an opportunity to consider different cultural experiences and expressions of distress, in line with the authors' hope that the PTMF may respect and validate other worldviews and be applicable cross-culturally (Johnstone & Kopua, 2019). She concludes by saying that the outcome of the training on the PTMF in New Zealand remains to be seen, but that she suspects the PTMF may fall short in the

context of their dominant diagnostic approach, but that any change in the right direction could be valuable (Johnstone & Kopua, 2019). This demonstrates a global interest in the PTMF and the potential for it to be applicable in a range of contexts and cultures. Much of the literature recognises the potential of the PTMF, however, as Johnstone emphasises the impact of the PTMF is still to be determined.

Several authors have also considered the public health and prevention work that could be made possible within the field of Clinical Psychology by using the PTMF to broaden conceptualisations and make causal links between social determinants and outcomes, facilitating a move beyond individualised responses to tackling structural inequalities pre-emptively (Anand, 2022; Darcy, 2022; Darcy et al., 2022).

Several brief articles in the *Clinical Psychology Forum* have begun to consider the potential theory-to-practice benefits of applying the PTMF in clinical practice directly with clients. One such article considers the potential for the PTMF to be applied to clinical settings with clients to understand their personal histories and current experiences (Bostock & Armstrong, 2019). The main author Nicola, a Patient and Carer Involvement Facilitator, reflects on how she felt a breakthrough in her own care as a patient when professionals began to ask questions that helped her, and them, to make sense of the impact of her experiences and her troublesome responses (Bostock & Armstrong, 2019). The author considers how the PTMF could be utilised to aid this process and improve their service delivery. In an open letter published in the *Clinical Psychology Forum* two Clinical Psychologists call on the DCP to provide clearer guidance on trauma informed approaches and endorse the use of the PTMF as an explicit trauma informed approach which could be drawn on for this purpose (Skelly & Shirley, 2022). This demonstrates how contextual factors influence clinical practice and raises questions about the extent to which professionals can take up a framework if it is not considered to be evidenced based and is not endorsed for clinical use by professional bodies such as the National Institute for Health and Care Excellence (NICE) and the DCP.

In another Forum article, the authors argue 'people up and down the country need us to put the PTMF into practice in many and varied ways', and that even the simple act of recognising the abuses and injustices for survivors diagnosed with personality

disorders and psychosis could ensure distress is responded to more effectively (Darcy et al., 2022, p.62). They also consider the theoretical benefits of co-production as demonstrated by the PTMF in both broadening and challenging our knowledge base and epistemology, and the value in legitimising co-production and working with communities to create specialist knowledge and for justice seeking to be a part of recovery which psychologists can assist with (Darcy et al., 2022).

The literature demonstrates that the PTMF has been a catalyst for widespread thoughtful reflections and provided a way for conceptualising mental distress, not just in the UK but across the world, and for professionals and researchers of varied theoretical backgrounds and clinical interests.

1.4.4. Clinical Applications and Contributions

Despite these extensive reflections on the conceptual contributions of the framework to the field, research on the PTMF's clinical applications remains limited. Only one article details the PTMF's clinical application by survivors themselves. The SHIFT Recovery Community (2022) outline their use of the PTMF within their peer support group, how the group read, discussed and reflected on the Overview document week by week. The PTMF was felt to have provided them with understanding, hope, inspiration and aided their recoveries. The group concluded that the PTMF has the potential to be used both as an educational tool across communities, as well as to support individual journeys of recovery.

There are several brief articles in the *Clinical Psychology Forum's 'Special Issue: The PTMF'* published via the BPS, detailing how Psychologists are using the PTMF in clinical settings, such as in adult forensic mental health settings with offenders to explore their experiences of prison (Reis et al., 2019). There are also articles exploring how the PTMF shapes organisational strategic policy to improve youth mental health services in Ireland, the frameworks use with abused women and the practitioners who support them, its use in teaching critical and community psychology to trainees and qualified psychologists' experience of using the PTMF in a national specialist Autism Spectrum Conditions service with children, families and adults (Aherne et al., 2019; Collins, 2019; Flynn & Polak, 2019; Griffiths & Baty, 2019). The use of the framework

to inform social work education and practice, as well as by teachers as a holistic compassionate framework for understanding the origins of emotional distress and teaching wellbeing in educational settings is also explored briefly in two articles (Fyson et al., 2019; O'Toole, 2019).

In the *Clinical Psychology Forum's 'Improving Services for Trauma Related Dissociation'* edition a Consultant Psychologist describes how the PTMF could help to inform structured clinical management and their work in developing a two-day training on trauma stabilisation work informed by the PTMF, which they have started to deliver to their specialist community mental health teams (Mitchell & Thorne, 2019). They hope that by allowing clients to feel heard they can help to promote safety, connection and a collaborative approach between clients and practitioners which can enable a rebalancing of power, and ongoing threats can be better understood (Mitchell & Thorne, 2019).

Beyond the *Clinical Psychology Forum*, two articles refer briefly to some of the PTMF's core concepts such as that of power dynamics in contributing to distress and the focus on narrative story-telling - one in working with a client group who are survivors of cults and the other in formulating a client's presentation with them (Amari, 2022; Hawkins et al., 2020). However, both articles appear to draw more heavily on alternative approaches, such as person-centred approaches, in the clinical work described than on the PTMF itself. Nonetheless, this demonstrates interest in applying concepts of the PTMF to clinical practice and different client demographics. Clinical Psychologists also appear to be attempting to document and disseminate their experiences of using the PTMF through other mediums, such as via Youtube (Let's Talk Forensic Psychology, 2021), and Trust service evaluations (Nikopaschos et al., 2020). This suggests Clinical Psychologists are interested in discussing and highlighting their work with this new framework, but these accounts remain anecdotal. Literature exploring the responses of other multidisciplinary colleagues to the PTMF, such as Psychiatrists and Psychotherapists, is not well established and thus it is not possible to draw explicit conclusions about the PTMF's reception in mental health services broadly, or amongst these professional groups specifically at present. It is likely that the PTMF may be of lesser interest to these professionals given the emphasis placed on medicalised understandings of distress within the Psychiatric profession and training, and the focus

on a single model of therapy for Psychotherapy colleagues. Some responses to the PTMF have been mixed, even amongst Clinical Psychologists, with scepticism and critiques being shared, for a fuller discussion of these see section 1.5. Nonetheless, the existing literature suggests the PTMF is starting to be applied in clinical contexts and that professionals such as psychologists, mental health nurses, and peer support workers are interested in its clinical uses; however, the full extent of its use and the impact of its applications is not yet clear.

There has been considerable discussion and publication detailing the potential ways in which the PTMF could and should be applied to clinical practice, to facilitate co-production, to re-focus public health and psychology work on prevention, to acknowledge wider social determinants and the influence of power when working with individual client's distress. However, peer reviewed research demonstrating the clinical applications of the PTMF remains limited. This raises the question of how Clinical Psychologists are using the PTMF, is it only useful theoretically to inform thinking or is it also applicable to clinical work? It is not entirely clear in which service settings the PTMF is being applied to clinical practice, how useful its application is in practice or what barriers may be facilitating or hindering the framework's uptake. There is, therefore, now an opportunity to explore these questions and fill this gap in the literature.

1.5. Criticisms of the PTMF

While the PTMF has enjoyed a positive reception, as demonstrated by the literature review, several concerns, criticisms and limitations have also been raised in relation to the framework. These responses could shed light on what factors may be hindering the framework's uptake and help to inform the focus and direction of further research into the PTMF.

While the framework seeks to highlight the impact of power it does not provide interventions or guidance for addressing structural power imbalances directly. It could also be seen to individualise difficulties, much like the other psychological models it is critical of, with its focus on individual threat responses, despite claiming to take

account of contextual power. Clinical Psychologist Navya Anand has raised similar concerns arguing that despite the frameworks intention to be applied at individual, group and community levels it may not easily be implemented in this way, particularly as its core constructs such as threat responses are interpreted at an individual opposed to community level meaning it is likely to be seen primarily as a resource for individual therapy (Anand, 2022). She goes on to argue that the complexity of the concepts and language could make the framework inaccessible (Anand, 2022). The author also wonders to what extent the PTMF which was developed in the UK could apply across geographical and cultural contexts (Anand, 2022). While the existing literature indicates an interest in the PTMF amongst several psychologists, other professionals and a small select group of service users across a large geographical area the extent of the PTMF's accessibility beyond this is not clear at present. Whether there are accessibility concerns experienced by professionals in applying the PTMF could be explored in research.

A Clinical Psychologist has raised concerns that the framework could lead to overly simplistic narratives about power in her area of forensic mental health work, narratives such as 'the police hate me, I've done nothing' which could pose challenges for both staff and service users (Ramsden, 2019, p.132). She also wonders if the framework could pose an ideological dilemma for staff on how to approach issues of power when they are mandated to act powerfully to ensure public safety within the criminal justice system, which could be felt to be oppressive by service users (Ramsden, 2019).

In response to early criticisms, the authors of the PTMF wrote 'Reflections on Responses to the PTMF', in which they begin to acknowledge the concerns raised and attempt to respond to these. In terms of concerns about the applicability of the PTMF to cultures or contexts beyond the UK, they highlight their acknowledgement of the euro-centric limitations of the PTMF in the original overview document. In which they acknowledged that 'since patterns in emotional distress will always be to an extent local to time and place, there can never be a universal lexicon' (Johnstone et al., 2019; Johnstone & Boyle, 2018b, p.11). Having themselves argued that expressions of distress are inextricably linked to the cultural contexts and narratives available to people the authors acknowledge the framework and its associated General Patterns of behaviour inevitably rely on Western cultural understandings and that they

themselves are a majority white group (Johnstone et al., 2019). Despite these limitations, the authors highlight that in the short time since the framework's publication the main documents and its supporting resources have begun to be translated into various languages such as Spanish, Italian and Norwegian and the authors have received numerous invitations to give talks on the PTMF internationally in New Zealand, Australia, Ireland and Greece to name a few (Johnstone et al., 2019).

The authors respond to concerns that the framework may be too ambitious and complex by drawing attention to attempts to provide a range of accessible resources such as the two-page summary, recorded talks and the 'Guided Discussion' documents all of which are freely available via the BPS. In response to concerns regarding the individualistic focus on threat responses the authors have argued that as opposed to providing another individualistic focus the PTMF might enhance and broaden existing practice to encourage a less individualistic approach and may provide additional or alternative validation and support as the framework intends to build on existing ideas and practices rather than replace them (Johnstone et al., 2019).

There has been some criticism that the PTMF only provides a framework for formulation, not interventions and that the framework assumes people will want to talk about their trauma (Ramsden, 2019). In response to these concerns, the authors have acknowledged that everyone may not wish to, or be able to tell a 'story', they argue making sense of experience alongside a witness can be validating and healing and they promote opportunities to do this but that the choice is always an individual one as there is no obligation to produce a story (Johnstone et al., 2019). These discussions raise questions about how professionals are using the PTMF in practice and to what extent the PTMF might be useful in interventive work beyond formulation.

There has been some criticism surrounding the lack of evidence base for the PTMF. In response, the authors have drawn attention to the extensive evidence discussed in relation to their initial arguments in the original document, including positivist based research while also challenging some of the positivist approaches assumptions (Johnstone et al., 2019). The authors argue that challenging positivisms unspoken assumptions is not equivalent to rejecting empirical research, and also wish to highlight their drawing on often marginalised forms of evidence such as survivor and

personal accounts (Johnstone et al., 2019). There has also been an increasingly critical response to the framework on social media, which has prompted the DCP to release a statement highlighting their concerns about the inaccurate claims being made about the PTMF and personal attacks on the authors online. The DCP have released a new statement in response stating that the PTMF is a 'co-produced, optional, evolving set of ideas, based on an extensive range of theory, research and evidence across disciplines' and states that it is not official policy and that the framework does not provide specific practical implications or recommendations (BPS, 2022, p.1). These criticisms and the DCP's statement raise questions about the extent to which it is possible for psychologists to draw on approaches which are not endorsed by regulatory or professional bodies.

Some have queried whether the framework may have the potential to create professional divisions, particularly between psychology and psychiatry and if this so called alternative approach could contribute to less effective team working, divisions and defensiveness (Ramsden, 2019). It is difficult to assess the impact of the PTMF on team dynamics in this respect at present, there may now be an opportunity to explore these concerns through further research.

It could be argued that the PTMF while seeking to highlight the impact of power has failed to draw attention to the inherent power of professionals in mental health services. In their reflections the authors acknowledge they could have addressed professional power more directly, they argue they provided an implicit critique of the clinical psychology field, but conclude that it is ultimately not a question of allegiance to either psychology, psychiatry or nursing but rather the untenability of all these major mental health professions which creates gaps that future editions of the PTMF must consider (Johnstone et al., 2019).

The authors also speak to confusion that may have arisen out of their description of the PTMF as an 'alternative'. They argue the PTMF is an attempt to demonstrate a system which could replace the diagnostic system, however, how this may be implemented and whether it would be a 'complete alternative' or an option alongside the diagnostic system, or even a resource to encourage thinking about alternatives within current systems are not their decisions to make but for professionals, services

and stakeholders to consider (Johnstone et al., 2019). There is, therefore, now an opportunity to assess the decisions professionals have made regarding how to use the PTMF in practice.

The PTMF could be criticised for being too broad and ambitious in its aims, meaning the nature of the framework's application could be highly varied and give rise to situations in which considerably different interpretations and meanings are derived from its use. This could contribute to difficulty in assessing the utility and effectiveness of the framework. It is not clear to what extent these may be theoretical concerns that do not interfere with the framework's application in clinical practice, and there may be opportunities to ask practitioners about their experiences of applying the PTMF in practice to shed light on this.

1.5.1. Theory to Practice

There are often tensions between theory and practice in the psychological field. For instance, debates surround the extent to which clinical practice is based on theory, or vice-versa, if it is theory that is informed by practice. Attention has also been drawn to the disparity which has developed between academic researchers and clinical practitioners in the psychological field, in which research focus and design may not be reflective of clinical practices while therapeutic practices are often considered to be challenging to assess through traditional empirical research methods (McWilliams, 2020). This creates challenges in producing theory and research which is of interest to clinical practitioners and service users, while also creating challenges for practitioners in evidencing and studying the impact of their clinical interventions.

The existing literature has highlighted the potential applications of the PTMF from theory to practice, as a way of understanding emotional distress and troubling behaviour in non-diagnostic terms, allowing for recognition and analysis of power in therapeutic work, a way to promote and facilitate co-production with service users, to invigorate prevention and public health work and to make casual links between social determinants and poor health outcomes. However, the PTMF is still in its infancy, and the existing literature has also highlighted the potential difficulties practitioners may have in applying the PTMF's theoretical contributions to clinical practice. For instance, that despite its theoretical contributions it does not provide explicit interventions or

guidance for practitioners to address power imbalances, that it sustains the existing focus on individual responses to adversities despite wishing to draw attention to systems and the wider context, that it's language may be inaccessible and it's cultural and geographical applicability limited. There have also been concerns that it may produce simplistic narratives about power for service users in practice, while creating a dilemma for staff about their own mandates to act powerfully as professionals and the potential divisions amongst staff teams that it could foster, particularly between psychiatrists and psychologists. Professionals have also expressed concern that the PTMF may not be clinically applicable due to the contradictions between the PTMF and existing frameworks services and mental health training courses currently rely on. These potential challenges, coupled with the limited literature outlining the PTMF's application in clinical settings to date raises questions about whether it is possible to translate the PTMF from a theoretical framework into clinical practices, what this might look like, and what barriers there may be or if the PTMF may simply be more useful theoretically than clinically.

Nonetheless, it is possible to see the PTMF itself as arising out of clinical practice and the perceived limitations and shortcomings of existing approaches. If the PTMF is viewed as having been funded and developed out of a clinical necessity for an alternative or replacement the framework may, in fact, be highly applicable and useful in clinical settings.

In general, the authors respond to criticism and limitations by agreeing that the framework is not an 'ideal, complete or unproblematic solution' but an attempt to move towards theory and practice that is not based on psychiatric diagnosis and an optional resource which practitioners and others may or may not wish to engage with (Johnstone & Boyle, 2018, p.14).

1.6. Clinical Psychologist's Theoretical Orientations and Use of Frameworks

To understand how the PTMF could be applied in clinical practice it is useful to consider the relationship Clinical Psychology has to theoretical orientations and frameworks more generally.

Studies of Clinical Psychologists' professional practice have highlighted that psychologists are not bound to a single theory, their theoretical orientations tend to be diverse and change over the course of their careers, and these shifts tend to mirror the theoretical developments of the field (Norcross & Dryden, 1991). Cognitive Behavioural, Systemic Family and Psychodynamic therapies are consistently named as the most influential theoretical orientations Clinical Psychologists are trained in and draw on in their work. It may be due to this diversity that psychologists have consistently identified an integrative approach to be their primary orientation over the past several decades (Norcross & Dryden, 1991; Norcross & Karpiak, 2012). Norcross who has extensively studied the theoretical backgrounds and professional practice of Clinical Psychologists in the US argues these findings suggest clinicians are aware that no single theory has a monopoly on utility and there is, therefore, a need for more integrative models of therapy (Prochaska & Norcross, 1983). This could explain, in part, why there has been a growing interest in the PTMF – the framework may be fulfilling a need for an integrative, trans-theoretical approach.

Studies of UK Clinical Psychologists more recently have produced similar findings, the nature and focus of Clinical Psychologists' work in NHS Trusts are variable depending on the service context and the staff's prior experiences (Christofides et al., 2012). However, the general role of the Clinical Psychologist in NHS settings is to work in multidisciplinary teams, not only as psychologists but as consultants, trainers and supervisors (Christofides et al., 2012). All the Clinical Psychologists interviewed drew on more than one model of therapy in their work, and most described their approach as integrative, with CBT, schema, systemic, narrative, attachment and psychodynamic therapy approaches being named (Christofides et al., 2012). This context could facilitate the application and use of the PTMF in clinical practice, as the PTMF is presented as a meta-framework within which other approaches and models can be combined.

Clinical Psychologists are trained to apply several frameworks, models and theoretical approaches in their clinical practice to understand and help clients and these frameworks provide a certain structure and practical guidance. Understandably, Clinical Psychologists use a combination of frameworks and models to provide

individualised care to clients given their training in a number of theoretical approaches (Aafjes-van Doorn & Llewelyn, 2017). A core clinical skill for psychologists is, therefore, to draw on their judgement and consideration of factors such as the service context, client preferences, clinical guidelines and research evidence to make decisions regarding the appropriate application of particular frameworks and approaches in clinical practice (Aafjes-van Doorn & Llewelyn, 2017). Psychologists are also trained in competencies which they continue to develop throughout their careers, these include assessment, formulation, intervention, research and evaluation, consultation, teaching, education, leadership and management (Aafjes-van Doorn & Llewelyn, 2017). In this respect, it is the broad range of competencies and theoretical approaches a Clinical Psychologist can provide to NHS services and multidisciplinary teams that seem to define the clinical role. This could make Clinical Psychologists particularly well placed to take up and apply a new framework in their clinical contexts.

Recent research on UK psychologists' use of and attitudes towards NICE guidelines has found that psychologists worry that guidelines can create an illusion of simplicity and tidiness which is unhelpful in what is actually a context of considerable clinical complexity in the NHS (Court et al., 2017). The psychologists felt they drew on their specialist competencies in their work, going beyond guidelines to provide collaborative and integrative approaches to therapy, informed by individualised formulations and a range of psychological theoretical approaches but felt unable to be transparent about this at work with their managers (Court et al., 2017). This indicates a concerning situation in which Clinical Psychologists are claiming to be doing single model therapy in line with guidelines and protocol whilst in reality providing much more sophisticated interventions that draw on numerous psychological theories and the use of several key competencies such as collaborative formulation with service users simultaneously. These findings reinforce the importance of permitting skilled practitioners flexibility in what they offer to clients (Court et al., 2017). It may be that it is challenging for Clinical Psychologists to introduce new ways of working due to expectations to provide evidence-based interventions and meet existing clinical regulatory guidelines, especially as the PTMF is a new and optional approach which is not clinically indicated.

Consideration of Clinical Psychologist's training in numerous clinical competencies, frameworks and theoretical orientations and the influence of clinical regulatory

standards are therefore relevant in considering what influences psychologists' clinical practices. The varied nature of their training and professional roles likely makes it easier for Clinical Psychologists to adopt new frameworks, in contrast to psychotherapists for instance who are more likely to have trained in relation to a single model of therapy. This may be particularly relevant in relation to the PTMF as the framework is not orientation-specific and therefore could be used as an integrative meta-framework - a way for psychologists to integrate their numerous models and approaches. In contrast, clinical guidelines impose certain restrictions on psychologists' clinical practices which could make the introduction of new ways of working challenging. These factors provide a helpful context in which to consider if and how the PTMF is being taken up and used by psychologists in clinical practice and the factors that may facilitate or hinder this process.

1.7. Research Rationale

There is a context of dissatisfaction with the limitations of existing ways of conceptualising and working with mental health difficulties in the UK, and there have been calls for alternative ways of working from professional bodies and government health policy. The PTMF is presented as an alternative approach allowing for social and relational adversities to be considered in relation to people's difficulties. The growing literature on the topic of the PTMF demonstrates interest and popularity in this new approach.

The literature on the PTMF suggests the framework has richly contributed to the field's theoretical and conceptual understandings of psychological distress, has allowed for considerations of power to be incorporated into psychological thinking and has begun to address the hermeneutic and epistemic injustices which have arisen from the ideological dominance of medicalised approaches and their framing of mental health in public consciousness.

While several publications begin to capture a sense of widespread and diverse use of the PTMF in clinical practice, research on the framework's clinical applications remains limited, dispersed and anecdotal. There is, therefore, an opportunity to study the

clinical applications of the Power Threat Meaning Framework within the field more systematically: for example, to consider if the PTMF is being used in clinical practice, and if so in what ways, especially given the framework's broad potential applications and optional status. There is also an opportunity to evaluate the utility and impact of the framework five years after its publication, and to consider the future direction and potential of this alternative way of conceptualising mental distress.

This may be particularly pertinent within the context of the NHS Long Term Plan with its emphasis on Trauma Informed approaches and projected developments to NHS care delivery to facilitate a shift towards increasingly personalised care, alongside long-standing debates concerning the ineffectiveness and illegitimacy of medicalised approaches to mental distress.

Given the expectation for Clinical Psychologists to bring psycho-social considerations to their clinical and team settings, the nature of their training involving the integration of numerous theoretical orientations and models and evidence of psychologists' willingness to adapt their theoretical leanings to reflect theoretical developments in the field Clinical Psychologists may be particularly inclined to take up the use of a new framework such as the PTMF in their clinical practice. Which makes them a suitable demographic for the focus of a study such as this.

Such research is likely to inform opportunities for widening the frameworks clinical and theoretical applications and support the development of a more socially conscious psychological approach which distinguishes itself from the dominant medical model. The research may also have implications for Clinical Psychologists professional practice and may shed light on how psychologists reconcile their training in numerous theoretical approaches and models in clinically complex contexts. Lastly, the research may also highlight areas of the PTMF itself which require further thought and development.

1.8. Research Questions

This research, therefore, aims to address the following questions:

- How is the PTMF being used by Clinical Psychologists?
- What contextual factors facilitate and hinder its use?
- What is the impact and utility of the PTMF's clinical applications?

2. METHODOLOGY

This chapter details the methodology which informed the research. A rationale for the critical realist epistemological position that was taken is provided, and a description of the underlying ontological assumptions of such a position. The methods carried out in regard to the recruitment, data collection, data analysis and ethical considerations are also detailed.

2.1. Epistemology

Epistemology refers to the theory of knowledge and all research is conducted and interpreted within a theoretical framework which makes assumptions about what it is possible to know, and how it is possible to know it (Braun & Clarke, 2022). It is therefore crucial to acknowledge one's epistemological position and its influence on the research study. This study took a critical realist epistemological approach, which can be understood as combining a realist aim of gaining a better understanding of the world, whilst acknowledging that data may not provide transparent, uncomplicated or direct access to reality (Willig, 2013).

Critical realism is defined by three key premises (Pilgrim, 2020). The first is that it is ontologically realist, the premise that there is a world independent of what we think or know about it, that the real material world existed before we were born and will continue to exist after we die (Pilgrim, 2020). The second premise is that of epistemological relativism, that we construe this real world within which we live, and can reflect upon it, but that the knowledge we obtain of the world is subject to historical and cultural contexts, and is therefore partial and subject to revision (Chamberlain, 2015; Harper et al., 2021; Pilgrim, 2020). The third and final premise is that of judgemental rationalism, the notion that in light of the previous two elements we are able to evaluate truths, likelihoods and claims of knowledge in a reasoned manner (Harper et al., 2021). All knowledge is fallible in this respect and judgements might be made cautiously (Pilgrim, 2020).

While the critical realist position assumes data can provide knowledge about the world it does not assume that this knowledge is self-evident or an absolute truth. Instead, it suggests that data needs to be interpreted to highlight the underlying structures which contribute to the human phenomena that we are attempting to study and gain knowledge of (Braun & Clarke, 2022; Willig, 2013). This epistemological position, therefore, invites a deeper analysis of the data's underlying structures to further our understanding of the studied topic. A critical realist position would consider that Clinical Psychologists professional practice exists within a particular social, political and historical context and that these influences should be reflected upon throughout the study. It would also consider factors that may be beyond surface level awareness such as psychological forces, for example, unconscious motivations, which are only likely to become apparent as a result of analytic interpretation of the data (Willig, 2013).

2.2. Qualitative Methodology

This research aimed not to provide absolute truth on the topic but to generate understandings of human experience that would be useful to knowledge and practice in the field of Clinical Psychology. As the study sought to generate contextualised knowledge, from a critical realist orientation – which assumes truth is situated within existing constructs and underlying structures which requires critical interpretative analysis – a qualitative methodological approach was proposed. A qualitative paradigm is broadly focused on meaning and allows for interrogation and identification of meaning around a study's topic, which was well suited to the research questions (Braun & Clarke, 2022). Since existing research on the focus of this study is limited, there was also a need to speak to psychologists about their practice without the imposition of premature assumptions. Consequently, semi-structured interviews were used for the collection of a dataset, to allow for a flexible way of gathering data without imposing too many assumptions about the nature of what was being studied and to allow for a critical interpretative analysis. For a discussion of the limitations of this approach and the study broadly see Chapter 4, section 4.4.1.

2.2.1. Data Analysis

The data set was analysed using thematic analysis, a qualitative research method for analysing, identifying and reporting patterns of meaning within data commonly used in social and health research (Braun & Clarke, 2006). Thematic analysis is compatible with several epistemological frameworks, including a critical realist approach in which a questioning and critical approach to life and knowledge is taken (Braun & Clarke, 2006, 2022). Thematic analysis has been used by several critical realist researchers, see for instance Harper and Timmons (2019). Thematic analysis was also felt to be compatible with the study's critical realist epistemological underpinnings as a method which can allow participants to name and discuss their realities, while also allowing the researcher to interpret and analyse the possible underlying structures that may influence this reality, such a psychological influence, for instance unconscious motivations or hidden feelings, or the social contexts which influence and provide frameworks of understandings for participants. In this respect thematic analysis can be a method which both reflects reality and can unpick the surface of reality.

Thematic analysis was also chosen over other analytic traditions such as IPA because such approaches may be better suited to the study of experiential phenomena and the examination of how people make sense of life experiences and the significance placed on these experiences, whereas this study was concerned with participants views of the PTMF (Smith et al., 2022). Alternative analytic approaches such as Discourse analysis were not chosen because of their typical focus on text and language, which similarly wouldn't have been suitable for addressing the research questions of this study. It was for these reasons that thematic analysis was chosen as a suitable research tool for this study to provide a detailed and complex account of the data, while also creating findings that are largely accessible to the public (Braun & Clarke, 2006).

2.3. Method

2.3.1. Ethical Considerations

The University of East London's School of Psychology Ethics Committee provided ethical approval for the study, prior to the commencement of any research activities.

Prospective participants were provided with details of the proposed study via a recruitment poster which can be found in Appendix G. Prospective participants who made contact expressing interest in participating in an interview were provided with the further information sheet and were invited to ask questions or express any concerns they might have had. Participants who wished to participate provided their informed consent by signing a consent form and were aware of their right to withdraw from the study. A copy of the information sheet and consent form can be found in Appendices H and I. There were no anticipated risks in taking part in the study.

2.3.2. Recruitment and Participation

The inclusion criteria for participation in the study were qualified Clinical Psychologists working in the UK, who were making use of the PTMF in their clinical practice. Recruitment was primarily conducted via social media including Clinical Psychology networks on Facebook and Twitter using the research poster, a copy of which can be found in Appendix G. Purposive and snowball sampling were also used, professionals who had expressed interest in the PTMF were contacted with the study's details. Participation in the study was entirely voluntary.

2.3.3. Data Collection

One-to-one semi-structured interviews were conducted via MS Teams to increase the accessibility of the study to UK wide practising psychologists. An interview schedule was used to inform the structure of the interviews and can be found in Appendix F. The interview questions were developed with the research questions in mind, and in discussion with the research supervisor and were chosen to provide some insight into the participants background and identity as a Clinical Psychologist, their views and understandings of the PTMF and the nature and experience of their use of the PTMF in their clinical work. The interview schedule therefore began by broadly asking participants about their main theoretical orientations, how they would describe their role as a Clinical Psychologist before asking about their work with and views on the PTMF more specifically. Participants were also invited to discuss the limitations of the PTMF, and to share any further thoughts or ideas that had not yet been raised towards the end of the interview. Prompts were used to encourage further thought, discussion

and exploration throughout and to encourage the participant to lead the discussion, this ensured the interviews were flexible and semi-structured in their approach.

Participants who expressed interest in taking part in the study and provided their informed consent were invited to attend an online interview. The length of the interviews ranged from 30-70 minutes and were recorded for transcription purposes. Participants were sent a debrief sheet immediately following the interview, a copy of which can be found in Appendix J.

2.3.4. Data Storage and Security

Data that was gathered and produced was stored in accordance with the University of East London's and GDPR regulations, on secure servers provided by the university. Personal data collected during the study's recruitment was stored separately to interview recordings. The process of transcribing the interview recordings was completed by the researcher, during which identifying information was altered and participants were given pseudonyms to protect their anonymity. The recordings and resultant transcripts will be destroyed after the study's completion.

2.3.4. Description of Sample

10 qualified UK Clinical Psychologists participated in the research study. A table of participant characteristics is provided below with participants assigned pseudonyms, see Table 1. Some of the participants' characteristics are detailed here to limit the potential identification of individuals and protect their anonymity. Participants provided their demographic details at the beginning of their interviews, participants described their ethnicity as Chinese British, Greek-Cypriot British, South African British, Turkish-Cypriot and six participants described their ethnicity as White British. The participants worked in a range of clinical settings and across a wide geographical area. Six participants worked in the Southeast of England in Outer, Central, West and North London localities. One participant worked in the North of England in Leeds, two participants worked in Northeast England, in Newcastle and Humberside, and one participant worked in East England in Norfolk. Five participants held the job title of 'Senior Clinical Psychologist', four of 'Lead Clinical Psychologist', and one of 'Consultant Clinical Psychologist'. Nine participants worked with adult client groups

and one participant worked with children and families. All the participants described working integratively by drawing on several theoretical approaches or models in their work.

2.3.5. Data Analysis Procedure

2.3.5.1. Transcription and Familiarisation with Data

Braun and Clarke's (2006, 2020) guidelines for conducting qualitative thematic analysis informed the data analysis procedures. Initially, I familiarised myself with the data by watching the interview recordings, transcribing the interviews, checking the transcriptions against the recordings and reading the transcripts.

2.3.5.2. Coding

Following this I began coding the transcripts for analytically interesting ideas, concepts or meanings while considering the research questions which provided a sense of what I was trying to gain insight into. Codes work to both reduce the content of the data and to provide an analytic take on the data (Braun & Clark, 2020). The coding was completed manually line-by-line on hard copies of the interview transcripts in an engaged and systematic process, an excerpt of a coded transcript can be found in Appendix A. Data which was relevant to the study's focus and the research questions was coded with a label, these codes sought to capture a single and specific idea and were applied as appropriate to different data segments, if an existing code label did not capture the essence of a relevant data segment a new code label was created. Both descriptive semantic codes, and interpretative latent codes were generated as part of the coding process which was compatible with the critical realist underpinnings of the research, although codes were predominantly descriptive semantic in nature due to the realist assumptions of the research questions. A second process of manual line-by-line coding was completed on all the interview transcripts, in a varied order. This second phase of coding allowed for codes to evolve, as understanding and insight into the data developed, consequently codes were reviewed, modified or combined. For instance, the codes 'staff interest' 'willing teams' and 'supportive colleagues' were combined into one code of 'staff willingness' during the second coding procedure. A list of initial code labels can be found in Appendix B. An example of a code label and all its associated data excerpts can be found in Appendix C.

2.3.5.3. Clustering Codes and Initial Theme Development

This was followed by an initial analysis of the codes, considering how they may be combined, overlap or clustered together and what overarching ideas, themes, could be identified from these data outputs. For instance, the code labels 'Accessibility', 'Compatibility', 'Positive responses of staff and clients', 'Opportunities', 'Co-production and collaboration' and 'Structure and guidance' were initially clustered together as being related to one another. This cluster of codes was felt to capture an overarching sense of the PTMF's Clinical Utility, and an initial theme of Clinical Utility was generated. These code clusters and their development into initial themes can be found in Appendix D.

2.3.5.4. Reviewing Initial Themes and Defining Final Themes

In this final phase of the data analysis procedure the initial themes were reviewed and refined in discussion with the researcher and research supervisor. During this discussion the initial themes were felt to be too numerous, and some to be related to each other, as a result the themes were further refined and combined. For instance, the initial themes of Clinical Versatility and Clinical Utility were combined into one superordinate theme and re-named 'The Clinical Usefulness of the Framework', as they were felt to convey similar aspects of the dataset. The themes were also given brief descriptions as part of this process of defining and finalising the analysis. Appendix E demonstrates the process by which initial themes were further reviewed, refined and combined into superordinate and sub-ordinate themes. This process allowed for more coherence amongst the themes while capturing what was conveyed by the coded extracts broadly and resulted in three main themes being established. Further discussion and a critical evaluation of the data analysis process is provided in Chapter 4, section 4.4.4.

Table 1. *Participant Characteristics*

Pseudonym	Age	Gender	Years Qualified	Clinical Setting	Speciality	Theoretical Orientations
Emily	35 - 39	Female	9	Charity	<ul style="list-style-type: none"> • Complex Trauma • Psychosis • Community Psychology 	<ul style="list-style-type: none"> • CBT • Attachment Theory • Trauma Informed • Compassion Focused
Arthur	40 - 44	Male	16	Early Intervention	<ul style="list-style-type: none"> • Complex Mental Health • Community Psychology 	<ul style="list-style-type: none"> • Systemic • Open Dialogue • Critical Psychology
Harriet	30 - 34	Female	3	Charity	-	<ul style="list-style-type: none"> • Systemic • CBT • Attachment Theory • CAT
Zoe	30 - 34	Female	7	Inpatient and Community Acute Psychology Services	<ul style="list-style-type: none"> • Trauma Informed Approaches • Adult MH 	<ul style="list-style-type: none"> • Psychodynamic Theories of Attachment Object Relations • Systemic • CBT
Charlotte	50 - 54	Female	20	Personality Disorder and Criminal Justice Services	<ul style="list-style-type: none"> • Complex Trauma • Personality Disorder 	<ul style="list-style-type: none"> • Psychodynamic and Attachment Theories • Mentalisation • Schema
Beatrice	50 - 54	Female	3	Community Mental Health and Psychology Service	-	<ul style="list-style-type: none"> • Psychodynamic • CAT
Alice	40 - 44	Female	14	Inpatient and Community Acute Psychology Services	<ul style="list-style-type: none"> • Acute Psychology 	<ul style="list-style-type: none"> • CBT • DBT • CAT

Olivia	30 - 34	Female	3	Inpatient and Community Acute Psychology Services	<ul style="list-style-type: none"> • Acute Psychology 	<ul style="list-style-type: none"> • Psychodynamic • ACT • CBT • Systemic
Selin	25 - 29	Female	1	Local Authority Children's Service	<ul style="list-style-type: none"> • Children and Families • Systemic Family Therapy 	<ul style="list-style-type: none"> • Systemic • Attachment Theory • Intersectionality and Feminist Theories
James	50 - 54	Male	24	Community Mental Health and Inpatient Psychology Services	-	<ul style="list-style-type: none"> • CBT • DBT • Psychodynamic

3. RESULTS

This chapter outlines the themes identified from the thematic data analysis carried out on the interview transcripts. Three superordinate themes are presented, each with corresponding sub-themes. The three main themes are Supporting Conceptual Change, The Clinical Usefulness of the Framework and Facilitating Institutional Change. These are detailed below and are demonstrated by extracts selected from the interviews.

Table 2. *Themes and Sub-Themes*

Theme	Sub-Theme
Supporting Conceptual Change	Making the Implicit Explicit
Clinical Usefulness of the PTMF	Accessibility
	Limits to Usefulness
	Versatility and Adaptability
Facilitating Institutional Change	General Factors Inhibiting Change
	PTMF Specific Factors Inhibiting Change
	Factors Facilitating Institutional Change

3.1. Supporting Conceptual Change

A theme explored by all ten of the participating Clinical Psychologists was the PTMF's impact on supporting conceptual change by creating an ideological shift in clinical contexts. Within this a subtheme was making the implicit explicit, as the PTMF was described as legitimising some of the existing but previously implicit practices in services.

The PTMF was seen to facilitate a change in how clinical work was thought about that allowed the participating psychologists, their teams and clients to reframe clients' difficulties to create new understandings and make connections to the wider contexts

from which mental health difficulties emerged. This was strongly associated to the framework's unique focus on the concept of power, which was felt to have been unacknowledged in the field and in other psychological models until the PTMF's publication:

Olivia - So I think the strengths are naming power. Naming things like racism, sexism, all the isms and discriminative and difficult things that can happen to people because of their identity and things that they can't control. And I think that is definitely a big strength because sometimes other models shy away from really naming or acknowledging those things.

All the participants described the explicit naming of power in the PTMF as a strength, as this allowed attention to be drawn to the multitude of ways in which power dynamics are ever-present and impacting on clients' lives and sense of self. For instance, Olivia refers to how focusing on ideological, cultural and coercive power helps clinicians to acknowledge client's experiences of power and oppression, such as racism, and its impact on identity and quality of life. The framework was described as orientating clinicians to these cultural ideologies that implicitly have a power to impact on people's identities, and how the PTMF could be drawn on philosophically to notice and attend to these elements of human existence. Olivia and several other participants described this as an oversight and limitation of other psychological models which were thought not to provide a structure for thinking about power, and to tend to ignore the cultural and systemic experiences we all live with, and the impact of this on individuals and communities. Several of the participants also described the PTMF's ability to broaden considerations of power for staff, and for them to consider their own roles in these dynamics:

Zoe - But one of the things I think specifically in my inpatient service is the concept of power being so useful and thinking about how our mental health services can perpetuate power imbalances, and it's given us a safe language to start to talk about that.

Zoe describes how the concept of power was useful for enabling staff to consider how the services they work in may also perpetuate power imbalances, and to begin to

consider which practices within services have the potential to re-enact these imbalances and inequalities. The PTMF was felt to be empowering in this way, by encouraging the individual, the team and the system to think about what the implications of power are and how to respond to this. For staff it was felt to have enabled a recognition of their own power in their clinical work as professionals to define what the 'problem' is and provided a foundation from which these conversations could begin to be explored. For example:

Selin – It's about reframing how we understand mental health, how we understand problems or symptoms or disorders to one that is all about recognising normal responses to adverse situations...for me, there's something about supporting the team and wider children services to move away from pathologising children. This then has an impact on the intervention that we choose to do, so if we can understand children in that way then we can move away from the individual 'let's fix you' way of working and move more into systemic ways of working and supporting the whole family and supporting the parents. And so it was a way for me to reframe and change the narrative around our children within the service.

This participant spoke of how the PTMF supported conceptual change by reframing mental health difficulties as understandable responses to adversity, which allowed for distress and presenting difficulties to be normalised. This shift in how an individual's difficulties were conceptualised in turn supported a widening of focus regarding the nature of interventions beyond the individual and the idea of individual responsibility to think about the wider system. This was echoed by other participants:

Zoe - I think that has particularly helped a really big shift, especially in relation to many of our male service users or many of our young black male service users who've been labelled as 'psychosis' and are seen as angry or aggressive in the context of illness, actually being able to step back and think about people being really aroused in the context of being terrified and the context of repeated, repeated experiences of being unsafe and how that then flips how staff might respond to or approach people. And I think that has been one of the most significant things that's had such an impact on our restrictive interventions.

This participant emphasises two main aspects of how the PTMF supported conceptual change, firstly through formulating clients so that their symptoms were reframed as threatened responses to adversity, and secondly the effect this had of helping staff to feel more empathetic to clients who might otherwise be seen as simply psychotic or aggressive.

Arthur – The thing that seems to really help the most is that change of language or change of thinking within teams about individual clients, or clients more generally, about survival strategies...reframing that to take it out of a kind of a moralistic thing to a survival thing can really shape teams approaches to those people. And just really reasserting the functionality of what people do.

Arthur similarly spoke to the reframing of clients' behaviour using the PTMF which facilitated a move away from thinking about behaviour moralistically as good or bad to seeing it as the individual's survival strategy in response to threat and adversity. The PTMF provided an opportunity to re-formulate different demographics such as children and racially minoritized groups presenting difficulties within the contexts in which they developed to re-assert the functionality of behaviours and how understandable such responses were in the context of power imbalances and threats to safety. The PTMF broadened the nature of discussions in this respect, instead of clients being described simply as 'psychotic' and this being the end of the discussion several of the participants spoke of how they had begun instead to consider 'why', 'why are people so detached from our shared reality?' - Alice. By making these connections, re-framing presenting difficulties and broadening the focus of their considerations, the PTMF allowed for new understandings and supported conceptual change which in turn affected staff responses to clients and provided new opportunities for interventions and ways forward.

3.1.1. Making the Implicit Explicit

The PTMF was described by eight of the participants as having legitimised working in line with their moral values and having provided a framework for implicit practices that were already present in mental health services to be named and recognised.

Olivia - I can actually bring in my personal values and use it as a tool, as a psychologist or as a therapist. That just feels very aligned. I feel like I can work in line with my own values and help other people to - I feel authentic and I think it helps other people to be authentic. And I think you can create this quite amazing therapeutic opportunity by doing that with somebody.

Charlotte – It's how we think anyway. So, it doesn't jar at all, it totally fits with what we do, and it adds to it.

Olivia and Charlotte spoke of how the PTMF made sense to them, that they were sympathetic to its core ideas and that it complemented and validated their existing ways of working and the values they held. There was also a sense that clinical work felt more useful and genuine when aligned with the clinician's values and that this could help to create therapeutic connections. The PTMF was also seen to have provided permission and support to work in previously implicit, unnamed ways:

Selin - One of its biggest strengths is that it gives permission to include those societal factors and on all the levels in between that and the individual which I think a lot of other frameworks don't do or don't kind of allow for as explicitly.

Selin also notes how the PTMF enabled considerations of social injustices, politics and wider levels of contexts to be brought more sharply into focus and incorporated into clinical work. This was echoed by other participants:

Emily - And I think without knowing it, they already thought in quite a power threat meaning way, you know national narratives around homelessness are blaming a person saying they've made poor choices. Whereas [our service] is very much that's not the case. So, I think they already came from quite a community focused non-medical model perspective, and I wanted to think about bringing in a framework that we could use that would be capturing that.

Emily speaks to how their service were already rejecting moralistic and blaming approaches to thinking about clients' circumstances such as homelessness and therefore felt the framework fit with their service's existing ethos and practices. The

majority of participants felt the framework complemented their existing but implicit practices by providing a new level of legitimacy to their ways of working and providing permission to broaden the focus of clinical work beyond the individuals' personal circumstances and the idea of individual responsibility.

3.2. The Clinical Usefulness of the Framework

A theme identified amongst all ten of the participants was the PTMF's ability to support clinical work for all mental health workers, to facilitate co-production and to provide opportunities for new ways of working. Subthemes within this include the accessibility of the framework, the limits of its usefulness and its adaptability and versatility.

Participants spoke of the framework being a helpful way to think beyond diagnoses, beyond medication, and beyond the frustrations staff may experience in attempting to engage or manage risk to thinking about what was really known about clients:

Alice - It really nicely opens up conversations within teams about someone's history and getting to know them as a person beyond their mental health history and beyond their mental health diagnosis. And I think it is really usable. I think it's really easy to use in mental health settings.

Alice speaks to the utility and usability of the framework as a clinical tool in clinical settings to facilitate team formulations, case discussions and thinking about clients beyond the standard or expected ways they've become accustomed to. While participants spoke to the conceptual value of the PTMF in the previous theme, here the participants speak to the PTMF's clinical applicability:

Alice - And it can translate into practice once you've done team formulation, you can make a plan that actually can be used with the service user, to discuss with them. Because I think sometimes something theoretically can make a lot of sense, but if you can't apply it and then really use it to influence someone's care, it has a bit of a shortcoming whereas I think the power meaning framework brings you nicely to 'OK, well, now we know this about someone what are we doing? What are we going to continue to do because we think that's helpful and

it's working, and what might we change? What might we do differently?' And I think is just nice that it works clinically as well.

Alice speaks to the PTMF's clinical value - that it could easily be applied to clinical contexts and was useful in guiding clinical work and shaping interventions, beyond formulation. Participating psychologists spoke of the clinical services changes they had introduced as a result of the PTMF, such as increasing co-production with service users and creating new groups centring the PTMF.

3.2.1. Accessibility

An important sub-theme was the accessibility of the framework. All ten participants spoke of the usefulness of the framework in being accessible to them, their colleagues from multidisciplinary teams and their clients.

Alice – It is really useful because I think it provides a really nice common language for everyone to use that helps people understand trauma and its impact on mental health.

Alice - it brings everyone together to think about a service user in a very different way and it's a framework that everyone can use. So, I don't think it has to be a psychology thing. I think if you learn the framework, know how to facilitate team formulation, it becomes a skill that everyone can use and that's what we really should be promoting is a trauma informed approach isn't a psychology thing, it's an everyone thing, and I think the framework really provides that both for staff and patients in that way.

This participant speaks to the idea that the PTMF is not only a psychological tool for psychologists but a resource everyone can make sense of, as well as make practical use of. They suggest the PTMF was able to provide unity amongst staff by providing an accessible shared language and a focal point to gather around regardless of staff's theoretical background or field of training. This was raised by other participants who spoke of the PTMF enabling non-psychology members to 'bring their own understanding, their own thinking' – James, to case discussions and formulations:

Zoe - You don't need to be a psychologist to come up with brilliant hypotheses and logical links between them. It enables things to make sense and sort of starts to demystify all of the sort of the very wordy and scientific [approaches].

This participant goes further to suggest the PTMF improves accessibility, for both staff and clients, by allowing client's presentations to become understandable when placed in their contexts, rather than mysterious and confusing medical illnesses. The accessibility of the PTMF to clients was also explored:

Arthur - I find that for lots of people it's a way that really helps to start to make sense of why they feel the way they do or behave the way they do.

Arthur reflects on the PTMF's accessibility to clients directly, that it can begin to help clients to make sense of their own difficulties, which can provide relief and be life altering. Many of the participants spoke of the positive feedback they had received from service users they had used the PTMF with directly, that clients reported 'feeling validated, feeling heard, feeling seen' - Beatrice. Beatrice spoke of the feedback received from clients following use of the PTMF in a psychology group, in which clients described it as 'bringing into consciousness our full experiences and making sense of our experiences'. This was echoed by Selin who spoke of the children they worked with as seeming to find it 'quite empowering, quite refreshing, possibly even a bit surprising'. So not only was the PTMF accessible to a range of service user groups - adults, children, families – it also appeared to have a profound impact on them.

3.2.2. Limits to Usefulness

In contrast the majority of the participants also identified features of the PTMF they found limiting or restricting, particularly confusing terms and concepts, and spoke of the need for adaptations to be made in response to these.

Emily - Initially the language isn't always the most accessible, but when you actually start to look at it and think about what it means it seems to bring about really rich narratives.

The language and terms referred to in the framework such as ‘threat responses’ were not considered to be immediately understandable. There was a concern that this could initially limit the accessibility of the framework, but that the concepts were beneficial once understood. Another concern about the limits of the framework were its publication documents:

Arthur - I think the document, particularly the long document, is for me, very inaccessible to most people. I think that there's such a lot of repetition and get out clauses.

The length of the original document and the perceived need to defend its position meant it was challenging to navigate and take in its entirety. There was a concern that this could make it harder for clients and colleagues to access and make use of themselves. Further concerns were raised by participants, such as the framework’s limited consideration of interpersonal relationships:

Charlotte - What it doesn't talk about, frankly, is the impact, is the dynamic really. So, I work with people who are very scary, very overwhelming, very seductive. All of these things, and it's the relationship dynamic that I have with them, and my colleagues have with them can be really fraught, for lots of reasons...and I think what the power threat meaning framework does is it assumes that that's always going to be straightforward. It doesn't really tell you what to do with that level of impact really, interpersonal impact.

Several participants raised concerns that the framework did not provide any guidance for thinking about or working with challenging interpersonal dynamics between staff and clients, or for clients in their personal relationships and that this was a considerable limitation as interpersonal relating typically is a significant component of therapeutic interventions and clinical work. Another limitation was thinking about organisational context:

Charlotte - I think the thing that's missing and that I bring to the training is something about threat responses of organisations...I don't think it talks very much about the threat responses of workers and organisations and how we

might respond really poorly or practice really badly because of our own threat responses.

As Charlotte states there was a concern that the PTMF might fail to promote recognition of the responses of services when threatened, how services and clinicians also have a capacity to feel unsafe and how this can affect the quality of our work. It was felt this could be overlooked as it is not explicitly attended to by the framework. Another concern related to how broad the framework was:

Selin - So I think it provides that broad picture and that broad story, but you'd still need to drill down a little bit further. So, I don't think you could just formulate in that way and that be the whole thing. It provides an overview...So I think it provides a springboard for further development of the ideas, which is where the other theoretical orientations come in more explicitly.

There was a sense that as a framework, and not a model, the PTMF provided understanding on the broadest level, which although useful, could often be insufficient without the addition or support of other theoretical approaches to provide more detailed, specific formulations and insights. Selin indicates that while clinically applicable and useful the framework could not be used in isolation from or to replace existing clinical practices. There was a further sense that features of the PTMF could be simultaneously both challenging to make use of and helpful:

Emily – So when we do the reflective practice there's a couple of the questions that definitely make you think more because it's not so obvious, well, what's the answer to this? But that is part of what I like about it. So the ones that prompt reflection around how does this all fit together? What might this mean? I think it makes you think, and you have to think about what's the meaning of this question and how does this fit? So, it's less accessible because it is reflective, so that is one of the strengths of it as well as one thing that I think could be a barrier to some people.

There was a sentiment amongst several of the participants that features of the framework could be both useful and restricting. That it could be confusing or difficult

to convey to colleagues, especially initially, yet still be a valuable resource worth drawing on, and that ultimately it was helpful to be prompted to think about such elements.

Olivia - Sometimes it can feel a bit inaccessible to people, but at the same time it's all about how you explain that and how you transfer that so maybe it's down to how we adapt it and make it a bit more understandable or accessible to people.

Many of the participants consequently expressed a sense that while the framework may have its limitations this was expected and typical of any approach, instead they felt it was a question of how to adapt and adjust to these in their clinical practice. There was a sense shared amongst the majority of the participants that the PTMF was an inherently adaptable framework, and more so than other guiding frameworks or models.

3.2.3. Versatility and Adaptability

Despite its limitations participants felt the PTMF was highly versatile and adaptable to their clinical needs. Participants detailed the ways in which they had overcome some of the framework's limitations by making personal adaptations to suit their clinical contexts, and how they had found it to be compatible with their different theoretical approaches and alternative models of formulation.

Olivia - There can be flaws in a tool, but it's how you use the tool, isn't it? And how you adapt the tool, that's the way I see it. And I feel like it's the kind of model that you could adapt.

Beatrice - I don't think it's about the framework, I think it's about what we make, how we make use of it, and I don't think I've seen anything quite as powerful a tool as this.

These participants draw attention to the potential of the framework to be versatile, viewing it as tool which is flexible to the needs of clinicians. There was a notable versatility in the clinical applications of the PTMF by all the participating psychologists.

Not only was the PTMF clinically useful, but it was also being applied in numerous clinical contexts for numerous demographic groups and in a myriad of clinical activities. For instance, participants' clinical settings varied considerably from children and families, adult inpatient, adult community, personality and criminal justice and early intervention NHS services as well as non-NHS services, such as third sector homelessness charities. All the participants were applying the PTMF to more than one clinical activity.

The PTMF was most consistently used to facilitate Team Formulation meetings; nine of the ten participants described applying the PTMF in this way in their clinical work. Eight participants described applying the PTMF directly in therapeutic work with service users, of these six described using the PTMF one-to-one with service users and their families, whilst two of the participants described use of the PTMF in Psychology Groups. Five participants described developing and providing training to other staff members on the PTMF, within their service, to the wider Trust or nationally to other colleagues. Of these five participants, three spoke of the training being co-produced and co-delivered with service users. One participant spoke of the PTMF informing the development of more genuine co-production in their service, including the employment of a colleague with lived experience of the criminal justice system. A visual of the PTMF's clinical applications by number of participants engaging in each activity is provided in Table 3.

Table 3. *PTMF's Clinical Applications*

Indirect	No. of Participants
Team Formulation	9
Staff Trainings	5
Informing Thinking and Working (Supervision, Service Development)	10
Co-Production with Service Users or those with Lived Experience	4

Direct	No. of Participants
Individual Therapy with Clients	8
Therapeutic Family and Network Meetings	6
Therapeutic/Psychoeducational Psychology Groups	2

All the participants described the PTMF as informing their thinking, supervision, or service decisions in some capacity:

Selin - so I use it indirectly through team formulation. I have used it directly. I've used the framework very explicitly with parents that I work with to try and develop a better understanding of their children and develop their insight. I've used it less explicitly, but with the ideas, directly working with young people...So that idea is always incorporated in my work with young people and helping them understand why they might be struggling the way that they are.

As indicated the participant speaks of the myriad of ways in which they apply the PTMF to their clinical practice, and how the frameworks concepts further underlie their work and thinking. Participants also detailed the adaptations they had made to the frameworks to suit their clinical spaces:

Alice – It's been adapted for different populations. So, a colleague...made the [staff training] 45 minutes because an acute ward, they don't have huge amounts of time...What we try and do is keep the [group using PTMF] quite brief...in the Crisis House we do it completely differently because people are only there for 7 days. So, it's varied...it's a lot of figuring out what works best at the moment.

This extract highlights how versatile the PTMF's applications can be even within one inpatient service context, and that it is being drawn on clinically for both staff training and service users' therapeutic interventions. The participant also reflects on how beginning to apply the PTMF is a process of trial and error. Another way in which several of the participants spoke of adapting the PTMF in their clinical work was by combining it with their theoretical approaches. All the participants spoke of working intergratively and drawing on a range of theoretical approaches.

Beatrice - So what I like about the power threat meaning framework is however we formulate someone if we can hold in mind the concept of power and systems that we live in and how it might operate, it applies, doesn't it?

And it doesn't matter your format, it doesn't matter if you're doing a psychoanalytic formulation with somebody, it doesn't mean you can't think about their systems. You can think about culture and class and race and all of those things, as well as the more personal intimate experiences that somebody may have.

As indicated by this extract there was a sense that the unique concepts of the PTMF, such as power, could be combined with existing theoretical models that were already being drawn on to formulate and think about client's presentations. This suggested the PTMF could be widely applied to clinical work regardless of the psychologist's prior training and clinical experience.

Alice - Sometimes I think it's nice to join it with maybe other models that we draw on. So, I sometimes stick very sort of firmly to the framework, and sometimes I might add in other kinds of ways of thinking about someone alongside.

Alice shares her experience that the PTMF could be used as it is as a framework, or in combination with alternative models in an integrative way. This echoes Selin's observation that the PTMF can benefit from the addition of other psychological models which provide more detailed and relational perspectives on clients' presentations while the PTMF may provide a broader overview. The compatibility of the PTMF with alternative approaches in this way is significant as all the participants described themselves as working intergratively – drawing on several theoretical approaches, suggesting the framework was compatible with clinicians existing ways of working. Overall, the PTMF appeared to be adaptable and versatile in its clinical applications, which participants felt was beneficial to their clinical practice.

3.3. Facilitating Institutional Change

This theme highlights the systemic factors that participants felt both facilitated and hindered application of the PTMF to their clinical contexts. Subthemes within this are general factors inhibiting change, PTMF specific factors inhibiting change and finally factors facilitating institutional change.

3.3.1. General Factors Inhibiting Change

All ten participants spoke of the pressures staff were under and how this could hinder attempts to facilitate change and compromise the introduction and use of the PTMF in mental health services. In this subtheme participants referred to institutional and service issues and pressures which were not directly related to the PTMF itself:

Zoe - I think it's very hard to support systems change when staff are on their knees.

Beatrice - we're so chronically under resourced, so exhausted all of the time and so we encounter people with these really quite immense difficulties and...there's a wish not to know, and I think there's a conflict in people's minds between wanting to understand how this has come about for this person, but also not having the capacity to understand because we're so under resourced and stretched.

These extracts highlight the contention of attempting to support conceptual change when staff are already overwhelmed in their clinical roles. While there may be a wish for new ways of working and thinking there may also be a difficulty in successfully integrating change when staff are at their capacity. Another factor that was felt by most of the participants to be inhibiting change was the pull to traditional, medical ways of thinking and working.

Harriet - It's so much easier to just use diagnosis, that's why we live in a society where that prevails because it's easier to say depression, PD etc than this person feels huge pain in their chest and stomach and more idiosyncratic ways of thinking about people's distress.

Harriet - The team that I'm in are so trauma informed, psychologically minded, thoughtful, reflective. But they still go back to the medical model so often and it's like a default and it's ingrained within people's ways of thinking about mental health.

In this extract the participant highlights that the medical model continues to dominate in mental health services and is evidently deeply ingrained in staff teams ways of thinking and working. Despite the team being thoughtful and trauma informed in a way which feels compatible to the PTMF's core ideas the participant notices a continued reliance on medicalised ways of speaking, thinking and intervening which can overshadow client's idiosyncratic presentations. Despite existing ways of working having shortcomings there was a sense that they provided 'predictability and safety' - Olivia, which was a barrier to change as it could be appealing to work in established and familiar ways when staff were overwhelmed and exhausted. In conversation about potential barriers to implementing the PTMF and facilitating change in services Arthur spoke of the wider system and the difficulty in navigating it:

Arthur - One of the barriers in terms of how to then get the wider mental health system to change accordingly when there's so many institutions, the mental health system generally but also obviously things that prop it up like the whole emphasis on NICE and NICE guidelines, which from early intervention dictates all our funding, posts and the standards that you have to work towards, targets etc

This extract indicates that evidence-based practice recommendations and expectations set by key institutions and professional body's significantly affect individual service practices and that attempting to implement change without these institutions support can be challenging as it goes against this established hierarchy and can leave services vulnerable if they don't appear to be meeting standards. Similarly, several participants raised the issue of power and hierarchy in the team and how this can be a potential barrier if key members of teams are not supportive of change:

Alice - The big thing we don't have so much of now but I think what would make a big difference which relates to power, I guess, is we don't have so much doctor presence, and there were certain key people that if you have them present ward teams tend to follow. So, Ward Managers if they're very proactive, very much promoting it, you'll see the team be more engaging. And equally if

you see doctors be more engaging, more promoting of it you'll also see a ward team move towards it.

Doctors and ward managers were staff seen to have power within teams. If key staff were seen to be supportive, encouraging and promoting of the PTMF this was thought to facilitate larger scale change to take place within the culture of the service. In this respect participants recognised the power of key people and institutions in their clinical settings to influence and promote change, or to inhibit it.

3.3.2. PTMF Specific Factors Inhibiting Change

Alongside these considerations of the systemic factors potentially inhibiting the use of the PTMF in services participants also reflected on features of the PTMF itself that could be inhibiting its use in clinical practice.

Emily - I just know that most of the staff I work with wouldn't feel comfortable printing it out and taking it into an appointment and introducing it and saying maybe this would be useful for us to work through. And I suppose it does take quite a lot of skills to work out when that would be useful, how to introduce it, how to do it collaboratively.

There was a sense amongst participants, as indicated in the extract, that the PTMF could potentially still be daunting for staff members to apply directly with clients, and that this could be tied to a lack of confidence in discussing the PTMF's core ideas, or perhaps reflected the level of skill and clinical judgement required to work through a therapeutic intervention. Another challenge arising from the PTMF that several participants noted was the ideological challenge it seemed to pose for some colleagues.

Beatrice - So some people were a bit like 'does this mean people don't take responsibility for themselves because they blame everybody else for their lack of power'...and I think in the team as a whole, there's real nervousness because people don't feel familiar with it.

The PTMF was described as posing an ideological challenge to the dominant notion of individual responsibility in services - that clients are responsible for the circumstances they find themselves in. As Beatrice highlights staff found this difficult to reconcile and expressed concern that this approach would mean clients were not accountable for themselves and their behaviours. The anxiety arising in response to the PTMF amongst some members of staff was explored further by Arthur:

Arthur - I suppose it emphasizes our limitations as practitioners, whether we're psychologists, whether we're care coordinators, whether we're psychiatrists, whatever. You know when you're presented with that wider social economic framework that highlights our own limitations and I guess that is potentially quite dispiriting for lots of people. I think a lot of people said, 'well, you're highlighting issues here that we can do nothing about, and so what's the point of that'.

This extract highlights that the PTMF brought attention to the limitations of professionals by demonstrating the need for greater political and policy changes in society, beyond individual therapy interventions. This was also felt to have made staff aware of their own feelings of powerlessness, which they might have preferred not to acknowledge. Consequently, participants described observing an anxiety and reluctance to embrace the framework as it was seen to raise more concerns than it addressed. Participants connected this to the pressures staff were under as they felt staff were not in a position to meaningfully deconstruct the ideological positions and concepts they had come to rely on in their work.

3.3.3. Factors Facilitating Institutional Change

In contrast all the participants also spoke of factors which promoted, encouraged and facilitated larger scale institutional change of this nature in their workplaces. One significant strand of this for several of the participants was how the PTMF aligned with policy, particularly the NHS Long Term Plan and the expectation for mental health services to become trauma informed in their delivery of care.

Zoe - I think the NHS 10 year plan has been very powerful because it's a very nice piece of policy and actually the NHS 10 year plan it's amazing in that it

really clearly said mental health services will be trauma informed, but it didn't give any clear idea of what that would be. So being able to take that away and operationalize it and say, look here's one practice that we can use within the NHS that is trauma informed has enabled us to get different bits of funding.

This extract highlights the importance of the changing context and the formal move to trauma informed ways of working in creating an agenda for change in mental health services. The policy having not specified how new ways of working would look also presented an opportunity, and the PTMF was felt to be a useful guiding framework that could be drawn on to achieve these objectives. Zoe also highlights that their service was able to point to their use of the PTMF to demonstrate how the policy was being operationalised to secure further funding. Another key factor facilitating the introduction of the PTMF was the participants own positions of power. All the participants were in senior positions and spoke of how they were able to make use of this to enable change:

Beatrice - Having power. That's what's helped. Becoming an 8A. Deciding that I can't deliver this crap group another time, and I'm going to rewrite it and I've got the power to do it and suggest that it's not working, and we want to make it more meaningful.

Selin – There's something about being in a leadership position. And that's been important in the sense I had the autonomy to incorporate it in the way that I saw fit for the service. And so, I could very much bring it in in a way that I felt would make it as successful as possible.

Participants spoke of their place in the hierarchy and how being in senior and leadership positions allows them a degree of power, autonomy and influence both to suggest and implement changes in clinical practice. There was also a recognition that institutional change of this nature must be collaborative, and that being allied with colleagues and seniors is necessary to create support structures to sustain the work and the professionals through this process:

Alice - So all of the psychologists who work across the inpatient setting across [our Trust] we meet monthly in two ways, we meet all together, to share practice, to think about team formulations, to try and resolve any bumps or challenges, but we also meet as boroughs with the trust lead for trauma informed care. So we've got a lot of support around us in that way.

James - regular monthly meetings with staff who are trying to implement it, across all the different boroughs...that's been a really good support structure there to help us in trying to implement it.

These two participants refer to the frequency of regular meetings concerning their implementation of the PTMF as being helpful in sustaining change. The presence of colleagues and seniors, including Trust leads, allowed the participants to feel supported and to bolster their work. These meeting also allowed for consideration of challenges and the opportunity to work towards resolutions. Another aspect of facilitating change explored was how to introduce it in non-threatening ways:

Olivia - thinking about how you position it so that it's not a threatening thing. I'm smiling because I'm using the word threat. I guess thinking about how all the things in the power threat meaning framework then come into play into the team as well and how you can make it a power resource in the team rather than a threat I suppose. And how you can invite people in and make it a space where it isn't about having the right answer and everybody's perspective is valid.

Olivia speaks to the ability to garner support and minimise feelings of anxiety amongst colleagues as being significant to creating successful change, and that the key concepts of the PTMF itself can be drawn on to enable this process.

Olivia – It's about sort of gently, and sort of positively, curiously, carefully, all these words are coming to mind, just trying and seeing, seeing whether people can come alongside you and think about things in a different way.

There was also a sense that institutional change is more easily achieved when staff feel willingly involved and that change is best broached tentatively with an emphasis on the positives and potential benefits. This was echoed by James:

James - I think the psychiatrists are often quite keen to think more about...some of the patients that have perhaps been a challenge for them on the ward. So, there is this willingness to be able to approach things from a different perspective and to think about things more.

Thus, there was a sense that some colleagues were interested in a different perspective and that there was an increased receptiveness to change when there were feelings of frustration or disillusionment with aspects of the clinical work, which allowed a different way of thinking to be welcomed. There was a recognition amongst participants that cultural change in services is not facilitated by arguments but is instead best introduced tentatively as a possible option to be taken up. There was also a reflection that introducing resources such as the PTMF with enthusiasm and framing it as an opportunity could feel more hopeful and enabled staff to feel they were partaking in something, opposed to being dragged alongside it. Finally, shortcomings in existing ways of working were observed to facilitate a willingness for change amongst some colleagues, such as Psychiatrists.

There was a notion shared by several of the participants that facilitating such cultural and conceptual change is an on-going piece of work which is not always linear, simple or satisfying but that there is a commitment to continuing the work regardless:

Alice - Big cultural changes like this do not like to suddenly magically happen, so we have weeks where we're like 'yes, we've cracked it and it's really happening' and then we have weeks where we're like 'oh gosh what's happened? It's not working so well'. I think that's part of cultural change is rolling with those.

4. DISCUSSION

This chapter will discuss the research questions in relation to the results and the research literature. It will then provide a critical evaluation of the study, a consideration of its limitations and implications for the profession, and future research.

4.1. How are Clinical Psychologists using the PTMF in Clinical Practice?

As the PTMF is still a relatively new and optional framework an implicit question underpinning the research was, 'Are Clinical Psychologists using the PTMF in practice at all?'. The willingness of the ten psychologists to participate in the study suggested that the answer to this was yes, some psychologists have opted to engage with it. This then leads to the question of how, and in what ways?

The PTMF was being used in a myriad of ways by the participants, across a wide geographical area, and in varied clinical settings with differing demographics. While the existing literature had argued that 'people up and down the country need us to put the PTMF into practice in many and varied ways', it was not clear if the PTMF was being used clinically on a larger scale in this way (Darcy et al., 2022, p.62). The findings from this study suggest the PTMF has started to be implemented clinically by some psychologists.

The PTMF was described in terms of its versatility and adaptability in clinical services, demonstrated by its application to a wide range of clinical activities such as team formulation, client work, clinical training but also supervision and service development. The literature had drawn attention to the role of psychologists working in multidisciplinary teams not just as psychologists but also as consultants, trainers and supervisors (Christofides et al., 2012). The emphasis on the PTMFs versatility suggested the PTMF could be well suited for use by Clinical Psychologists in clinical practice as the PTMF was seen to support the participants in fulfilling the multi-faceted nature of their clinical roles. The PTMF was described by several participants as a framework rather than a model of therapy, which made it more versatile in that it could be approached and applied in numerous ways.

The results indicate that the PTMF has helped the participants in this study to bring an alternative psychosocial perspective to their multidisciplinary teams where the medical approach might otherwise dominate, particularly through team formulations but also by naming the PTMF as a service tool and drawing on it as a shared resource. The literature indicated that Clinical Psychologists have a visible and active role in team decision-making in which they increasingly bring psychosocial perspectives and that this contribution is valued by colleagues and service users (Christofides et al., 2012). The PTMF was described by the participants as a guiding framework supporting them to bring these alternative psycho-social contextual understandings to their teams and thereby aiding them in fulfilling the expectations of their clinical roles. This in turn was also felt to enable colleagues and other mental health professionals to make use of the framework in their clinical practice.

Nearly all the participants made use of the PTMF in team formulations and to inform their clinical thinking which supports the existing literature's emphasis on the framework's applicability in making sense of lived experiences and resultant distress (Colbert et al., 2022; Darcy, 2022; Enlander et al., 2022; Jagasia et al., 2022; Leeming et al., 2022; Newton et al., 2022; Willmot & Siddall, 2022). The PTMF was described as facilitating a move away from individualising problems to reconceptualising clients' presentations in the context from which they emerged. This was felt to help clients, their systems and the team to think beyond individual personal circumstances, and the typical focus on individual responsibility. This was described as subsequently leading to new opportunities for intervention and response. While an individual focus is still likely in services, particularly in adult services, the results highlight that the participants felt the PTMF was broadening and enhancing existing practices to encourage less individualistic and less blaming approaches to clinical work, in line with the authors' hope (Johnstone et al., 2019).

All the participants described themselves as working integratively and the PTMF was generally felt to be compatible with the several existing theoretical orientations and models the psychologists used in their practice. This supports the literature's findings that an integrative approach is predominantly how Clinical Psychologists work and that there may be interest in more integrative frameworks of therapy (Aafjes-van Doorn &

Llewelyn, 2017; Norcross & Karpiak, 2012; Prochaska & Norcross, 1983). The authors of the PTMF hoped that it could be used as a meta-framework within which other approaches were integrated and the findings suggest it is being used in such a way by the participants of this study (Johnstone & Boyle, 2018).

Despite this varied use, the resulting themes emphasised that the psychologists' use of the PTMF can be thought of in two main ways: firstly, as a framework to reconceptualise how they think about their work on a philosophical and ideological level, and secondly as a clinical tool which can be applied directly to clinical practices such as to therapeutic psychology groups and individual therapy with clients. A substantial portion of the existing literature on the topic of the PTMF focused on the potentially novel conceptual and theoretical benefits it might have for clinicians (Albanese et al., 2021; Boyle, 2022; Grant & Gadsby, 2018; Harper, 2022; Johnstone, 2022; Pilgrim, 2022; Pilgrim & Cromby, 2020; Ramsden, 2019; Strong, 2019; Willmot & Evershed, 2018). However, it was not clear if the framework would have clinical utility beyond its theoretical benefits and the impact of the PTMF on clinical practices was still to be determined (Johnstone & Kopua, 2019). The participants in this study described processes of translating the framework's conceptual benefits into clinical contexts and felt the PTMF had a noticeable impact on their clinical practices in this respect.

The authors of the PTMF had stated that whether the PTMF is used in practice, and whether it is seen as a replacement to the diagnostic system or as an alternative resource alongside it to broaden thinking was a decision for professionals and services to make (Johnstone et al., 2019). The findings from this study suggest the PTMF is a valuable alternative approach to the participating professionals who have opted to make use of it in clinical practice, but that it is not presently being implemented as a replacement for the medical model.

4.2. What is the Impact and Utility of the PTMF in Clinical Practice?

A key aspect that was felt to be unique to the framework and useful to clinical practice was the concept of power and allowing power dynamics in society to be acknowledged

and brought into the clinical work. This was touched upon in the existing literature, as Boyle (2022) and Ramsden (2019) spoke of how discussions of power are missing from mainstream psychological accounts of distress and that the PTMF offers a potential way of explicitly naming and incorporating analysis of power into therapeutic work. This orientation to power was described by the participating psychologists as being particularly impactful in making sense of marginalised clients' anger or aggression and encouraging staff to consider clients feeling threatened in the context of repeated experiences of being unsafe, oppressed and disadvantaged in society. This finding supports the literature suggesting that high diagnostic rates of paranoia and schizophrenia amongst black and minoritized groups would be better understood as understandable responses to racism and imbalances of power in society, rather than signs of psychiatric disorder (Cromby et al., 2013).

Considerations of power had the additional impact of increasing staff sympathy for and understanding of clients' threatened reactions and allowed what might otherwise be thought of as challenging behaviour or mental illness to be reconceptualised as survival strategies which were less blaming and highlighted the functionality of how people behave. This, in turn, minimised the use of restrictive and restraining interventions and allowed for alternative responses to be explored by staff. The participating psychologists also reflected on their service user responses to the PTMF, which appeared to them similarly to emphasise relief, insight and feelings of validation that their difficulties were comprehensible and understandable. The theorised potential of the PTMF in the literature to recognise the injustices clients have endured and allow distress to be more appropriately responded to has started to be demonstrated by the participants' accounts of the re-conceptualisation of clients distress and the focus on societal power imbalances (Bostock & Armstrong, 2019; Darcy et al., 2022; Henrich, 2022; Mitchell & Thorne, 2019; Ramsden & Beckley, 2022; Willmot & Evershed, 2018). Concerns raised in the literature that the PTMF may only provide a framework for formulation without implications for interventions or clinical practice were not shared by the majority of psychologists making use of it, who felt that it had affected their responses to clients and the clinical and service decisions that they made (Ramsden, 2019).

There was a call in the literature for professionals to reflect on their own professional authority over the lives of others and a suggestion that the PTMF could facilitate such reflections (Harper & Cromby, 2022; Pilgrim, 2022; Pilgrim & Cromby, 2020; Read & Harper, 2022; Strong, 2019). The findings of this study suggest that the PTMF had the effect of enabling reflections amongst the participants and their colleagues about their own power as professionals, and to have provided a safe basis from which these conversations could be started. Criticism of the PTMF suggested that despite seeking to highlight the impact of power, the framework failed to draw attention to the inherent power of professionals in mental health services, and the authors have also acknowledged that they could have addressed professional power more directly (Johnstone et al., 2019). The participants felt the framework had enabled them to begin considering their own power as professionals, but that this could have been more explicitly named by the framework.

Reflections on power that the PTMF generated further facilitated a redressing of power in services through increased co-production with service users. Several of the participants spoke of how the PTMF had enabled co-production to be prioritised, and that the PTMF project demonstrated the value of co-producing work and modelled this process. The PTMF's legitimising of co-production and the potential to begin working with communities to create specialist knowledge was also briefly touched on in the literature (Darcy et al., 2022).

Existing literature on the PTMF suggested professionals of differing backgrounds were interested in the potential benefits and uses of the framework, such as mental health nurses and teachers (Grant & Gadsby, 2018; O'Toole, 2019). Several of the participating psychologists indicated that the PTMF appeared to have been useful to their multi-disciplinary colleagues, which may support the idea that the framework is accessible to a wide range of professionals. The PTMF was often described as a shared resource, providing a shared language and bridging differences in colleagues' theoretical backgrounds. There was a sense that considerations of clients' contexts and adversities were not just for psychology and that the PTMF provided a guiding framework that all staff could make use of to this end. This raises further questions about the extent to which colleagues of differing specialities find the PTMF accessible and useful in their own clinical practices, and this could be the focus of future research

inquiries. The increasing number of citations of the PTMF documents may also indicate a broad and growing interest in the framework beyond the psychological professions.

The PTMF was also felt to have shortcomings when applied in clinical contexts. Several participants spoke of how some of the core constructs and language such as 'threat responses' could be initially confusing and limit the use of the framework. The length and nature of the original documents also raised concerns for several participants who felt others were unlikely to read such documents in their entirety. Concerns that as a framework the PTMF provided a broad overview which could be useful but could also be insufficient without the addition of additional therapeutic models allowing for more detailed formulation or consideration of interpersonal dynamics were also raised. These findings suggest that the framework itself may need further work to improve its utility and accessibility in clinical contexts.

While there are increasing publications on the PTMF very few papers explore the applications of the PTMF in clinical practice by professionals. John Cromby's 2020 Conference paper 'Translating the PTMF into Practice: Issues and Reflections', although not published, provides an opportunity for comparison of findings. Cromby (2020) interviewed thirteen clinicians familiar with the PTMF about their views and experiences of its use. Milligan's thesis, also unpublished, explored six Educational Psychologists' uses and experiences of the PTMF and is also drawn on for comparison (Milligan, 2022). Cromby reported findings that the PTMF legitimised existing practices for the participants and helped to overcome prominent ideas of individualism (Cromby, 2020). This echoes this study's findings that the PTMF allowed for participants' existing but unnamed practices to be officiated and that the PTMF challenged dominant notions of individual responsibility. Similarly, Milligan reports that the Educational Psychologists interviewed reported that the PTMF allowed for previously overlooked contexts and the multi-factorial causes of distress to be acknowledged, which supports this study's finding that the PTMF can help to facilitate a change in how distress is conceptualised (Milligan, 2022).

Similar to this study Cromby also found clinicians felt the PTMF could be more accessible in its language and writing, a concern that was also raised more broadly in

the literature (Anand, 2022; Cromby, 2020). Milligan also highlighted that understanding, explaining and applying the PTMF required a lot of time, which the Educational Psychologists felt they often didn't have (Milligan, 2022). Whether features of the PTMF itself may need further consideration to be clinically useful are, therefore, raised by the findings of this study and the broader literature. Milligan suggests that the PTMF may be less applicable to Educational Psychologist's professional roles, and as Cromby interviewed clinicians of differing professional backgrounds the question of if the PTMF is accessible and useful to all or only some mental health professionals is once again raised and could be addressed in future research.

Despite these similarities, there were also differences in findings, Cromby's findings differed in that participants spoke of how the PTMF was unable to aid in changing service structure or delivery, whereas the participants of this study felt the PTMF had supported service development such as increased co-production with service users (Cromby, 2020). Milligan's findings suggested there were feelings of optimism about the PTMF and the wider changes that may subsequently be possible (Milligan, 2022). Clinicians' experiences of applying the PTMF can both converge and differ in these respects and the full impact of the PTMF is still yet to be determined, further research is therefore needed to continue to evaluate the PTMF.

The PTMF authors hoped to produce a shift in policy, practice, thinking and research focus with the publication of the framework. The findings of this study begin to suggest that the PTMF may have had an impact on clinical practice and thinking for the practitioners making use of it. There may be opportunities for future research to expand on this, as well as to explore the PTMF's potential effects on policy and research focuses.

4.3. What Contextual Factors Facilitate and Hinder the Use of the PTMF?

An interesting new finding of the study is that some of the psychologists felt they could implement the PTMF in their services because of a context of change surrounding mental health work. This was partly linked to the government's NHS Long Term Plan

policy, which created an agenda for change and the PTMF was seen to be a framework that could be named and pointed to as evidence of such change. Even though the practices and ethos of the PTMF were felt to already be present for many of the participants in their work, they spoke of how the PTMF legitimised and helped to officiate what might otherwise be unnamed or implicit practices. Research had suggested psychologists and some of their colleagues had been dissatisfied with aspects of the medical model for several decades and supported the development of alternatives in theory but did not appear to be familiar with alternatives in practice (Gayle & Raskin, 2017; Raskin, 2019; Raskin et al., 2022; Raskin & Gayle, 2016; Recovery in the Bin, 2016). The recent shift in which professional bodies such as the United Nations, service users and professional groups such as Recovery in the Bin, and government policy such as the NHS Long Term Plan have acknowledged shortcomings of the medical model and actively sought to redress these by moving towards a more contextualised lived experience understanding of mental distress have created a greater context of acceptability for an alternative such as the PTMF in clinical services.

The application of the PTMF in practice appeared to be further facilitated by the inherently integrative nature of the participating Clinical Psychologists' profession. The existing literature highlighted that Clinical Psychologists may be particularly well suited to taking up new frameworks and working integratively due to their training in a variety of theoretical approaches (Aafjes-van Doorn & Llewelyn, 2017; Norcross & Dryden, 1991; Norcross & Karpiak, 2012). Research had also suggested Clinical Psychologists' theoretical orientations are changeable and tend to orient to theoretical developments in the field over the course of their careers (Norcross & Dryden, 1991). The integrative nature of Clinical Psychology training differs, however, from other mental health professional training experiences, such as psychotherapists and psychiatrists. While the participating psychologists felt the PTMF was largely accessible to their colleagues it is not possible to draw definitive conclusions from their accounts alone. This too raises further questions about the extent to which the PTMF is accessible to multi-disciplinary colleagues if their training is less integrative and purer in theoretical focus, potentially making implementing more recently published frameworks more challenging.

The literature predicted considerable hostility and resistance to an alternative approach among clinicians (Rapley et al., 2011). There were concerns that as professionals are socialised through their training into certain ways of thinking change may be challenging, especially if there is only exposure to a single conceptualising approach and minimal exposure to alternatives (Grant & Gadsby, 2018; Johnstone & Boyle, 2018; Ramsden, 2019). There were concerns that the PTMF could cause an ideological challenge to staff in this respect, and potentially create professional divisions, defensiveness and less effective team working (Ramsden, 2019). The results demonstrated that for the participants and some of their colleagues who were feeling disillusioned from their work and felt they needed a different perspective to work effectively with some clients, the PTMF was welcomed as an alternative. In contrast, there was also a sense that for some the PTMF did pose an ideological challenge, particularly against the established notion of individual responsibility in mental health work. This could feel threatening, and anxiety provoking for staff and exposed them to their own feelings of powerlessness in the face of societal power dynamics that were outside of their control. The findings suggest that alternative approaches such as the PTMF may be best introduced slowly and tentatively, with an emphasis on what they can contribute to clinicians and clients and presented as an optional alternative to run alongside or integrate with existing practices rather than being imposed as a replacement.

Finally, despite a context of change that seemed to welcome an alternative approach, certain contextual factors continued to pose obstacles to the PTMF's clinical application. Participants described that the framework not being considered evidenced-based and not being recommended for clinical use by NICE Guidelines or the DCP made it more challenging for practitioners to implement in practice. This concern was echoed in the existing literature in the psychologists' call on the DCP to provide clearer guidance on trauma informed approaches and to endorse the use of the PTMF explicitly in relation to this (Skelly & Shirley, 2022). Similarly, Court et al (2017) demonstrated that NICE Guidelines can be restrictive to clinicians trying to navigate complex clinical contexts and that psychologists reported often going beyond the guidelines but feeling unable to be transparent about this. Despite the PTMF project being funded by the DCP and the resultant framework and resources being published by the BPS the PTMF's optional status made it more challenging for some

of the psychologists to apply in practice. Participants spoke of the difficulty in creating change from the bottom up while still maintaining expected standards of practice which affect their targets and funding. This finding raises further questions about the processes by which new frameworks or approaches get sanctioned for clinical use.

The nature of the PTMF and its application in mental health services could be compared to the implementation of trauma informed care approaches that have also been adopted by UK mental health services in recent years. The trauma informed approach recognises that exposure to trauma affects individuals neurological, biological, psychological and social development and that trauma can pervasively impact on a person's worldview and relationships (Sweeney et al., 2016). Trauma informed approaches may be comparable to the PTMF in focusing on contextual and adversarial experiences as a framework for understanding service users holistically in non-diagnostic terms. The ideological shift to trauma informed approaches and its popularity has been a response in part to traditional models being insufficient and in part to research evidencing that trauma is widespread and highly correlated with mental health difficulties (Sweeney et al., 2018; Sweeney & Taggart, 2018; Thirkle et al., 2021). The emergence and interest of the trauma informed approaches and the PTMF are comparable in these respects.

Many of the barriers identified in the implementation of trauma informed approaches are similar to the barriers highlighted in this study. The barriers to trauma informed approaches included reluctance amongst staff to shift from the familiar medical model, the focus of staff training having been heavily bio-medical, an empathetic approach being seen as rewarding bad behaviour from a psychological behavioural perspective, organisational cultures failing to support or conflicting with trauma informed approaches and limited resources and low morale amongst staff (Sweeney et al., 2016, 2018). This corresponds to this study's findings that staff can often revert to medicalised understandings and that the PTMF can feel like a significant ideological departure from what feels familiar to staff's training and clinical experiences. All the participants of this study also highlighted the challenges of staff being overwhelmed and under-resourced, which can understandably limit enthusiasm and motivation for change. The parallels in applying trauma informed approaches to clinical settings to

those of applying the PTMF raise dilemmas about facilitating institutional and systemic change in services, and how to aid such processes in the future in light of these persistent contextual and ideological obstacles.

The implementation of trauma informed approaches did, however, also differ from the PTMF's clinical applications in several ways. For instance, the trauma informed approach was not described as being inaccessible in its language in the same way as the PTMF. Trauma informed approaches were not tied to any one professional group, while the PTMF appears to be associated with the professional field of psychology. It again may be that the features of the PTMF itself hinder its application in clinical contexts in this respect and may need further consideration and revision to allow for increased clinical utility.

4.4. Critical Evaluation

Within this section, the limitations of the research are initially acknowledged and considered. The study is then evaluated using Spencer and Ritchie's (2011) guiding principles for producing quality qualitative research, focusing on the three principles of contribution, rigour and credibility. An evaluation of the thematic analysis undertaken is also presented as part of this, using Braun and Clarke's (2022) guidelines. Finally, reflections on the researcher's personal reflexive position are also presented.

4.4.1. Limitations

As is the case with all research this study has its limitations. While the sample size was not unusual for a qualitative research study it may still be considered a small sample from which to make wider generalisations about the field and profession. A quantitative mixed methods approach with a larger number of participants may have provided an opportunity to form a clearer picture of the extent to which psychologists are familiar with the PTMF and the extent of its use clinically - in different geographical regions as well as in different clinical settings and with different service user demographics. A quantitative survey of this kind may also have increased participant numbers as participation would not have required as great a commitment as a qualitative interview.

The study was limited in that it only recruited Clinical Psychologists, therefore the extent of the PTMF's use and its reception amongst other mental health professionals cannot be determined. Similarly, most of the participants, nine out of the ten, worked in adult services and thus limits the conclusions it is possible to draw about the extent of the PTMF's clinical use. It may also be that the PTMF is more applicable to adult services than systemic services such as Learning Disability or Children and Family services and this could be a focus of future investigations.

Since all the participants were drawing on the PTMF in their clinical work this is likely to reflect a bias toward the framework and its clinical utility which may fail to capture the full range of responses to the framework since its publication. Participation was also entirely voluntary and thus reflects a motivation to participate and likely a certain bias toward the PTMF. For instance, practitioners who may have attempted to make use of the PTMF but discontinued its use may not have felt able to, or willing to, take part in a research project such as this.

Data was collected via semi-structured interviews and while this allows for a degree of insight no direct observations of clinical practice occurred. Thus, all the conclusions were drawn from descriptions of clinical practice which may not provide a complete, or entirely accurate, evaluation of the PTMF's clinical applications.

4.4.2. Contribution

The principle of contribution refers to the relevance and value of a study's findings and whether they advance knowledge or practice. The conceptual, practical and theoretical contributions of the study are initially explored in the discussion sections 4-4.3. and expanded upon for their relevance to the Clinical Psychology professional field, clinical practice and research in the implications section 4.5. The study provides analytic and theoretical generalisations which can be applied more broadly in this sense (Spencer & Ritchie, 2011).

While the notion of generalisability is typically a concept associated with quantitative as opposed to qualitative research findings it is necessary to consider the contribution

or relevance of findings beyond the individual participants involved in any study. The participating professionals represented a cross range of the profession in terms of their age, length of clinical service, geographical location and theoretical orientation. In this respect, the study's findings provide a degree of external validity and transferability which may contribute to knowledge and practice.

4.4.3. Rigour

The principle of rigour refers to the appropriateness of the research decisions and transparency of the research processes (Spencer & Ritchie, 2011). A detailed rationale for, and description of the research strategy, including the methodological underpinnings of the research, the research methods, processes and justification for decisions made is presented in Chapter 2. Reasoning for the study's focus and its research questions is provided in sections 1.7 – 1.8.

An evaluation of the thematic analysis undertaken is presented here, in accordance with Braun and Clarke's (2022) guidance. As data analysis of any kind is underpinned by theoretical assumptions it is necessary to acknowledge and reflect on these as part of the research process, this can be found in the methodology section in Chapter 2. A rationale is provided for the methodological approach chosen, and for the use of thematic analysis as part of this approach. The theoretical constructs that would inform the analysis were explored particularly the critical realist orientation.

It is recommended that the analytic procedure be recursive in nature, meaning that the process is not strictly linear and that certain stages of the analysis may be revisited, revised, or repeated (Braun & Clarke, 2022). Braun and Clark (2022) also recommend thematic analysis be undertaken in five phases. Firstly, that the researcher becomes familiar with the data, before systematically coding the data in a fine-grained way to identify interesting and relevant ideas in relation to the research questions. This leads to the third phase in which codes with shared and patterned meanings can be identified and initial themes generated. A process of developing and reviewing the initial themes is then recommended in the fourth phase in which themes may be joined or collapsed together or split into new themes. In the final phase, the themes are refined and clearly defined.

These guidelines were followed through an initial but extensive process of immersion in, and familiarisation with, the data, which was achieved by watching the interview recordings, transcribing the interviews, checking the transcriptions against the recordings and reading and re-reading the transcripts. A similar recursive process was conducted during the coding phase of analysis in which the data was initially coded, followed by a second coding of the entire dataset. An example of a coded extract of the dataset is provided in Appendix A, codes such as 'context of change' and 'colleague willingness' and 'support' are demonstrated by this excerpt. A further demonstration of the coding procedure can be found in Appendices C, which highlights all the raw data associated with the code 'aligns with personal values'. Upon review, these codes allowed for themes to begin to be identified and named such as the themes of 'Barriers to Change' and 'Change Process', as is demonstrated in the tables presented in Appendix D. In the fifth and final phase, these themes were further developed and streamlined by review and in conversation with the project supervisor. This is demonstrated in Appendix E in which the final themes were refined, for instance, the potential themes of 'Barriers to Change' and 'Change Process' were combined within the final superordinate theme of 'Facilitating Institutional Change'.

The importance of acknowledging the researcher's influence in developing the analytic themes as part of a process of meaning making rather than fact finding is emphasised by qualitative researchers and is explored in section 4.4.5. on personal reflexivity (Braun & Clark, 2022).

4.4.4. Credibility

For research to be credible the research claims must be defensible and plausible, and the conclusions reached should, therefore, be demonstrable by evidence (Spencer & Ritchie, 2011). Spencer and Ritchie (2011) suggest this is achieved by methodological transparency, detailed documentation of the research process and claims being demonstrated by evidence. The results are presented in Chapter 3 with data excerpts to demonstrate how the claims and interpretations presented in the analysis were derived from the raw data. A constructed representation of the analysis process is

provided in Appendices A-E, to provide an audit trail and to further demonstrate how the analytic output was constructed.

4.4.5. Personal Reflexivity

While the notion of neutrality and scientific objectivity is seen to be misguided within qualitative research practices as the researcher is seen to have an inevitable and intricate relationship to the research, the concept of reflexivity provides an opportunity to acknowledge the impact of the researcher's role in guiding the research (Spencer & Ritchie, 2011). Since research is informed by the researcher's beliefs, feelings and ideas about the world, in this way insight into our own perspectives should make up part of the evaluative process (Braun & Clarke, 2022).

I had been interested in people's social histories and personal stories long before my clinical training in Psychology and at least since studying for my undergraduate degree in History. This interest has influenced the nature of my work and study and likely contributed to my interest in the Clinical Psychology profession. My clinical experiences within the NHS and my training have further contributed to my interest in psycho-social understandings of identity and lived experiences. One of my concerns has been that the complexity of human experiences appears increasingly to be minimised by the psychological and psychiatric professions, often in a well-intentioned effort to make psychological input more accessible to both professionals and clients. Alongside this I have been concerned about the less well-intentioned nature by which societal disadvantages have been obscured from psychological work and the evidenced impact of social determinants on people's lives has been overshadowed. These concerns are likely linked to my identity and lived experiences as a second-generation immigrant in the UK.

The long-standing debates regarding the medicalisation of distress and the calls within the Clinical Psychology profession to re-evaluate our ideological assumptions about people's mental distress have therefore captured my attention and align with my personal values. While this provides some insight into my personal positioning it is worth noting that reflexivity is a recursive process of reflections that are never final and complete insight into our own positioning is rarely possible (Braun & Clarke, 2022).

4.5. Implications

4.5.1. Clinical Psychology Profession

The PTMF's clinical application is likely to be of increased interest and significance in the context of the NHS Long-Term Plan and the move toward trauma informed approaches in mental health services (NHS Long Term Plan, 2019).

The participants suggested that the PTMF could be used to support conceptual change and the development of a more social and contextually conscious psychological approach of this nature, but that this could also be the cause of tension, concern and resistance amongst staff. Increased opportunities for discussion about the place of individual responsibility within the contextual approach of the PTMF could be facilitated in clinical contexts to address and support staff anxieties about a conceptual change of this nature.

Participants also suggested introducing the PTMF in a non-threatening way, highlighting its potential benefits to clinicians and clients as a possible alternative as opposed to as a replacement for familiar ways of working that could best facilitate its use clinically. Thus, psychologists considering introducing the PTMF to clinical contexts may want to emphasise the PTMF as an optional approach that can positively supplement and contribute to existing work which may make its application less threatening and overwhelming for staff.

In contrast, the profession is still influenced by the extent to which an approach is endorsed or sanctioned by professional bodies and evidenced-based clinical recommendations. The fact that the PTMF is not recommended for clinical use may limit interest in its use within the profession. However, this research could encourage the increased application of the PTMF as the study highlights that the clinicians who make use of the PTMF endorse it, which could influence other clinicians to consider making use of the framework in their own services.

4.5.2. Clinical Practice

As some participants said it might be necessary to initially introduce the framework to multi-disciplinary teams in a scaffolded way to help make sense of the new terms and

concepts such as ‘threats’ and ‘threat responses’, which may be unclear. Building on this initial introduction it would be advisable to offer ongoing reflective practice groups to staff, as participants suggested that although colleagues found the framework helpful some also seemed to remain unsure or might lack the confidence to make use of it themselves. This could increase the likelihood that the PTMF is accessible and usable for colleagues. Such provisions could enable the development of what some of the participants referred to as a ‘shared language’ in which colleagues had a shared understanding and could make collaborative use of the concepts and terms.

On-going reflective groups and meetings would also be beneficial for Clinical Psychologists making use of the PTMF in clinical practice, as the participants who had access to such support described it as being beneficial in feeling supported in their attempts to implement conceptual and institutional change. Such meetings could also provide opportunities for recognition that implementing large scale cultural change is not a linear or simple process and that progress may feel static at times, and that obstacles and challenges may be an inevitable feature of creating change.

Participants also suggested explicit support from seniors and influential members of the teams helped to endorse and sanction the PTMF’s use in their clinical contexts. It may be beneficial to highlight the PTMF’s endorsement by seniors and influential members of the team in clinical settings in this way to promote confidence and interest in its use.

Future clinical applications of the PTMF may be as highly varied in nature as it was for the participants of this study, who felt the framework was adaptable to their differing clinical service needs. However, there may now be a precedent to apply the PTMF as a clinical tool to therapeutic and psychoeducational service user groups, as a formulation or therapeutic tool with individuals, as well as with parents or families in network meetings, to staff trainings, supervision and service development projects.

4.5.3. Future Research

Future research studies may wish to adopt a quantitative approach to establish the extent of the PTMF’s use in the UK more broadly, and to extend participation to other

professionals beyond the Clinical Psychology profession. A larger scale quantitative approach of this nature would further demonstrate the extent of the PTMF's use, and its accessibility to other professionals beyond the Psychology profession.

While this study has focused on professional use and views there is now an opportunity to assess service user experiences and attitudes toward the PTMF in future studies. This would also shed further light on the extent of the PTMF's accessibility, particularly as there were concerns that the framework may not initially be accessible because of potentially confusing terms and concepts.

There is also now an opportunity to explore the views of those that remain sceptical of the framework, or who may have found it challenging or unsuccessful to apply in clinical practice. This could further highlight the limitations of the framework that may require more thought.

While this research has focused on the PTMF's impact on and implications for thinking and practice there would be scope for future research to assess the impact of the PTMF on research focus and policy.

Finally, it may be that further research is needed around the topic of institutional and conceptual change as the similarities in barriers to the implementation of trauma informed approaches and the PTMF indicate wider structural and systemic challenges in facilitating change in mental health services.

4.6. Conclusion

The study sought to explore the clinical application of the PTMF by Clinical Psychologists in the UK since its publication in 2018. Despite the growing interest in the PTMF within and beyond the field of Clinical Psychology the extent of its use, particularly in clinical contexts, was unclear. The framework's ambitious aims, broad possible uses and optional status also raised questions about if and how it might be applied in practice and what impact its application might have.

Although the participants were a small, self-selected sample the study has demonstrated that the PTMF has been taken up by Clinical Psychologists, both within the NHS and in third sector charity services. That its use is felt to be conceptually and clinically useful to the practitioners making use of it and from their perspective to colleagues, clients and families. The PTMF was described by the participants as being applicable to numerous clinical activities, supporting the multi-faceted nature of their roles and allowing for an integrative clinical approach as it was seen to both supplement and complement existing ways of working.

The PTMF's limitations, such as its potentially confusing terms and concepts and the broad overview it provides requiring supplementation from other therapeutic approaches have been acknowledged. As well as the potential discomfort it can pose to staff who may feel overwhelmed by the ideological departure from existing ways of conceptualising and approaching distress in mental health work.

Implications resulting from the study's findings for the Clinical Psychology profession, clinical practice and future research were highlighted and subsequent recommendations were made.

5. REFERENCES

- Aafjes-van Doorn, K., & Llewelyn, S. (2017). *Clinical Psychology: A Very Short Introduction*. Oxford University Press.
<https://doi.org/10.1093/actrade/9780198753896.001.0001>
- Aherne, C., O'Brien, G., & Moloney, O. (2019). Youth Mental Health and the Power Threat Meaning Framework: Jigsaw's systems perspective. *Clinical Psychology Forum Special Issue: Power Threat Meaning Framework*, 313, 3–8.
- Albanese, A., Blane, D. N., & Williamson, A. E. (2021). Mental health in context: Structural vulnerability and support in primary care. *British Journal of General Practice*, 71(713), 565–567. <https://doi.org/10.3399/bjgp21X717965>
- Amari, N. (2022). Trust, acceptance, and power: A person-centered client case study. *Person-Centered & Experiential Psychotherapies*, 21(1), 16–30.
<https://doi.org/10.1080/14779757.2022.2028662>
- Amari, N. (2023). Self-formulation in counselling psychology: The Power Threat Meaning Framework. *Journal of Humanistic Psychology*, 002216782311542.
<https://doi.org/10.1177/00221678231154292>
- Anand, N. (2022). Models of public health and prevention. *Clinical Psychology Forum Special Issue: Public Health and Prevention, Part One*, 356, 16–24.
- Beshara, R. K. (Ed.). (2020). *A critical introduction to psychology*. Nova Science Publishers.
- Bostock, J., & Armstrong, N. (2019). Developing trauma-informed care and adapted pathways using the Power, Threat, Meaning framework (Part 1: Being heard and understood differently). *Clinical Psychology Forum Special Issue: Improving Services for Trauma-Related Dissociation*, 314, 25–29.

- Boyle, M. (2022). Power in the Power Threat Meaning Framework. *Journal of Constructivist Psychology*, 35(1), 27–40.
<https://doi.org/10.1080/10720537.2020.1773357>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.
<https://doi.org/10.1191/1478088706qp063oa>
- Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. SAGE.
- Brown, L. R. (2020). *Experiences of Workplace Bullying from the Perspectives of Trainee Clinical Psychologists: A Qualitative Study*.
<https://doi.org/10.18745/TH.23305>
- Chamberlain, K. (2015). Qualitative Research in Clinical and Health Psychology. In *Qualitative Research in Clinical and Health Psychology*. Macmillan Education UK. https://doi.org/10.1007/978-1-137-29105-9_2
- Christofides, S., Johnstone, L., & Musa, M. (2012). ‘Chipping in’: Clinical psychologists’ descriptions of their use of formulation in multidisciplinary team working: *Formulation in MDTs. Psychology and Psychotherapy: Theory, Research and Practice*, 85(4), 424–435. <https://doi.org/10.1111/j.2044-8341.2011.02041.x>
- Colbert, S., Caswell, H., & Dunstan, R. (2022). Power, Threat, Meaning Framework informed audit: The ubiquitous experience of trauma in adults with psychosis. *Clinical Psychology Forum Special Issue: Trauma Informed Care in Clinical Psychology*, 350, 48–53.
- Collins, N. (2019). The ‘Own my life’ course: Building literacy with women about trauma through the Power Threat Meaning Framework. *Clinical Psychology Forum Special Issue: Power Threat Meaning Framework*, 313, 38–41.

- Court, A. J., Cooke, A., & Scrivener, A. (2017). They're NICE and Neat, but Are They Useful? A Grounded Theory of Clinical Psychologists' Beliefs About and Use of NICE Guidelines: Beliefs About and Use of Nice Guidelines. *Clinical Psychology & Psychotherapy*, 24(4), 899–910.
<https://doi.org/10.1002/cpp.2054>
- Craddock, N., & Mynors-Wallis, L. (2014). Psychiatric diagnosis: Impersonal, imperfect and important. *British Journal of Psychiatry*, 204(2), 93–95.
<https://doi.org/10.1192/bjp.bp.113.133090>
- Cromby, J. (2020). *Translating the PTMF into practice: Issues and reflections*.
- Cromby, J. (2022). Meaning in the Power Threat Meaning Framework. *Journal of Constructivist Psychology*, 35(1), 41–53.
<https://doi.org/10.1080/10720537.2020.1773355>
- Cromby, J., Harper, D., & Reavey, P. (2013). *Psychology, mental health and distress* (pp. xxix, 420). Palgrave Macmillan/Springer Nature.
<https://doi.org/10.1007/978-1-137-29589-7>
- Darcy, A. (2022). Allowing for multiple stories of threats, meaning and ethnicity in The North of Ireland. *Clinical Psychology Forum Special Issue: Public Health and Prevention, Part Two*, 357, 66–73.
- Darcy, A., Armstrong, J., & Vaughan, S. (2022). Power and meaning within patriarchal societies: Thinking within, against and beyond the system. *Clinical Psychology Forum Special Issue: Public Health and Prevention, Part Two*, 357, 60–65.

- Dawson, J. P. R. (2018). Book Review: The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis. *Counselling Psychology Review*, 33(1), 57–59. <https://doi.org/10.53841/bpscpr.2018.33.1.57>
- Department of Health. (1999). *National service framework for mental health: Modern standards and service models*.
- Division of Clinical Psychology. (2013). *Classification of behaviour and experience in relation to functional psychiatric diagnoses: Time for a paradigm shift*. British Psychological Society. <https://shop.bps.org.uk/classification-of-behaviour-and-experience-in-relation-to-functional-psychiatric-diagnoses-time-for>
- Downs, C. M., & Rayner-Smith, K. (2022). The space between the rock and the hard place: Personality disorder diagnosis in people with intellectual disabilities. *Advances in Mental Health and Intellectual Disabilities*, 16(2), 76–86. <https://doi.org/10.1108/AMHID-11-2021-0045>
- Enlander, A., Simonds, L., & Hanna, P. (2022). Using the power threat meaning framework to explore birth parents' experiences of compulsory child removal. *Journal of Community & Applied Social Psychology*, 32(4), 665–680. <https://doi.org/10.1002/casp.2581>
- Faulconbridge, J., Hunt, K., & Laffan, A. (Eds.). (2019). *Improving the psychological wellbeing of children and young people: Effective prevention and early intervention across health, education and social care*. Jessica Kingsley Publishers.
- Ferrari, R. (2015). Writing narrative style literature reviews. *Medical Writing*, 24(4), 230–235. <https://doi.org/10.1179/2047480615Z.000000000329>

- Flynn, A., & Polak, N. (2019). Incorporating the Power Threat Meaning Framework into an autism and learning disability team. *Clinical Psychology Forum Special Issue: Power Threat Meaning Framework*, 313, 42–46.
- Fyson, R., Morley, K., & Murphy, A. (2019). Using the Power Threat Meaning Framework in social work education. *Clinical Psychology Forum Special Issue: Power Threat Meaning Framework*, 313, 33–37.
- Gayle, M. C., & Raskin, J. D. (2017). DSM-5: Do Counselors Really Want an Alternative? *Journal of Humanistic Psychology*, 57(6), 650–666.
<https://doi.org/10.1177/0022167817696839>
- Grant, A., & Gadsby, J. (2018). The Power Threat Meaning Framework and international mental health nurse education: A welcome revolution in human rights. *Nurse Education Today*, 68, 1–3.
<https://doi.org/10.1016/j.nedt.2018.05.007>
- Greenhalgh, T., Thorne, S., & Malterud, K. (2018). Time to challenge the spurious hierarchy of systematic over narrative reviews? *European Journal of Clinical Investigation*, 48(6), e12931. <https://doi.org/10.1111/eci.12931>
- Griffiths, H., & Baty, F. (2019). Bringing the outside in: Clinical psychology training in socially aware assessment, formulation, intervention and service structure. *Clinical Psychology Forum Special Issue: Power Threat Meaning Framework*, 313, 20–24.
- Harper, D. (2020). Diagnosis, Classification and the Expansion of the Therapeutic Realm. In N. Moller, A. Vossler, D. Jones, & D. Kaposi (Eds.), *Understanding Mental Health and Counselling*. SAGE Publications.
<https://uk.sagepub.com/understanding-mental-health-and-counselling/book267350>

- Harper, D. (2022). Framing, Filtering and Hermeneutical Injustice in the Public Conversation about Mental Health. *Journal of Constructivist Psychology*, 35(1), 68–82. <https://doi.org/10.1080/10720537.2020.1773360>
- Harper, D., & Cromby, J. (2022). From ‘What’s Wrong with You?’ to ‘What’s Happened to You?’: An Introduction to the Special Issue on the Power Threat Meaning Framework. *Journal of Constructivist Psychology*, 35(1), 1–6. <https://doi.org/10.1080/10720537.2020.1773362>
- Harper, D., O’Donnell, E., & Platts, S. (2021). A “trigger”, a cause or obscured? How trauma and adversity are constructed in psychiatric stress-vulnerability accounts of “psychosis”. *Feminism & Psychology*, 31(1), 19–40. <https://doi.org/10.1177/0959353520954313>
- Harper, D., & Timmons, C. (2019). How is paranoia experienced in a student population? A qualitative study of students scoring highly on a paranoia measure. *Psychology and Psychotherapy: Theory, Research and Practice*, papt.12250. <https://doi.org/10.1111/papt.12250>
- Hawkins, R., Falconer Al-Hindi, K., Moss, P., & Kern, L. (2020). Reflections on a collective biography journey. *Emotion, Space and Society*, 37, 100731. <https://doi.org/10.1016/j.emospa.2020.100731>
- Henrich, S. (2022). Critical Reflection of Gender Identity Assessments with Trans and Gender Binary Individuals: Challenges, implications and a newly proposed approach in Forensic Psychology. In G. C. Liell, L. F. Jones, & M. J. Fisher, *Challenging Bias in Forensic Psychological Assessment and Testing* (1st ed., pp. 314–328). Routledge. <https://doi.org/10.4324/9781003230977-14>

Howard, V., & Adan, A. (2022). "The end justifies the memes": A feminist relational discourse analysis of the role of macro memes in facilitating supportive discussions for victim-survivors of narcissistic abuse. *Cyberpsychology: Journal of Psychosocial Research on Cyberspace*, 16(4).
<https://doi.org/10.5817/CP2022-4-10>

Jagasia, K., Saunders, P., & Roufeil, L. (2022). "Now I Can See Things for What They Are": The Experiences of Adult Children of Narcissists. *Journal of Constructivist Psychology*, 1–23.
<https://doi.org/10.1080/10720537.2022.2048285>

James, I., Morris, S., Johnstone, A., & Glover, D. (2022). Treating mental stress in elite footballers using a stigma-free psychological approach: The Power Threat Meaning Framework. *BJPsych Advances*, 1–8.
<https://doi.org/doi:10.1192/bja.2022.48>

Johnstone, L. (2022). General Patterns in the Power Threat Meaning Framework – Principles and Practice. *Journal of Constructivist Psychology*, 35(1), 16–26.
<https://doi.org/10.1080/10720537.2020.1773358>

Johnstone, L., & Boyle, M. (2018). *The power threat meaning framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. British Psychological Society.

Johnstone, L., & Boyle, M. (2018b). *Power Threat Meaning Framework: Overview* (p. bpsrep.2018.inf299a). British Psychological Society.
<https://doi.org/10.53841/bpsrep.2018.inf299a>

- Johnstone, L., Boyle, M., Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D., & Read, J. (2019). Reflections on responses to the Power Threat Meaning Framework one year on. *Clinical Psychology Forum*, 47–54.
- Johnstone, L., & Kopua, D. (2019). Crossing Cultures with the Power Threat Meaning Framework. *Psychotherapy and Politics International*, 17(2).
<https://doi.org/10.1002/ppi.1494>
- Khan, S., & Haque, S. (2021). Trauma, mental health, and everyday functioning among Rohingya refugee people living in short- and long-term resettlements. *Social Psychiatry and Psychiatric Epidemiology*, 56(3), 497–512.
<https://doi.org/10.1007/s00127-020-01962-1>
- Kinderman, P., Read, J., Moncrieff, J., & Bentall, R. P. (2013). Drop the language of disorder. *Evidence Based Mental Health*, 16(1), 2–3.
<https://doi.org/10.1136/eb-2012-100987>
- Leeming, D., Lucock, M., Shibazaki, K., Pilkington, N., & Scott, B. (2022). The Impact of the COVID-19 Pandemic on Those Supported in the Community with Long-Term Mental Health Problems: A Qualitative Analysis of Power, Threat, Meaning and Survival. *Community Mental Health Journal*, 58(7), 1297–1309. <https://doi.org/10.1007/s10597-021-00932-4>
- Let's Talk Forensic Psychology (Director). (2021). *Let's Talk Power Threat Meaning Framework* [Youtube]. <https://www.youtube.com/watch?v=yqUMKNdK0-o>
- McWilliams, N. (2020). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process* (second edition). Guilford Press.
- Milligan, E. (2022). *Exploring Educational Psychologists' views and experiences of the Power Threat Meaning Framework* [Unpublished]. University of Essex.

- Mitchell, S., & Thorne, E. (2019). Developing trauma-informed care and adapted pathways using the Power Threat Meaning framework (Part 2: Being helped differently). *Clinical Psychology Forum Special Issue: Improving Services for Trauma-Related Dissociation*, 314, 30–33.
- Moncrieff, J. (2014). The Nature of Mental Disorder: Disease, Distress, or Personal Tendency? *Philosophy, Psychiatry, & Psychology*, 21(3), 257–260.
<https://doi.org/10.1353/ppp.2014.0028>
- Moncrieff, J., & Middleton, H. (2015). Schizophrenia: A critical psychiatry perspective. *Current Opinion in Psychiatry*, 28(3), 264–268.
<https://doi.org/10.1097/YCO.0000000000000151>
- Morgan, G., Barnwell, G., Johnstone, L., Shukla, K., & Mitchell, A. (2022). The Power Threat Meaning Framework and the climate and ecological crises. *Psychology In Society*, 63, 83–109.
- Newton, D., Lucock, M., Armitage, R., Monchuk, L., & Brown, P. (2022). Understanding the mental health impacts of poor quality private-rented housing during the UK's first COVID-19 lockdown. *Health & Place*, 78, 102898. <https://doi.org/10.1016/j.healthplace.2022.102898>
- NHS Long Term Plan. (2019). NHS Long Term Plan.
<https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/better-care-for-major-health-conditions/adult-mental-health-services/>

- Nikopaschos, F., Burrell, G., Holmes, S., Rhodes, N., & Boado, C. (2020). Trauma-Informed Approaches (TIA) Harrow Acute Mental Health Services: Using the Power Threat Meaning Framework to Develop a Trauma-Informed Approach to Adult Acute Inpatient Mental Health Care on Eastlake and Ferneley Wards, Northwick Park Hospital. *Central and North West London NHS Trust*, 1.
- Norcross, J. C., & Dryden, W. (1991). *A dialogue with John Norcross: Toward integration*. Open University Press.
- Norcross, J. C., & Karpiak, C. P. (2012). Clinical psychologists in the 2010s: 50 years of the APA division of clinical psychology. *Clinical Psychology: Science and Practice*, 19(1), 1–12. <https://doi.org/10.1111/j.1468-2850.2012.01269.x>
- O'Toole, C. (2019). Time to teach the politics of mental health: Implications of the Power Threat Meaning Framework for teacher education. *Clinical Psychology Forum Special Issue: Power Threat Meaning Framework*, 313, 15–19.
- Paradiso, J., & Quinlan, E. (2021). Mental Health Caregiver's Experiences From the Perspective of the Power Threat Meaning Framework. *Journal of Humanistic Psychology*, 002216782110417. <https://doi.org/10.1177/00221678211041789>
- Phillips, G., & Raskin, J. D. (2021). A primer for clinicians on alternatives to the Diagnostic and Statistical Manual of Mental Disorders. *Professional Psychology: Research and Practice*, 52(2), 91–103. <https://doi.org/10.1037/pro0000327>
- Pilgrim, D. (2010). British Clinical Psychology and Society. *Psychology Learning & Teaching*, 9(2), 8–12. <https://doi.org/10.2304/plat.2010.9.2.8>
- Pilgrim, D. (2020). *Critical realism for psychologists*. Routledge, an imprint of the Taylor & Francis Group.

- Pilgrim, D. (2022). A Critical Realist Reflection on the Power Threat Meaning Framework. *Journal of Constructivist Psychology*, 35(1), 83–95.
<https://doi.org/10.1080/10720537.2020.1773359>
- Pilgrim, D., & Cromby, J. (2020). Some philosophical roots of the Power Threat Meaning Framework. *Clinical Psychology Forum*, 327, 22–26.
- Priest, P. (2018, March). Committed to Change. *The Psychologist*, 16–17.
- Prochaska, J. O., & Norcross, J. C. (1983). Contemporary psychotherapists: A national survey of characteristics, practices, orientations, and attitudes. *Psychotherapy: Theory, Research & Practice*, 20(2), 161–173.
<https://doi.org/10.1037/h0088487>
- Ramsden, J. (2019). Editorial: The power threat meaning framework and forensic mental health settings. *Criminal Behaviour and Mental Health*, 29(3), 131–133. <https://doi.org/10.1002/cbm.2118>
- Ramsden, J., & Beckley, K. (2022). The Power Threat Meaning Framework: Implications for Practice within the Criminal Justice System. In G. C. Liell, L. F. Jones, & M. J. Fisher, *Challenging Bias in Forensic Psychological Assessment and Testing* (1st ed., pp. 213–227). Routledge.
<https://doi.org/10.4324/9781003230977-14>
- Randall, J., Johnson, E., & Johnstone, L. (2020). Self-formulation: Making sense of your own experiences. In *Surviving Clinical Psychology: Navigating Personal, Professional and Political Selves on the Journey to Qualification*. Routledge.
- Rapley, Moncrieff, J., & Dillon, J. (2011). *De-Medicalizing Misery: Psychiatry, Psychology and the Human Condition*. Palgrave Macmillan UK.
<http://ebookcentral.proquest.com/lib/ucl/detail.action?docID=797941>

- Raskin, J. D. (2019). What Might an Alternative to the DSM Suitable for Psychotherapists Look Like? *Journal of Humanistic Psychology*, 59(3), 368–375. <https://doi.org/10.1177/0022167818761919>
- Raskin, J. D., & Gayle, M. C. (2016). DSM-5: Do Psychologists Really Want an Alternative? *Journal of Humanistic Psychology*, 56(5), 439–456. <https://doi.org/10.1177/0022167815577897>
- Raskin, J. D., Maynard, D., & Gayle, M. C. (2022). Psychologist attitudes toward DSM-5 and its alternatives. *Professional Psychology: Research and Practice*. <https://doi.org/10.1037/pro0000480>
- Read, J., & Harper, D. (2022). The Power Threat Meaning Framework: Addressing Adversity, Challenging Prejudice and Stigma, and Transforming Services. *Journal of Constructivist Psychology*, 35(1), 54–67. <https://doi.org/10.1080/10720537.2020.1773356>
- Read, J., Haslam, N., Sayce, L., & Davies, E. (2006). Prejudice and schizophrenia: A review of the ‘mental illness is an illness like any other’ approach. *Acta Psychiatrica Scandinavica*, 114(5), 303–318. <https://doi.org/10.1111/j.1600-0447.2006.00824.x>
- Read, J., & Moncrieff, J. (2022). Depression: Why drugs and electricity are not the answer. *Psychological Medicine*, 52(8), 1401–1410. <https://doi.org/10.1017/S0033291721005031>
- Recovery in the Bin. (2016, February). Recovery in the Bin: A critical theorist and activist collective. *About*. <https://recoveryinthebin.org>

- Reis, M., Dinelli, S., & Elias, L. (2019). Surviving prison: Using the Power Threat Meaning Framework to explore the impact of long-term imprisonment. *Clinical Psychology Forum Special Issue: Power Threat Meaning Framework*, 313, 25–32.
- Rössler, W. (2016). The stigma of mental disorders: A millennia-long history of social exclusion and prejudices. *EMBO Reports*, 17(9), 1250–1253.
<https://doi.org/10.15252/embr.201643041>
- Salkovskis, P., & Edge, J. (2018, May). Power Threat Meaning Framework: Innovative and important? *The Mental Elf*.
<https://www.nationalelfservice.net/mental-health/power-threat-meaning-framework-innovative-and-important-ptmframework/>
- Schweitzer, R., Vromans, L., & Asic-Kobe, M. (2018). *A Best Practice Framework: Informing Settlement Services for Women-at-Risk from Refugee Backgrounds in Australia*. <https://eprints.qut.edu.au/125615/>
- Seery, C., Bramham, J., & O'Connor, C. (2021). Effects of a psychiatric diagnosis vs a clinical formulation on lay attitudes to people with psychosis. *Psychosis*, 13(4), 361–372. <https://doi.org/10.1080/17522439.2021.1901302>
- SHIFT Recovery Community. (2022). Using the Power Threat Meaning Framework in a Self-Help Group of People with Experience of Mental and Emotional Distress. *Journal of Constructivist Psychology*, 35(1), 7–15.
<https://doi.org/10.1080/10720537.2020.1773361>
- Skelly, A., & Shirley, L. (2022). What are clinical psychologists doing to create a trauma informed psychology central to our practice? A call for clear policy direction from the DCP. *Clinical Psychology Forum Special Issue: Trauma Informed Care in Clinical Psychology*, 350, 8–11.

- Smith, J. A., Flowers, P., & Larkin, M. (2022). *Interpretative phenomenological analysis: Theory, method and research* (2nd edition). SAGE.
- Sowers, W., Ranz, J. M., Group for the Advancement of Psychiatry, & American Psychiatric Association Publishing (Eds.). (2021). *Seeking value: Balancing cost and quality in psychiatric care* (First edition). American Psychiatric Association Publishing.
- Strong, T. (2019). Brief Report: A Counselling-Friendly Alternative to the DSM-5? A Review of The Power Threat Meaning Framework. *Canadian Journal of Counselling and Psychotherapy*, 53(3), 296–302.
- Stupak, R., & Dobroczyński, B. (2021). From Mental Health Industry to Humane Care. Suggestions for an Alternative Systemic Approach to Distress. *International Journal of Environmental Research and Public Health*, 18(12), 6625. <https://doi.org/10.3390/ijerph18126625>
- Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: What is it and how can we further its development? *Mental Health Review Journal*, 21(3), 174–192. <https://doi.org/10.1108/MHRJ-01-2015-0006>
- Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: Relationships in trauma-informed mental health services. *BJPsych Advances*, 24(5), 319–333. <https://doi.org/10.1192/bja.2018.29>
- Sweeney, A., & Taggart, D. (2018). (Mis)understanding trauma-informed approaches in mental health. *Journal of Mental Health*, 27(5), 383–387. <https://doi.org/10.1080/09638237.2018.1520973>
- The BPS. (2022). *DCP Statement on the Power, Threat, Meaning Framework*. <https://www.bps.org.uk/news/dcp-statement-power-threat-meaning-framework>

- Thirkle, S., Sice, P., & Kennedy, A. (2021). Instruments for Exploring Trauma-Informed Care. *Journal of Health and Human Services Administration*, 30–44. <https://doi.org/10.37808/jhhsa.44.1.2>
- UN General Assembly. (2017). *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. (pp. 5–6). United Nations Human Rights Council. <http://www.ohchr.org/EN/Issues/Health/Pages/SRRightHealthIndex.aspx>
- Watson, M., Stroud, L., & Barnwell, G. (2020). Critical reflections from South Africa: Using the Power Threat Meaning Framework to place climate-related distress in its socio-political context. *Clinical Psychology Forum Special Issue: Psychology and the Climate and Environmental Crisis*, 332, 7–15.
- Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed). McGraw-Hill Open University Press.
- Willmot, P., & Evershed, S. (2018). Interviewing people given a diagnosis of personality disorder in forensic settings. *International Journal of Forensic Mental Health*, 17(4), 338–350. <https://doi.org/10.1080/14999013.2018.1508097>
- Willmot, P., & Siddall, Y. (2022). Trauma, Violence, and Gender. In P. Willmot & L. Jones, *Trauma-Informed Forensic Practice* (1st ed., pp. 32–48). Routledge. <https://doi.org/10.4324/9781003120766-4>

6. APPENDICES

Appendix A: Coded Excerpt Example Scan

Mmm, yeah. And I was wondering if you have a sense of what has helped to kind of facilitate the frameworks use in your clinical work, kind of contextually, if it's kind of the context of the work or and the values of other people that you work with or? In what way did you kind of manage to start using it?

Support

Active, conscious, hard work.

7/17, NHS long term. context of change!

work in system

Change process slow, gentle

PTMF

Embed, expand.

Staff + colleague willingness

I see it as an alternative to diagnosis. I don't think you need a formulation and a diagnosis to sit together, but we work with in a specific context in a multidisciplinary way, within a very established system and actually from my experience you don't make change by going and having big political fights with people and trying to take them down. So I think it's a round sort of slowly and sensitively coming alongside and providing an alternative in not directly challenging but you provide an alternative where maybe some of the other is less needed, I don't know.

Thoughtful Change process

dominant system of medical

Umm, yeah, that's yeah, absolutely. And I just wanted to check as well when you were saying that you kind of had allies and there were a group of you who were kind of going quite above

9

Appendix B: List of Initial Codes

Initial Codes

Integrative Approach	Developing Staff Training
Identities: Therapist, Supervisor, Manager	Psychology Group
Supervisors Influence	Formulation Tool
Interest in Service Development	Informs Supervision
Change process	One to one
Conscious process	Team Formulation
Staff Willingness	Network Family Meetings
Context of Support	MDT
Medical Model	Acknowledges Social Context
Dominance of Medical Model	Political action
Trauma Informed Approaches	Normalising
Long Term Plan	Validating
Revolutionary	Staff need support
Ideological Power	On-going work
Permission	Organisational Barriers
Concept of Power as New	Alternative
Reframing	Understanding
Refocusing Responsibilities	Embedding
Recognition	Translates into Intervention
Informing Thinking	Making Connections
Legitimising	Collaborative
Officiating existing values	Broadening Focus
Making the implicit explicit	Helpful Theoretically
Aligns with personal values	Usable
Shared values with colleagues	Inaccessible language
Teams Ethos	Unique
Personal Adaptions/Adaptable	NICE Guidelines
Accessibility	Own limitations
Common Language	Overwhelmed
For everyone	Wider Context of Change
Compatibility with other approaches	Beyond the individual
Positive responses of staff and clients	Stuckness
New Opportunities	Non-pathologising
Co-production	Reject medical model
Structure and Guidance	Individual responsibility narrative
Time poor	Informing all work
Workload	
Confusing	
Lack of confidence	
Ideologically challenging	
Hard work	

Leadership
Slow and Gentle process
Reluctance
Nurturing relationships for change
Co-production rarity
Clinical Identity
Psychologically Informed
Desire for change
Theoretical Development in the field
Sense making
Versatility
Positive Impact
Variety
Perpetuate Imbalances
Professional Power
Changed Practice
New Conversations
Facilitates Change
Unmysterious
Thoughtful
NHS Long-Term Plan
Expanding
Usefulness
Clinical Application
Inequality
Shifts Thinking
Change outside of the person
Political Tool
PTMF's limitations
Lacks interpersonal lens
Unreflective Teams
Staff/Organisations Threat Responses
Staff's Own Power
Contributes to Service Development
Dilemma for staff
PTMF as a clinical tool
Seeing it used by others
Resistance
Hopeful
Additions/Supplements to PTMF
Challenges with current system
Clinical Judgement
Optional/Voluntary
Powerful professional positions

Appendix C: Example Code with Associated Excerpts

<p>Aligns with personal values</p>	<p>Participant 1 - One of the things that drew me to working for [this homelessness charity] is because it is an organization that recognizes the social causes of someone's difficulties and I was getting a little bit jaded with the NHS kind of placing a problem within a person. So [our service] explicitly doesn't do that and you know, researchers what change we might need within society and lobbies the government for welfare change, for example.</p> <p>Participant 1 - I think for me it was time to move on and very much for me the power threat meaning framework fits with my values around being able to think about somebody's difficulties, their experiences and their distress in a much more kind of normalized empowering way.</p> <p>Participant 1 - I do like that it has a political basis in terms of setting itself up as an alternative framework and you know [the authors] aren't shy about speaking up about the downsides of the medical model. So I like that and I like the way that it was, well I wasn't there, but the way it was co-produced.</p> <p>Participant 2 - when power threat meaning came out it kind of sort of as a model readily made sense to me and. And you know, I guess I could kind of see the potential application of that.</p> <p>Participant 2 – for me the power threat meaning does accord with my values and ideas</p> <p>Participant 5 – I think I'm probably just quite naturally sympathetic to it.</p> <p>Participant 6 - it kind of it makes complete sense to me.</p> <p>Participant 8 - is incredibly powerful. It's one of, you know, my favourite bits of the job being able to bring in the power threat meaning framework.</p> <p>Participant 8 - It feels like an I can actually bring in my personal values and use it as a tool, as a psychologist or as a therapist. That just feels very like aligned. I feel like I can work in line with my own values and help other people to sort of be - I feel authentic and I think it helps other people to be authentic. And I think you can create this quite amazing therapeutic opportunity by doing that with somebody.</p> <p>Participant 9 - I first learned about the PTMF early on in training kind of learned more about it just completely aligned with you know the way I the way I view things from the kind of psychologists that I want to be</p> <p>Participant 9 - So when the PTMF came along, it felt like here was finally this thing that really aligned with my values.</p>
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Appendix D: Initial Theme Development

Code Clusters	Possible Theme 1
Revolutionary Inequality Concept of power as new Unique Legitimised + Officiated Existing Values Permission Refocusing responsibilities/ Reframing Recognition New Interventions Team Ethos Permission Helpful Theoretically	Ideological Shift

Code Clusters	Possible Theme 2
Team Formulations Coproduction Staff Trainings Informs thinking, clinical work and service developments Psychology Group One to one Family and Network Meetings Personal Adaptions/Adaptability	Clinical Versatility

Code Clusters	Possible Theme 3
Accessibility For everyone - not just Psychologists Compatibility with other approaches Positive responses of staff & clients Opportunities Co-productions and collaborative Structure Guidance Clinical Tool PTMF'S Limitations Common Language	Clinical Utility

Code Clusters	Possible Theme 4
Time poor Workloads Confusing Overwhelm Lack of confidence Threat responses of staff Ideologically challenging – out of control, not individual responsibility Resistance Reluctance	Barriers and Challenges

Code Clusters	Possible Theme 5
Hard work Conscious effort Powerful, leadership positions Slow, gentle change process Staff Willingness Reluctance, change fatigue TIA Long Term Plan Voluntary/Optional	Change Process

Appendix E: Refining and Defining Themes

Theme 1	Code Clusters
<p>Supporting Conceptual Change Theme 1 is what is the PTMF bringing as a framework, what's different about it, changes it led at a conceptual level</p>	<p>Concept of power – new Unique Reframing Making Connections Refocusing responsibilities/Recognition Revolutionary conceptually Helpful Theoretically</p>
<p>Sub-Theme: Moral Values (Combine with the below sub-theme)</p> <p>Not just conceptual change also about moral values, working in line with people's existing values.</p>	<p>Aligns with personal values Team Ethos Permission</p>
<p>Sub-Theme: Making Implicit Practice Explicit</p> <p>Acknowledging staff's values but also legitimising implicit practice and giving it a vocabulary</p>	<p>Structure Guidance Legitimised + Officiated Existing Values Permission</p>

Theme 2 (Combines initial themes 2 + 3)	Code Clusters
<p>The Clinical Usefulness of the Framework</p>	<p>Positive responses of staff & clients Facilitate co-production work New Opportunities</p>
<p>Sub-Theme: Accessibility Created opportunities for new interventions – giving away psychology to all staff.</p>	<p>Accessible Common Language Compatible with other approaches, a way to think across theoretical approaches</p>
<p>Sub-Theme: Limits to Usefulness Limitations which require adaptations.</p>	<p>Inaccessible language Length of Document Lack of Confidence Lacks interpersonal lens PTMF's limitations</p>

<p>Sub-Theme: Versatility and Adaptability What are the ways in which it's been applied directly and indirectly to clinical work and adapted to different clinical settings, needs, demographics.</p>	<p>Clinical tool Team Formulation Psychology Group One-to-one Family and Network Meetings Coproduced Staff Trainings Informs thinking, clinical work and service developments</p>
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Theme 3 (combines initial themes 4 + 5)	Code Clusters
<p>Facilitation of Institutional Change</p> <p>Theme 3 is about the process of institutional change, trauma informed care to change service philosophies, not focused on PTMF itself broadly.</p>	
<p>Sub-Theme: General Factors Inhibiting Change</p>	<p>Time poor Workloads Resistance Reluctance Overwhelmed Dominance of medical model</p>
<p>Sub-Theme: PTMF Specific Factors Inhibiting Change</p>	<p>Confusing Lack of confidence Threat responses of staff Ideologically challenging Individual responsibility dominant narrative</p>
<p>Sub-Theme: Factors Facilitating Institutional Change</p>	<p>Hard work Conscious effort TIA Long Term Plan Powerful, leadership positions Staff Willingness Slow Gentle Change Process</p>

Appendix F: Interview Schedule

Remind the participant about confidentiality, right to withdraw. Ask whether they have any Qs before starting the interview.

To find out a bit more about you, context for the data.

Demographics: Age, Gender identity, Ethnicity, Qualification Length, Service Context, Speciality, Seniority?

Questions

1. What are the main theoretical models you draw on in your work? (CBT, Systemic, Integrative)
2. How would you describe your identity as a CP, Clinician, Researcher, Supervisor, Manager, Consultant?
3. Do you do you think where you where you studied had an impact on your theoretical background and or was it more something that took shape after you qualified?
4. How did you first hear about the PTMF?
5. What is your understanding of the PTMF?
6. How do you use the PTMF in your clinical work? (Directly or Indirectly - with SU, Groups, Formulation, Team Form, Service design, Supervision, Staff training)
7. Why do you use the PTMF? What are its contributions to your practice?
8. What are its strengths?
9. What are its limitations?
10. What has facilitated its use in your practice? (contextually) How did you start using it?
11. What factors may have hinder its use in your practice?
12. Are there any other ways beyond what we've discuss, in which you think the PTMF could be improved?

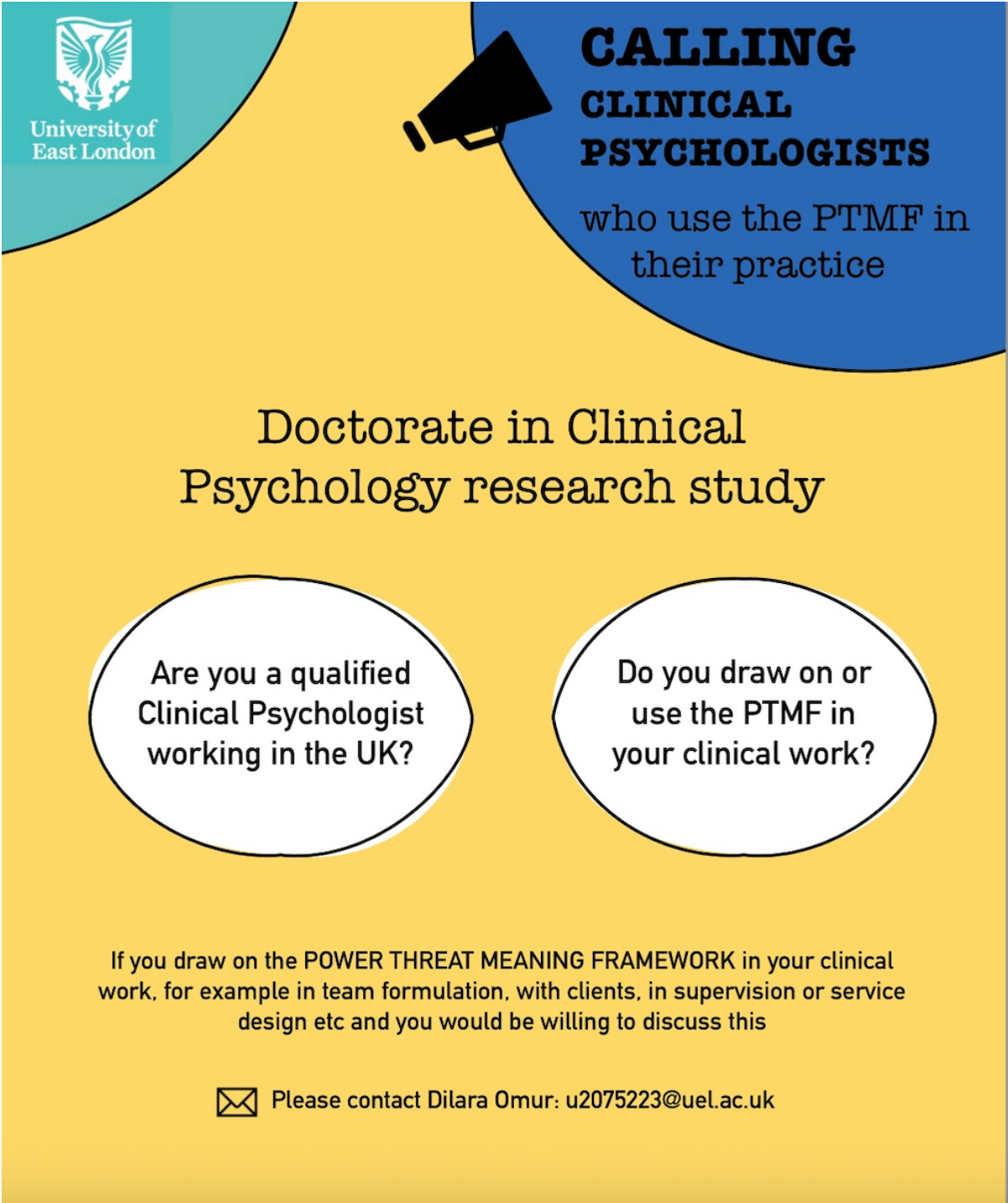
Anything else they would like to tell me about the PTMF or its use that I haven't asked?


Prompts: Could you give me an example of that, could you tell me more about that


Debrief

Thank for contribution. Remind them that they are able to speak to the researcher or supervisor if they have any Qs/concerns

Appendix G: Research Recruitment Poster




University of
East London




**CALLING
CLINICAL
PSYCHOLOGISTS**
who use the PTMF¹ in
their practice

Doctorate in Clinical
Psychology research study

Are you a qualified
Clinical Psychologist
working in the UK?

Do you draw on or
use the PTMF in
your clinical work?

If you draw on the POWER THREAT MEANING FRAMEWORK in your clinical work, for example in team formulation, with clients, in supervision or service design etc and you would be willing to discuss this

 Please contact Dilara Omur: u2075223@uel.ac.uk

Appendix H: Consent Form



CONSENT TO PARTICIPATE IN A RESEARCH STUDY

How is the Power Threat Meaning Framework being used by Clinical Psychologists in Clinical Practice?

Contact person: Dilara Omur

Email: u2075223@uel.ac.uk

	Please Initial
I confirm that I have read the participant information sheet dated for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that the interview will be recorded using MS Teams video recording.	
I understand that my personal information and data, including video recordings will be securely stored and remain confidential. Only the researcher will have access to personally identifiable information, including video recordings. The research team and examiners will only have access to anonymised transcripts.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview may be used in a thesis which will be available online, as well as material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name

.....

Researcher's Signature

.....

Date

.....

Appendix I: Information Sheet

Invitation to Participate in a Study

How is the Power Threat Meaning Framework being used by Clinical Psychologists in Clinical Practice?



What is the study about?

The aim of the study is to explore the different ways in which UK Clinical Psychologists are using the Power Threat Meaning Framework in their clinical practice.

We are also interested in the theoretical backgrounds of Psychologists who are using the PTMF and factors that may be facilitating or hindering the frameworks use in clinical contexts.

Who am I?

I am a Clinical Psychologist Trainee at the University of East London, studying for a Doctorate in Clinical Psychology. As part of my studies, I am conducting the research you are being invited to participate in.

Why have you been asked to participate?

You have been invited to participate as you fit the criteria of being a qualified Clinical Psychologist who practices in the UK and uses or draws on the Power Threat Meaning Framework in their work. This may involve using the Power Threat Meaning Framework in several ways, for instance in team formulations, with clients directly, to inform supervision, in staff training or in service design and delivery.

What will participation involve?

- If you choose to take part, you will be invited to discuss your understanding of and work with the Power Threat Meaning Framework in your clinical practice.
- Individual interviews will be facilitated by the researcher remotely via MS Teams at a time that suits you. The approximate time available to conduct the interview will be agreed at the start, but is likely be between 30-60 minutes.
- Your participation would be valuable in helping to develop knowledge and understanding of the research topic.

Are there any risks?

- There are no anticipated risks to taking part in the proposed study. It is unlikely but possible there might be some discomfort.
- In the unlikely event that I am worried about your safety or the safety of someone else, it is my responsibility to tell someone who may be able to help or who may need to know. I will discuss this with you first, if possible.

How will the information I provide be kept secure and confidential?

- Interviews will be recorded on MS Teams and auto-transcribed.
- You will be given a pseudonym and identifiable information will be anonymized in the transcripts. Anonymized quotations from the interviews will be used in the write up of the research.
- The anonymized transcripts may be read by the research supervisor at the University of East London and examiners assessing the thesis.

- A list of names and contact details will be stored, on a password protected folder, separately from the video recordings and transcripts.
- The recording and transcript will be saved on a computer that is password protected. After examination, recordings will be deleted. The transcripts will be kept for five years and may be used for additional articles or publications based on the research.
- The data gathered for this study will be retained in accordance with the University's Data Protection Policy.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

Do I have to take part and can I withdraw?

- You do not have to take part in this study, and should not feel under any obligation to. If you decide to participate you are free to withdraw your participation without providing a reason.
- After the interview has taken place, you may also request to withdraw all or part of your data from the study, provided that this request is made within 3 weeks of the data being collected. After this point analysis will have begun and it will not be possible to withdraw data though any extracts used will be anonymised.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g. academics, clinicians, public, etc.) through journal articles, conference presentations and talks. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Professor David Harper for a maximum of 5 years, following which all data will be deleted.

Who has reviewed the research?

My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?

If you would like further information or have any questions or concerns, please do not hesitate to contact me:

Dilara Omur: u2075223@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Professor David Harper School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: D.Harper@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology,
University of East London, Water Lane, London E15 4LZ.
Email: t.patel@uel.ac.uk

Thank you for taking the time to read this information sheet

Appendix J: Participant Debrief Sheet

PARTICIPANT DEBRIEF SHEET

How is the Power Threat Meaning Framework being used by Clinical Psychologists in Clinical Practice?

Thank you for participating in the research study on how the Power Threat Meaning Framework is being used by Psychologists in practice. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations and talks. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally, personally identifying information will either be removed or replaced.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Professor David Harper for a maximum of 5 years, following which all data will be deleted.

What if I been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation may have been challenging, distressing or uncomfortable in some way.

If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

You may wish to speak to your line manager, supervisor or Occupational Health Department. You may also find the following resources/services helpful in relation to obtaining information and support:

The Samaritans

Telephone number: 116 123

Website: <https://www.samaritans.org/how-we-can-help/contact-samaritan/>

Email Address: jo@samaritans.org

You are also welcome to contact me or my supervisor if you have specific questions or concerns.

Who can I contact if I have any questions or concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Dilara Omur: u2075223@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Professor David Harper School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: D.Harper@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology,
University of East London, Water Lane, London E15 4LZ.
Email: t.patel@uel.ac.uk

Thank you for taking part in the study



UNIVERSITY OF EAST LONDON
School of Psychology

**APPLICATION FOR RESEARCH ETHICS APPROVAL
FOR RESEARCH INVOLVING HUMAN PARTICIPANTS
(Updated October 2021)**

**FOR BSc RESEARCH;
MSc/MA RESEARCH;
PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING &
EDUCATIONAL PSYCHOLOGY**

**Section 1 – Guidance on Completing the Application Form
(please read carefully)**

1.1	Before completing this application, please familiarise yourself with: <ul style="list-style-type: none">▪ British Psychological Society's Code of Ethics and Conduct▪ UEL's Code of Practice for Research Ethics▪ UEL's Research Data Management Policy▪ UEL's Data Backup Policy
1.2	Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback.
1.3	When your application demonstrates a sound ethical protocol, your supervisor will submit it for review.
1.4	Your supervisor will let you know the outcome of your application. Recruitment and data collection must NOT commence until your ethics application has been approved, along with other approvals that may be necessary (see section 7).
1.5	Research in the NHS: <ul style="list-style-type: none">▪ If your research involves patients or service users of the NHS, their relatives or carers, as well as those in receipt of services provided under contract to the NHS, you will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance.▪ Useful websites: https://www.myresearchproject.org.uk/Signin.aspx https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/

	<ul style="list-style-type: none"> ▪ If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required. ▪ HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example. ▪ The School strongly discourages BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
1.6	<p>If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for completing the online form is provided on the GBG website: https://fadv.onlinedisclosures.co.uk/Authentication/Login</p> <p>You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service</p>
1.7	<p>Checklist, the following attachments should be included if appropriate:</p> <ul style="list-style-type: none"> ▪ Study advertisement ▪ Participant Information Sheet (PIS) ▪ Participant Consent Form ▪ Participant Debrief Sheet ▪ Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5) ▪ Permission from an external organisation (see section 7) ▪ Original and/or pre-existing questionnaire(s) and test(s) you intend to use ▪ Interview guide for qualitative studies ▪ Visual material(s) you intend showing participants

Section 2 – Your Details

2.1	Your name:	Dilara Omur
2.2	Your supervisor's name:	David Harper
2.3	Name(s) of additional UEL supervisors:	Matthew Jones Chester 3rd supervisor (if applicable)
2.4	Title of your programme:	Professional Doctorate in Clinical Psychology
2.5	UEL assignment submission date:	03/2022 Re-sit date (if applicable)

Section 3 – Project Details

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and purpose of your research.

3.1	Study title: <u>Please note</u> - If your study requires registration, the title inserted here must be <u>the same</u> as that on PhD Manager	How is the Power Threat Meaning Framework being used by Clinical Psychologists in Clinical Practice?
3.2	Summary of study background and aims (using lay language):	The Power Threat Meaning Framework (PTMF) was published in 2018 as an alternative to psychiatric diagnosis, a way of conceptualising psychological distress through a contextual framework. This study seeks to explore how the PTMF is being used by Clinical Psychologists in clinical practice, and what factors may be facilitating or hindering its use.
3.3	Research question(s):	1. How is the PTMF being used by Clinical Psychologists? 2. What contextual factors facilitate and hinder its use?
3.4	Research design:	Qualitative
3.5	Participants: Include all relevant information including inclusion and exclusion criteria	8-12 UK Clinical Psychologists working clinically with the PTMF will be sought.
3.6	Recruitment strategy: Provide as much detail as possible and include a backup plan if relevant	Purposive and snowball sampling may be used, professionals engaging with the PTMF clinically known to the researcher and supervisor may be contacted and invited to take part. Social media including the Clinical Psychology Facebook group and the Twitter psychology network will be utilised
3.7	Measures, materials or equipment: Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	A personal laptop
3.8	Data collection: Provide information on how data will be collected from the point of consent to debrief	The study would involve individual semi-structured interviews with 8-12 UK Clinical Psychologist's via video conferencing site MS Teams, which will be recorded and auto-transcribed.

3.9	Will you be engaging in deception?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
	If yes, what will participants be told about the nature of the research, and how/when will you inform them about its real nature?	If you selected yes, please provide more information here	
3.10	Will participants be reimbursed?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
	If yes, please detail why it is necessary.	If you selected yes, please provide more information here	
	How much will you offer? <u>Please note</u> - This must be in the form of vouchers, <u>not cash</u> .	Please state the value of vouchers	
3.11	Data analysis:	Transcripts from the MS Teams video recordings will be analysed using Thematic Analysis by the researcher, and possibly NVivo analysis software.	

Section 4 – Confidentiality, Security and Data Retention

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here.

4.1	Will the participants be anonymised at source?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
	If yes, please provide details of how the data will be anonymised.	Please detail how data will be anonymised	
4.2	Are participants' responses anonymised or are an anonymised sample?	YES X	NO <input type="checkbox"/>
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	Participants will be given a pseudonym and identifiable information will be anonymized in the transcripts. Video recordings will be destroyed following transcription. Anonymized quotations from the transcripts will be used in the write up of the research.	
4.3	How will you ensure participant details will be kept confidential?	A list of participants names and contact details will be stored, on a password protected device, separately from the anonymised transcripts.	

4.4	How will data be securely stored and backed up during the research? Please include details of how you will manage access, sharing and security	Video files and transcriptions will be stored on separate password protected folders which will only be accessible to the researcher on UEL OneDrive for business as encrypted .docx files.	
4.5	Who will have access to the data and in what form? (e.g., raw data, anonymised data)	Only the researcher and researcher supervisor will have access to raw and anonymised data.	
4.6	Which data are of long-term value and will be retained? (e.g., anonymised interview transcripts, anonymised databases)	Anonymised interview transcripts will be held by the researcher supervisor following completion of the thesis for five years before being destroyed.	
4.7	What is the long-term retention plan for this data?	Anonymised interview transcripts will be held by the researcher supervisor following completion of the thesis for five years before being destroyed.	
4.8	Will anonymised data be made available for use in future research by other researchers?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
	If yes, have participants been informed of this?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
4.9	Will personal contact details be retained to contact participants in the future for other research studies?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
	If yes, have participants been informed of this?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Section 5 – Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g., a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

5.1	Are there any potential physical or psychological risks to participants related to taking part? (e.g., potential adverse effects, pain, discomfort, emotional distress, intrusion, etc.)	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
	If yes, what are these, and how will they be minimised?	A low risk of discomfort.	

		The researcher will actively monitor the situation, has skills in emotion support and may terminate interviews prematurely or suggest a break as needed.		
5.2	Are there any potential physical or psychological risks to you as a researcher?	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	
	If yes, what are these, and how will they be minimised?	There is a low risk of verbal abuse or discomfort. The researcher will actively monitor the situation, has skills in emotion support and may terminate interviews prematurely or suggest a break as needed.		
5.3	If you answered yes to either 5.1 and/or 5.2, you will need to complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a GRA form as an appendix:	YES <input checked="" type="checkbox"/>		
5.4	If necessary, have appropriate support services been identified in material provided to participants?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
5.5	Does the research take place outside the UEL campus?	YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>
	If yes, where?	Please enter details about the location of the research		
5.6	Does the research take place outside the UK?	YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>
	If yes, where?	Please state the country and other relevant details		
	If yes, in addition to the General Risk Assessment form, a Country-Specific Risk Assessment form must also be completed and included (available in the Ethics folder in the Psychology Noticeboard). Please confirm a Country-Specific Risk Assessment form has been attached as an appendix.	YES <input type="checkbox"/>		

	<p>Please note - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants.</p>	
5.7	<p>Additional guidance:</p> <ul style="list-style-type: none"> ▪ For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance. ▪ For on campus students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Director of Impact and Innovation, Professor Ian Tucker (who may escalate it up to the Vice Chancellor). ▪ For distance learning students conducting research abroad in the country where they currently reside, a risk assessment must also be carried out. To minimise risk, it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, it must be signed by the Director of Impact and Innovation (or potentially the Vice Chancellor). ▪ Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree. 	

Section 6 – Disclosure and Barring Service (DBS) Clearance

6.1	<p>Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?</p> <p>If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project</p>	<p>YES</p> <p><input type="checkbox"/></p>	<p>NO</p> <p><input checked="" type="checkbox"/></p>
<p>* You are required to have DBS or equivalent clearance if your participant group involves:</p> <p>(1) Children and young people who are 16 years of age or under, or</p> <p>(2) 'Vulnerable' people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care,</p>			

	<p>living in institutions or sheltered accommodation, or involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak with your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible.</p>		
6.2	<p>Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?</p>	<p>YES <input type="checkbox"/></p>	<p>NO <input type="checkbox"/></p>
6.3	<p>Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the duration of the research project?</p>	<p>YES <input type="checkbox"/></p>	<p>NO <input type="checkbox"/></p>
6.4	<p>If you have current DBS clearance, please provide your DBS certificate number:</p>	<p>Please enter your DBS certificate number</p>	
	<p>If residing outside of the UK, please detail the type of clearance and/or provide certificate number.</p>	<p>Please provide details of the type of clearance, including any identification information such as a certificate number</p>	
6.5	<p>Additional guidance:</p> <ul style="list-style-type: none"> ▪ If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian). ▪ For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language. 		

Section 7 – Other Permissions

7.1	<p>Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?</p>	<p>YES <input type="checkbox"/></p>	<p>NO <input checked="" type="checkbox"/></p>
	<p>If yes, please provide their details.</p>	<p>Please provide details of organisation</p>	
	<p>If yes, written permission is needed from such organisations (i.e., if they are helping you with</p>	<p>YES <input type="checkbox"/></p>	

	recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation). Please confirm that you have attached written permission as an appendix.	
7.2	<p><u>Additional guidance:</u></p> <ul style="list-style-type: none"> Before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application or approval letter. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as ‘my’ or ‘I’ with ‘our organisation’ or with the title of the organisation. This organisational consent form must be signed before the research can commence. If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s. 	

Section 8 – Declarations		
8.1	Declaration by student. I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor:	YES <input checked="" type="checkbox"/>
8.2	Student's name: (Typed name acts as a signature)	Dilara Omur
8.3	Student's number:	U2075223
8.4	Date:	17/01/2022
<i>Supervisor's declaration of support is given upon their electronic submission of the application</i>		

Student checklist for appendices – for student use only

Documents attached to ethics application	YES	N/A
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Study advertisement	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Participant Information Sheet (PIS)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Consent Form	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Participant Debrief Sheet	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Risk Assessment Form	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Country-Specific Risk Assessment Form	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Permission(s) from an external organisation(s)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Pre-existing questionnaires that will be administered	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Researcher developed questionnaires/questions that will be administered	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Pre-existing tests that will be administered	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Researcher developed tests that will be administered	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Interview guide for qualitative studies	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Any other visual material(s) that will be administered	<input type="checkbox"/>	<input checked="" type="checkbox"/>
All suggested text in RED has been removed from the appendices	<input checked="" type="checkbox"/>	<input type="checkbox"/>
All guidance boxes have been removed from the appendices	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Student checklist for Participant Information Sheet (PIS) – *for student use only*

Information to include in PIS	TICK
Study title	<input checked="" type="checkbox"/>
Who you are	<input checked="" type="checkbox"/>
Purpose of research, including any advantages to taking part	<input checked="" type="checkbox"/>
Inclusion/exclusion criteria	<input checked="" type="checkbox"/>
What participation will involve: location, duration, tasks, etc.	<input checked="" type="checkbox"/>
Right to withdraw participation: withdraw involvement at any point without the need to provide a reason or negative consequences	<input checked="" type="checkbox"/>

Right to withdraw data: a time specified to do this within (typically a three-week window)	<input checked="" type="checkbox"/>
Participation is voluntary	<input checked="" type="checkbox"/>
Potential risks to taking part (pain, discomfort, emotional distress, intrusion)	<input checked="" type="checkbox"/>
Attempts to minimise risks	<input checked="" type="checkbox"/>
Contact information of supporting agencies/relevant organisations	<input checked="" type="checkbox"/>
How data will be kept confidential	<input checked="" type="checkbox"/>
When confidentiality might be broken	<input checked="" type="checkbox"/>
How data will be managed by UEL	<input checked="" type="checkbox"/>
How data will be securely stored (e.g., where, who will have access, etc.)	<input checked="" type="checkbox"/>
How long data will be retained for, where and by whom	<input checked="" type="checkbox"/>
Dissemination activities	<input checked="" type="checkbox"/>
Clearly communicated that participants will not be identifiable in any material produced for dissemination purposes	<input checked="" type="checkbox"/>
Your name and UEL email address	<input checked="" type="checkbox"/>
Your supervisor's name and UEL email address	<input checked="" type="checkbox"/>
The Chair of the SREC's name and UEL email address	<input checked="" type="checkbox"/>

Appendix K: UEL Ethics Approval Letter

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in **blue** | **Student:** Please complete/read sections in **orange**

Details

Reviewer:	Tom MacKay
Supervisor:	David Harper
Student:	Dilara Omur
Course:	Prof Doc Clinical Psychology
Title of proposed study:	Please type title of proposed study

Checklist

(Optional)

	YES	NO	N/A
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Detailed account of participants, including inclusion and exclusion criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concerns regarding participants/target sample	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Detailed account of recruitment strategy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concerns regarding recruitment strategy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clear and detailed outline of data collection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Data collection appropriate for target sample	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concerns regarding data storage (e.g., location, type of data, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concerns regarding data sharing (e.g., who will have access and how)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If required, General Risk Assessment form attached	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If required, Country-Specific Risk Assessment form attached	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If required, a DBS or equivalent certificate number/information provided	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All relevant information included in the participant information sheet (PIS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information in the PIS is study specific	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language used in the PIS is appropriate for the target audience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All issues specific to the study are covered in the consent form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language used in the consent form is appropriate for the target audience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All necessary information included in the participant debrief sheet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language used in the debrief sheet is appropriate for the target audience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Study advertisement included	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Decision options

APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES	<p>In this circumstance, the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records.</p> <p>Minor amendments guidance: typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.</p>
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	<p>In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.</p> <p>Major amendments guidance: typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the</p>

	project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.
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Decision on the above-named proposed research study

Please indicate the decision:	APPROVED
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Minor amendments

Please clearly detail the amendments the student is required to make

Major amendments

Please clearly detail the amendments the student is required to make

Assessment of risk to researcher

Has an adequate risk assessment been offered in the application form?	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
	If no, please request resubmission with an <u>adequate risk assessment</u> .	

If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:

HIGH	Please do not approve a high-risk application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	<input type="checkbox"/>
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MEDIUM	Approve but include appropriate recommendations in the below box.	<input type="checkbox"/>
LOW	Approve and if necessary, include any recommendations in the below box.	<input type="checkbox"/>
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature

Reviewer: (Typed name to act as signature)	Tom MacKay
Date:	08/06/2022

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee

RESEARCHER PLEASE NOTE

For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

Confirmation of minor amendments

(Student to complete)

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data

Student name: (Typed name to act as signature)	Please type your full name
Student number:	Please type your student number
Date:	Click or tap to enter a date

Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required