Trauma-Informed Practice in Schools: Perceptions of School Staff

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ABSTRACT

Background: The concept of 'trauma-informed practice' (TIP) has developed over the last twenty years. Recently, TIP has been applied to schools in acknowledging the widespread nature of trauma and preventing impacts on education, and mental health and wellbeing more broadly. 'Trauma-informed schools' are increasingly prevalent in the USA and are beginning to emerge in the UK. Preliminary research suggests positive results however research exploring school staff perspectives is lacking. This is important in informing the development of this approach.

Aims: This research explores school staff perceptions on the impact of trauma and TIP in UK schools. It aims to present perceptions of trauma and TIP, to explore experiences of responding to trauma and identify any barriers and areas for development.

Method: Semi-structured interviews took place with thirteen school staff members working in a variety of roles, across a range of schools. Interviews were analysed using Thematic Analysis.

Results: Thematic Analysis generated three themes: 'Theory to practice: challenges defining trauma and TIP'; 'Practice to theory: current response to trauma in schools'; 'The influence of the wider context'. Eight subthemes were also generated.

Conclusions: Although staff are largely unfamiliar with TIP and internalise a lack of expertise in the absence of training or guidelines, their individual practice is consistent with TIP. Indeed, findings suggest the barriers to a whole-school approach lie in the wider context. Implications highlight the need for an education paradigm shift towards prioritising wellbeing, and for greater funding and resource in schools and other public services, enabling a systemic approach. With greater resource and capacity, findings suggest TIP may be an acceptable and meaningful framework to embed in schools. This should involve strategic investment, whole-school policy and training, staff support, and community involvement. The Covid-19 pandemic has both increased barriers and provided hope for a systemic shift.

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1. INTRODUCTION

1.1. Chapter Overview

This chapter provides an overview of the dominant psychological models used to conceptualise responses to childhood trauma. Prevalence of childhood trauma and what is known about the impact is then discussed. Within this, there is consideration of the role that social inequalities play in terms of prevalence and impact. The dominant approaches in terms of intervention for childhood trauma are reviewed. Within this, there is critique of the dominant, medical approach. Non-diagnostic approaches are introduced, alongside the concept of 'trauma-informed practice' (TIP). This chapter then discusses the move towards early intervention in the context of recent government policy and the emergence of a trauma-informed (TI) approach to education. The chapter then provides an overview of the current status of research in this field, and the available literature on perspectives of school staff on TI practice in schools is reviewed. The chapter concludes with the rationale for the current study and the study aims.

1.2. Introduction to Childhood Trauma

In this thesis, the word 'trauma' is used to refer to the experience of an event, or series of events, or set of circumstances, as emotionally or physically harmful or life threatening, which can have long-lasting impacts on an individual (Substance Abuse and Mental Health Services Administration, 2014). This thesis will focus on 'childhood trauma' which refers to trauma that occurs during childhood. Childhood trauma will be used as an umbrella term to also include 'developmental 'or 'complex' trauma, which refer to the impact of early, repeated traumas that occur within the child's caregiving or wider relational systems and often early in their life (van der Kolk et al., 2009). There are several models that conceptualise childhood trauma and offer different understandings of the mechanisms of impact, some of which are reviewed below.

1.2.1. Psychological Models to Understand Childhood Trauma Response

Cognitive, neurodevelopmental, attachment, and socioecological frameworks are often drawn upon in Psychology for conceptualising childhood trauma. These models and frameworks will be discussed with consideration of strengths and limitations.

1.2.1.1. *Cognitive models.* According to Brewin et al. (1996), trauma memories are stored differently to 'normal' memories, and following a traumatic event(s), attention is narrowly drawn to threat-related information, impacting the processing and integration of the memory. This may lead to distress, 'flashbacks', or nightmares when triggered by trauma-related stimuli. Ehlers and Clark (2000) model elaborates on the role of trauma memory and cognitions in maintaining the trauma response. The inadequate elaboration of the memory and integration in context (e.g., in time, place, and with other memories) leads to a sense of current threat and involuntary intrusive memories, 'flashbacks', or re-experiencing of the event. A sense of threat may be maintained due to 'excessively negative appraisals such as, 'nowhere is safe' or 'I deserve the bad things that happen to me' (Ehlers & Clark, 2000). Thought suppression, increased vigilance, and avoidance trauma reminders may also maintain a sense of threat. Meiser-Stedman (2002) proposes that a child-specific conceptualisation of trauma response is necessary based on evidence that the developing brain is particularly sensitive to stress. Actually, very young children may not experience 'flashbacks', but display signs of 're-experiencing' through re-enactment of the trauma. This can also occur in children in response to stimuli un-related to the trauma (Schwarz & Perry, 1994).

Cognitive models have a robust evidence base and many practical applications (National Institute for Health and Care Excellence, 2018). However, cognitive models are based on White, Eurocentric ideas and concepts, and the evidence-base underpinning these models can be critiqued for the under-representation of non-White participants (Williams, 2015). This means that cognitive models are generally culture-specific. Further, cognitive models generally fall short of considering the impact of trauma on the *developing* brain. This will be discussed in the section below. Cognitive models can also be critiqued for being reductionist in that they place too much emphasis on internal processes and failing to account for the influence of interpersonal relationships, and the wider social context, on trauma.

1.2.1.2. *Neurodevelopmental models.* In early childhood, the brain develops the ability to filter sensory input to detect and respond to threatening information. In an actual or anticipated threatening situation, sensory information is processed by the hypothalamus, sent to the pre-frontal cortex and then to the amygdala which initiates the 'fight, flight or freeze' response. 'Fight or flight' refers to the activation of the autonomic nervous system, release of stress hormones, and bodily changes including increased heart rate. 'Freeze' refers to a dampened or blunted physiological response to stress, which is also self-protective, often referred to as 'dissociation'. As the brain develops, a child will move away from reliance on the right side of the brain and will shift towards primary reliance on the left side (Cook et al., 2005; Cross et al., 2017). However, repeated exposure to trauma can prevent this shift (Cook et al., 2005). This means that they operate predominantly in 'survival mode', and that there is little resource left for the development of higher-level skills such as emotion regulation skills, cognitive skills, and identity development (Greene et al., 2014). This can lead to seemingly 'inappropriate' emotional or behavioural responses (Cross et al., 2017). This impact may also be seen through concrete thinking, forgetfulness, poor problem-solving or ability to read social cues (Greene et al., 2014).

Whilst this model is useful in explaining the vulnerability of children to repeated exposure to trauma based on brain development, it does not consider relational influences. Polyvagal theory addresses this and posits that if children can turn to trusted others for safety when faced with threat, the 'social engagement system' can be activated which leads to the regulation of the bodies stress or threat response (Porges & Dana, 2018). If children experience others as consistently failing to provide safety, the fight-flight-freeze response becomes hard-wired (Porges & Dana, 2018). However, neurodevelopmental conceptualisations and specifically 'hard-wired' neural responses can be critiqued in that increasingly, research suggests that our brains can continually adapt throughout our lives based on available support and developing coping skills (Boukezzi et al., 2017; Cisler et al., 2016; Eichinger, 2018).

1.2.1.3. *Attachment models.* Original attachment theorists propose that the early relationship with our primary caregiver influences the internal working models we have of

ourselves, others, ourselves in relation to others, and our emotional, cognitive, and social development (Bowlby, 1979). Ainsworth (1978) theorised that that based on our early relationship with our primary caregiver, we develop ‘attachment styles’. In the presence of responsive and sensitive caregiving, a child will develop a ‘secure attachment’ style. This means that as they grow up, they will develop a positive view of themselves and others, an ability to develop satisfying relationships, be independent, and able to self-regulate. In a frightening environment, or where caregivers are insensitive, unresponsive, or unpredictable (for example, in situations of abuse or neglect) a child may develop ‘avoidant-insecure’ or ‘ambivalent-insecure attachment styles (Ainsworth, 1978). A child with an ‘avoidant’ attachment style will be physically and emotionally independent of their caregiver. A child with an ‘ambivalent’ attachment style will be very distressed when their caregiver leaves however not soothed by their return.

The Dynamic Maturational Model of Attachment builds upon the original theory and proposes that attachment styles are adaptive strategies developed as a means to prevent harm (Crittenden, 2006). For example, a child growing up in a traumatic environment may learn that showing their feelings brings on danger or results in care being withdrawn, and may therefore hide their emotions and seem ‘okay’ even if frightened. A child may also learn that the only way to receive care is to show ‘exaggerated’ emotion or behaviour. Whilst these children may feel internally unloved or anxious, they may seem externally aggressive or hostile. They may be resistant to an adult ‘solving the problem’ as this may mean care is withdrawn (Crittenden, 2006).

Our early relationships can have long-lasting impacts on the way that we relate to others (Ainsworth, 1978). Children who have experienced trauma often feel that they are ‘unwanted’ or ‘unlovable’ and may struggle to form a sense of identity or belonging. This can mean that they are vulnerable or exploited in relationships, and that they struggle to ‘fit in’ (van der Kolk, 2014; Treisman, 2016). A child’s early attachment can also influence emotion and behaviour regulation. When there is a lack of parental regulation of emotions or comforting, or violent or panicked responses to emotion, a child may learn that their feelings are dangerous, or harmful and may not develop self-regulation skills (van der Kolk, 2014). These children may

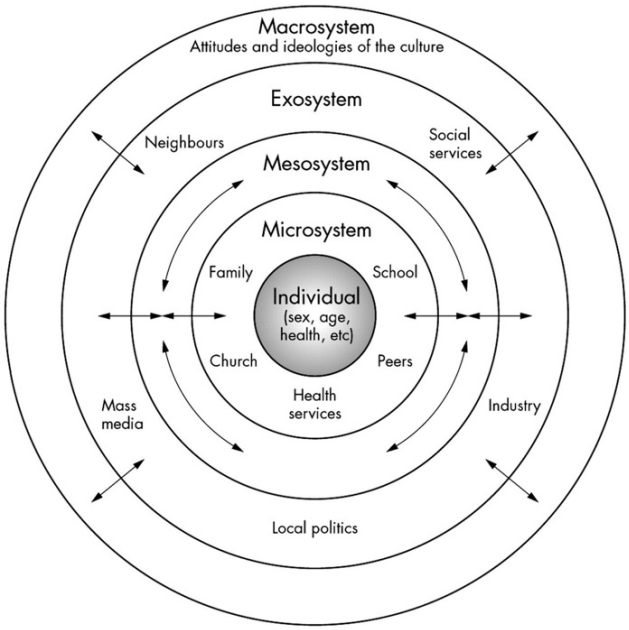
have emotional reactions that seem ‘over the top’ and may be labelled ‘naughty’ (van der Kolk, 2014; Treisman, 2016). However, according to Crittenden (2006), our attachment styles are not fixed and can change depending on the circumstances.

Whilst this model has a large evidence base and practical application (National Institute for Health and Care Excellence, 2018), as is the case with the previous models, the ideas have been developed through a White, Eurocentric, experimental lens. The relational models can be critiqued for an over-emphasis on dyadic relationships, and the parent’s responsibility to effect change (Field, 1996). Indeed, parenting varies across cultures, and this may represent a culturally-specific understanding. The model falls short of considering the inter-play between individual, relational and wider contextual factors. The nature of attachment relationships may be impacted by a child’s wider environment. For example, their access to resources, and experiences of social inequality or discrimination (Bronfenbrenner, 1979).

1.2.1.4. *Socioecological model.* The ecological systems theory conceptualises a child’s development in terms of an interaction between their individual development and the five inter-related systems that they exist within (Bronfenbrenner, 1979). These systems are presented in Figure 1. According to this framework, the neurodevelopmental, cognitive and attachment impacts of trauma will be influenced by a child’s wider community and environment including access to external support and services, and the wider political and economic climate.

Figure 1

Ecological systems theory (Bronfenbrenner, 1979).



The social context may not only increase vulnerability or protect against trauma on a micro level, but it may also be the cause of trauma. Indeed, trauma can occur on a community or collective level as a result of systemic social inequality or discrimination (Hirschberger, 2018). This refers to trauma that is experienced by a society or group as a whole and impacts on collective identity, also for future generations (Hirschberger, 2018; Mahmud, 2022). Collective or community level trauma can represent historic trauma with roots in systemic oppression, which continues to have an impact on communities in the present day through discrimination (Bernard et al., 2021). Just as trauma influences assumptions about oneself and the world on an individual level, or our relationships with those in our microsystem, collective trauma can impact group perceptions of the world and the relationship between them and other groups in society (Hirschberger, 2018).

Throughout the thesis, childhood trauma will be conceptualised in terms of the interplay between individual, relational and wider social contextual factors, and particular attention will be paid to the influence of systemic social inequality.

1.3. Prevalence of Childhood Trauma

1.3.1. Adverse Childhood Experiences Research

Since the 1990s, 'adverse childhood experiences' (ACEs) have been widely researched and have been influential in evidencing the prevalence of childhood trauma. The original ACEs study (Felitti et al. 1998) was a largescale study conducted in the USA, involving over 17,000 people. A questionnaire was sent to adults who had completed a medical evaluation, and measured the number of ACEs they had experienced, seeking to investigate the relationship between number of ACEs and health problems. The adults were asked about early experiences of abuse (physical, emotional, sexual), neglect (physical, emotional) and family circumstances (domestic violence, substance abuse, mental illness, parental separation or parental imprisonment). Findings suggested childhood trauma was much more prevalent than previously thought. For example, 28.3% of participants experienced physical abuse, 20.7% sexual abuse and 10.6% emotional abuse. 26.9% reported substance abuse within the family, and 14.8% reported emotional neglect. Almost two thirds of participants reported at least one ACE (Felitti et al. 1998).

ACEs research has since been replicated, further evidencing the high prevalence of childhood trauma. For example, a national study across England found that of 3,885 adults, 46.4% had experienced at least one ACE and 8.3% had experienced four or more (Bellis et al., 2014). A Welsh study (Bellis et al., 2016) also found that almost half of the adult population in England had at least one ACE. ACEs have been explored at a local level in the UK. For example, Ford et al. (2016) found that of 5621 adults across Hertfordshire and Northamptonshire, 43.1% had experienced at least one ACE, 16% experienced two to three ACEs and 9% had experienced four or more.

1.3.2. Social Inequality and Trauma Prevalence

Whilst the ACEs research has been influential in highlighting childhood trauma prevalence, it is acknowledged that ACEs research has limitations. For example, it does not account for severity or duration, meaning that an ACE score of one could not be representative of the extent of the trauma (Bateson et al., 2020). Limitations

extend to most trauma prevalence research, in that often trauma is narrowly conceptualised, excluding trauma experiences that may not fit diagnostic categories or the categories of ACEs most commonly acknowledged. For example, the original ACEs exclude trauma caused by wider contextual factors and social inequality. Indeed, the prevalence of trauma has been found to be higher in some communities, for example, those experiencing more poverty, violence, racism, sexism, homophobia (Bernard et al., 2021; Morris et al., 2019; Strompolis et al., 2019).

Ellis and Deitz (2017) propose a 'resilient communities' approach, and describe ACEs (maternal depression, emotional and sexual abuse, divorce, physical and emotional neglect, mental illness, incarceration, homelessness, domestic violence, substance abuse) in the context of 'Adverse Community Environments' (discrimination, community disruption, lack of opportunity, economic mobility and social capital, poor housing quality and affordability, violence). As well, Bernard et al. (2021) proposed a culturally-informed ACEs model (C-ACE) which conceptualises trauma through a historical racism perspective. In line with Bronfenbrenner's ecological model (Bronfenbrenner, 1979), this model highlights the interaction between ACEs, racism-informed social conditions, historical trauma, biological vulnerability, and mental health outcomes.

1.4. Impact of Childhood Trauma

1.4.1. Short-term Impacts

Children who have experienced trauma are at increased risk of developing cognitive, social, emotional, behavioural or academic difficulties (Perfect et al., 2016; Romano et al., 2015). Indeed, research suggests that a large proportion of children accessing Child and Adolescent Mental Health Services (CAMHS) have experienced trauma (Reay et al., 2015). Research has specifically explored the mental health outcomes of Looked After Children (LAC), who have often experienced neglect or abuse, and indicates that these children are significantly more likely to experience mental health difficulties (Herwig, 2022; National Institute for Health and Care Excellence, 2021). Looked After Children have also been found to be four times more likely to have a special education need (SEN) and are five times more likely to have a fixed period of exclusion (Department for Education, 2023). Indeed, the social, education and

mental health impacts may be worsened by a failure to acknowledge difficulties in the context of traumatic experiences. For example, behavioural difficulties in the context of trauma may be mislabelled ‘conduct disorder’ and increase the risk of school exclusion (Perfect et al., 2016).

1.4.2. Long-term Impacts

The ACEs research was influential in highlighting the association between ACEs and life-long health impacts (Felitti et al., 1998; Bateson et al., 2020). Felitti et al. (1998) assessed the correlation between ACEs and ten risk factors that were contributing to the leading causes of mortality in the USA at the time. This research identified a strong relationship between the seven ACEs and the risk factors and disease conditions leading to the greatest mortality rates. For example, experience of ACEs was found to be associated with alcoholism, physical inactivity and obesity, as well as with cancer, lung disease and heart disease (Felitti et al., 1998). The greater number of ACES, the greater the impact on health and wellbeing later on in life. The association between childhood trauma and adult health outcomes has been further highlighted in other research. For example, Afifi et al. (2016) carried out a large-scale Canadian study and identified that all types of child abuse were associated with higher odds of health issues including arthritis, cancer, and chronic fatigue.

Research also indicates that childhood trauma has long-term mental health and social impacts (Hughes et al., 2016: McKay et al., 2021). For example, Herrenkohl et al. (2013) found adults who had been maltreated in childhood were more likely to experience depression and anxiety as adults. McKay et al. (2021) also report that meta-analyses of psychosis literature indicate associations between childhood trauma and psychosis in adulthood. Regarding social impacts, Bellis et al (2014) found in a large-scale study that adults in the UK who had experienced childhood trauma were more likely to be unemployed. Research also explored social outcomes in relation to the UK LAC population and indicates that these children are four times more likely to be unemployed as adults, and 60 times more likely to be sent to prison (Cocker & Scott, 2006). Evidence from homelessness charities also suggests a large proportion of people who are homeless have been in care as children (Step By Step, 2020).

1.4.3. Social Inequalities and Impact of Childhood Trauma

Research highlights that social inequalities, poverty, and marginalisation can put people at a greater risk of developing both physical and mental health difficulties following traumatic experiences (Allen et al., 2014; Bernard et al., 2021; Gauffin et al., 2016). Contributing to the greater impact may be the increased barriers to accessing services. Indeed, the Circles of Fear theory (Byrne et al., 2017) posits that stereotypical views, cultural ignorance and racism can impact the services offered to minoritised groups and can lead to reluctancy to ask for help and therefore worsened difficulties. In line with this, evidence suggests that Black people are over-represented in mental health inpatient services and more likely to be detained under the mental health act (Byrne et al., 2017).

1.5. Intervention for Childhood Trauma

1.5.1. The Medical Model

NHS services predominantly apply a medical model to treatment. The medical model conceptualises trauma as arising from genetic, chemical, cognitive and behavioural changes occurring within the individual (Bracken et al., 2012). The dominant intervention is therefore diagnosis, and an individual or family-level psychological intervention (National Institute for Health and Care Excellence, 2018).

1.5.1.1. *Diagnosis:* According to the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-V) and International Statistical Classification of Diseases and Related Health Problems (ICD-11), children and young people can be given a diagnosis of Post-Traumatic Stress Disorder (PTSD) if they been exposed to actual or threatened death, serious injury or sexual violence through directly experiencing the event(s), witnessing the event(s) occur to others, learning about the event(s) happening to others, or experiencing repeated or extreme exposure to details of the event(s). In order to meet diagnostic criteria, one of each of the following clusters of symptoms should be present, including experiencing intrusive symptoms (e.g. flashbacks, nightmares, vivid memories), avoidance of traumatic reminders, changes to mood or cognition (e.g. difficulty remembering details, persistent negative beliefs about the self or others), and changes in arousal (e.g. concentration or sleep difficulties, or

hypervigilance) (American Psychiatric Association, 2013; World Health Organisation, 2019).

The PTSD diagnosis has received ongoing criticism in terms of the narrow conceptualisation of trauma response and failure to capture the full range of difficulties (Cook et al., 2005). van der Kolk et al. (2009) developed a set of diagnostic criteria for Developmental Trauma Disorder, to capture the wider impacts on children exposed to chronic traumatic stress. van der Kolk (2005) argues that individuals who have experienced developmental trauma may benefit from a different treatment approach. The proposed diagnostic criteria include experience or witnessing of multiple or prolonged adverse events over a period of at least one year beginning in childhood, including 'disruptions of protective caregiving', 'affective and physiological dysregulation', 'attentional and behavioural dysregulation', 'self and relational dysregulation' and 'posttraumatic spectrum symptoms'. Whilst this continues to be a useful framework, the diagnosis was not accepted in the DSM-5 diagnostic manual due to a 'lack of empirical evidence'. The ICD-11 has more recently introduced the diagnosis of Complex Post Traumatic Stress Disorder (CPTSD) to capture the experience and impact of developmental trauma. The criteria expand on the PTSD criteria to include 'affect dysregulation', 'negative self-concept' and 'interpersonal difficulties' (World Health Organisation, 2019).

1.5.1.2. Recommended psychological intervention: NICE guidelines for the treatment of PTSD amongst children and young people suggest cognitive behavioural therapies (CBT) such as trauma-focused CBT (TFCBT), narrative exposure therapy for children and adolescents (KidNET) or mindfulness-based cognitive therapy (MBCT). Other interventions include Eye Movement Desensitisation and Reprocessing (EMDR), or parent and family interventions such as attachment-based interventions, or child-parent psychotherapy (National Institute for Health and Care Excellence, 2018).

Whilst there is an extensive evidence base supporting these interventions and research suggests positive outcomes to treatment (National Institute for Health and Care Excellence, 2018), they can be critiqued in that the evidence base for treatment often excludes individuals from non-White backgrounds (Williams, 2015). This

challenges the applicability of the dominant approaches to people from racially or ethnically minoritised backgrounds and raises concerns around discriminatory treatment for trauma. Further, individual or family-level interventions, that are usually diagnosis-dependent, can be critiqued for 'problematising' response to adversity.

1.5.2. Alternatives to Diagnosis

Mental health services are typically underpinned by medical model assumptions. For example, having a diagnosis such as PTSD, is often required to access a specific treatment or therapy. However, diagnosis is ultimately based on subjective judgement around what constitutes 'normal' and 'abnormal' in the absence of objective 'biomarkers' (Bracken et al., 2012). What is perceived to be 'abnormal' and to warrant a diagnosis, reflects one cultural understanding, and could alternatively be understood as an intelligible, culturally determined response to adversity (Malott et al., 2023). It can be argued that diagnosis, medicalisation, and individualisation of trauma pathologise understandable reactions to traumatic events (Bisson, 2009; Patel, 2011). Diagnosis and individualisation of PTSD distracts from the adversities that an individual has experienced and the wider social, political and cultural context (for example, the experience of poverty or racism) which may cause or perpetuate a trauma response (Johnstone & Boyle, 2018). Indeed, the diagnosis of PTSD can be understood as a socio-political construct (Summerfield, 2005).

In shifting the paradigm in mental health, alternative, non-medicalised frameworks have been proposed. For example, The Power Threat Meaning Framework (PTMF) is a formulation model that has been introduced as an alternative to diagnosis (Johnstone & Boyle, 2018). The framework focuses on understanding an individual's experiences rather than 'symptoms'. The PTMF conceptualises 'symptoms' as adaptive threat responses, utilised when faced with threat caused by power structures and operations. The operation of power could be economic, ideological, sociocultural, interpersonal, and may include the re-traumatisation by mental health services. The framework acknowledges a person's social, cultural, and political context, and accounts for cultural differences in the experience of distress. According to this approach, there is no assumption of pathology or an 'internal fault'. This framework formulates difficulties in terms of the question *'what has happened to you?'* rather than *'what is wrong with you?'* (Johnstone & Boyle, 2018).

1.5.3. Organisational Approaches: Trauma-Informed Practice

Based on the research evidencing the prevalence and impact of trauma, trauma-informed (TI) approaches to mental health services have also developed in the last 20 years. The term 'trauma-informed' was introduced by Harris and Fallot (2001) in the context of advocating for staff's recognition of the trauma histories of substance abuse patients. This involved understanding the impact of trauma on individual service-user's experiences and presentations and advocating for care systems addressing trauma to further promote active engagement with service-users and their recovery (Harris & Fallot, 2001).

Trauma-informed practice (TIP) is not understood as an alternative to diagnosis, but rather an organisational framework encouraging services to recognise the prevalence and impact of adversity or trauma, when formulating or treating an individual's distress. This framework also shifts the focus from '*what is wrong with you?'* to *'what has happened to you?';* promoting a non-pathologising, person-centred approach (Sweeney & Taggart, 2018). It also encourages services to recognise the way in which the environment impacts distress *(*Sweeney & Taggart, 2018). TIP does not adopt a specific definition of trauma. However, most guidelines refer to broad conceptualisations that include but also extend beyond PTSD; recognising developmental trauma, social trauma, and the influence of context (Sweeney & Taggart, 2018). It is also not underpinned by specific trauma theory, however a range of theories are often drawn upon in guidelines including cognitive, neurobiological, and attachment theories (Sweeney & Taggart, 2018; Substance Abuse and Mental Health Services Administration, 2014). Although a TI approach may include individual trauma-specific interventions (such as CBT or EDMR), this is not seen as sufficient in achieving optimal outcomes and this framework proposes that a whole-organisation approach that focuses on the relationships established between members of the system is most important in supporting serviced-users holistically (Sweeney & Taggart, 2018).

There is not a universal definition of TIP however various guidelines have been created. The UK government working definition of TIP (Office for Health Improvement and Disparities, 2022) reflects the guidelines developed in the USA by

Harris and Fallot (2001) and the Substance Abuse and Mental Health Services Administration (SAMHSA) (2014). According to the UK guidelines, underpinning assumptions include: *realising* that trauma can impact individuals, groups, and communities in terms of neurological, biological, psychological and social development; *recognising* the impact of trauma, for example, on sense of powerlessness, ability to feel safe, or develop trusting relationships; *responding* with practice informed by the six guiding principles and *resisting re-traumatisation,* which refers to preventing activation of previous trauma through reminders of the trauma. Indeed, in medicalised healthcare settings, an individual who has experienced childhood trauma in the form of abuse or neglect, may be re-traumatised through the power dynamics that exist between professionals and service-users, a lack of control or choice over treatment, or invasive procedures. In the absence of a TI lens, an individual's distrust of a service, stemming from early childhood trauma, may also be misconstrued as 'non-engagement' which could 're-traumatise' or perpetuate the impacts of trauma (Office for Health Improvement and Disparities, 2022).

The TIP framework comprises of six principles: safety, trust, choice, collaboration, empowerment, and cultural consideration. Safety can be prioritised through asking what someone needs to feel safe, there being reasonable freedom from threat or harm, preventing re-traumatisation, and putting policies, practises, and safeguards in place. Trustworthiness can be prioritised through the organisation explaining the reasons for their decisions, and the organisation doing what they say they will do, with clear expectations that can be met. It is recommended that choice is prioritised through giving individuals a voice, listening to their needs and wishes, and explaining choices clearly. Services should also prioritise collaboration and empowerment; involving service-users, tuning into their needs, and supporting people to make decisions. Services should move beyond cultural biases and stereotypes, incorporate culturally responsive policies, and provide culturally responsive services (Office for Health Improvement and Disparities, 2022).

1.5.4. UK Trauma-Informed Practice Policy Context

TIP is increasingly incorporated into UK policy and integrated into practice (Emsley et al., 2022). Emsley and colleagues identified 24 relevant UK policy documents published between 2012 and 2021. These include strategy documents such as 'The

Five Year Forward View' (Mental Health Taskforce, 2016) and NHS planning documents, such as 'NHS Long Term Plan' (National Health Service, 2019). These documents reference a commitment to developing a TI approach and call for it to be a core component in service development. They highlight the importance of this in providing an environment where an individual who has experienced trauma can feel safe and develop trust, and how this can be achieved, for example, through compassion, collaboration, and offering choice (Emsley et al., 2022).

Emsley et al. (2022) found that between 2017-2021 there has been a clear increase in policy specifically referencing TI care. For example, *'Trauma Informed Practice: Developing real world system capability in trauma informed care: learning from good practice'* (Kennedy, 2020). This document proposes a framework for change for commissioners, practitioners, and people with lived experience of trauma. The framework involves process, interpersonal, and structural standards. 'Process standards' relate to the way care is delivered, 'structural standards' refers to the way services are organised, and 'intrapersonal standards' refer to services prioritising TI relationships. Human experience, de-medicalisation of distress, safety, collaboration, empowerment, and relationships are prioritised and recommended to be incorporated into the commissioning, set-up and monitoring of services and day-to-day practice.

1.5.5. Rationale for Trauma-Informed Practice in Schools

Increasingly, TI organisation-wide approaches are being embedded in other public service sectors such as the education context (Avery et al., 2021). In the UK, schools are increasingly expected to contribute to the early intervention for and prevention of mental health difficulties in children and young people (Department of Health and Department for Education, 2017; National Institute for Health and Care Excellence, 2022). This is in the context of the increasing prevalence of mental health difficulties amongst children and adolescents, and services unable to meet the demand (Spence et al., 2021). Even more so since the pandemic, children and young people are not receiving help on time, further impacting on their mental health (Care Quality Commission, 2019; Huang & Ougrin, 2021; Spence et al., 2021).

Transforming Children and Young People's Mental Health Provision: A Green Paper (Department of Health and Department for Education, 2017) outlined a plan for schools involving Senior Mental Health Lead (SMHL) training, and the implementation of Mental Health Support Teams (MHSTs), to support to embed a whole-school approach. The governmental plan is to offer SMHL training to all state-funded schools by 2025 and for there to be over 500 MHSTs established by 2024 (Department of Health and Department for Education, 2017). NICE guidelines (National Institute for Health and Care Excellence, 2022) outline that whole-school approaches should be TI. There is rationale for this based on the widespread prevalence of childhood trauma and what is known about the impacts on social, emotional and cognitive development and therefore educational attainment (Perfect et al., 2016; Romano et al., 2015) and long-term outcomes more broadly (Felitti et al., 1998).

Indeed, schools are thought to be well-placed in that they are the most accessed community service, and have the potential to offer familiarity, consistency, trusting relationships, and a sense of belonging (Thomas et al., 2019). However, in the absence of a TI approach, schools may re-traumatise and create barriers to learning. For example, trauma-related emotional regulation difficulties, may be misattributed to 'poor behaviour' (Maynard et al., 2019). Traditional discipline, such as punishment in the form of shouting or exclusion, may perpetuate and trigger feelings of lack of safety and trust, powerlessness, and low self-esteem (Maynard et al., 2019). A whole-school TI approach may enable more children and young people to succeed in education and prevent poor social and mental health outcomes and the need for higher-level mental health support (Avery et al., 2021).

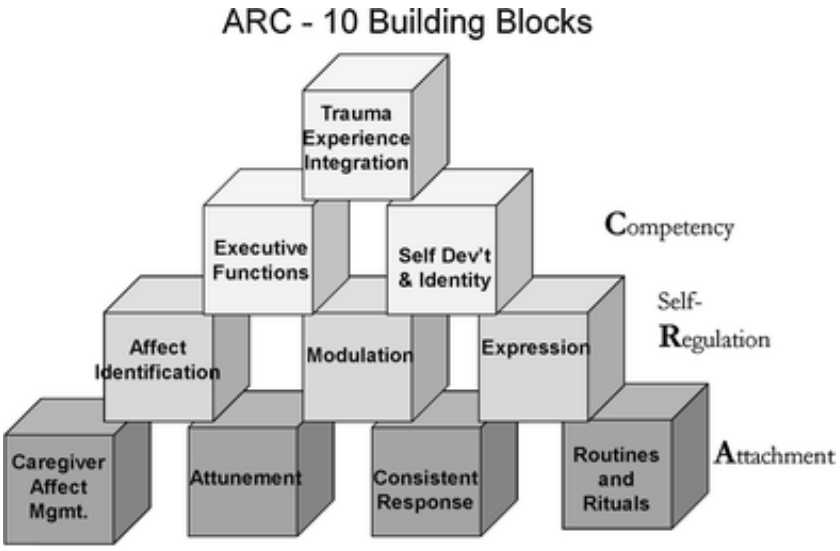
1.5.6. Current Status of Trauma-Informed Practice in Schools

The TI schools initiative (also referred to as 'trauma-sensitive', 'trauma-responsive' or 'trauma-aware' schools), began in the USA and is becoming more established with TI school approaches implemented across 17 states (Overstreet & Chafouleas, 2016). Whilst there is no consistent definition or framework, reflective of a broader issue in relation to TIP (Emsley et al., 2022), many TI programmes apply the Attachment Regulation Competency (ARC) model (Blaustein & Kinniburgh, 2017; Holmes et al., 2015). The ARC model outlines three domains which are impacted by

trauma in childhood; attachment, regulation (self) and competency (developmental). Within these domains, Blaustein and Kinniburgh (2017) identify ten areas for intervention, which can be applied as a whole-service approach, in clinical or non-clinical settings including schools (Figure 2).

Figure 2

Attachment, Regulation and Competency (Blaustein & Kinniburgh, 2017).



The Missouri Model (Missouri Department of Elementary and Secondary Education, 2018) is another TI school model. The stages include: 'trauma-awareness' (through training, staff are informed about trauma and can speak about the impacts), 'trauma-sensitive' (staff begin to explore principles of TIP and allocate leaders to drive the process), 'trauma-responsive' (changes to practice and policy and individual staff responses and actions), and 'trauma-informed' (schools begin to see results from changes, continue to work closely with the community and acknowledge this stage is never 'complete' and schools should continue to change).

Preliminary evaluation of programmes in the USA indicates positive results (Holmes et al., 2015; Jankowski et al., 2019; Rishel et al., 2019; Williams, 2022). For example, Holmes et al. (2015) preliminarily evaluated the Head Start Trauma Smart (HSTS) intervention using the Childhood Trust Events Survey, the Child Behaviour

Checklist and the Classroom Assessment Scoring System. They found that carers noted ‘positive changes’ in their child’s behaviours and teachers reported significant changes in terms of school readiness and overall academic performance. Avery et al. (2022a), Wall (2021) and Schimke et al. (2022) have also evaluated the impact of TI school programmes through thematic analysis of interviews with teachers or school staff and reported positive results in terms of staff’s awareness, responses to behaviour, flexibility, and self-care. Indeed, although this is a framework underpinned by trauma prevalence and impact, it has been shown to benefit the wellbeing of the whole organisation regardless of whether or not there has been adversity (Sweeney et al., 2018).

This movement is in the early stages of emerging in the UK and elsewhere globally. In the UK, The Virtual School in Derbyshire, set up for Looked After Children introduced the Attachment Aware Schools (AAS) programme (The Derbyshire County Council, 2023). The programme aims to improve staff’s knowledge and understanding of trauma and attachment theory in informing their practice (Kelly et al., 2020). Schools are asked to evidence that they have taken steps such as whole-school training, embedding a ‘developmentally sensitive’ behaviour policy, effective use of external agencies, and close work with families. 77 UK schools have taken part (Kelly et al., 2020). Pre and post questionnaires indicate significant improvement in attachment awareness individually and across the whole school, and interviews identified positive impacts in terms of developing whole-school policies and system changes, and on pupils and relationships with parents and carers (Kelly et al., 2020).

The Islington Trauma Informed Practices (iTIPS) programme was piloted in the London borough of Islington in 2017. The local authority and the NHS worked together to embed TIP into five primary schools. This involved implementing the Attachment, Regulation and Competency (ARC) framework. Each school was allocated a clinician from CAMHS who offers training and consultation for staff. The pilot scheme is currently in its third wave. Research has not yet been published evaluating this pilot scheme however initial audits indicate that 77% of staff found the training to be relevant, with themes such as improved understanding of reasons behind behaviour, identifying triggers to behaviour that challenges, and an increased

ability to respond empathetically. Systemic changes also include a greater emphasis on emotion regulation and adaptations to the behaviour policy (Aspland et al., 2020).

Increasingly, TI training is available to schools in the UK through external providers. For example, 'THRIVE' is a whole-school trauma-sensitive approach that UK schools can access training for. The approach is underpinned by four pillars; attachment theory ('what is the behaviour communicating?') child development theory ('how can social and emotional development be optimised?'), neuroscience ('what can we learn from development'?) and play and creativity ('how can safe, supportive relationships be built with children?') (Fronting the Challenge Projects Ltd, 2022). Other training providers include Trauma Informed Schools UK (2023). To note, the evidence-base underpinning TI training is still limited but growing (Gibby-Leversuch et al., 2019). Whilst there is evidence for the effectiveness of training in the USA, Canada and Australia (Bellamy et al., 2022; Kim et al., 2021; Orapallo et al., 2021; Parker et al., 2020; Post et al., 2020; Purtle, 2020; Sonsteng-Person & Loomis, 2021), there is a scarcity of studies evaluating training in the UK. To the authors knowledge, there is one UK evaluative study which found significant improvement in TI attitudes and a decrease in burnout (MacLochlainn et al., 2022).

1.5.7. Limitations of the Evidence Base

This chapter has discussed a body of literature relating to TIP in schools, including the TI programmes that have been implemented and evaluative research in support of these approaches. Maynard et al. (2019) conducted a systematic review and found that although there has been a rapid increase in TI school approaches in the USA, there are limited rigorous, controlled studies evaluating its impact (Maynard et al., 2019). The majority of evaluative studies are pilot or preliminary studies, lacking generalisability due to sample size or biased or non-reported demographics (Thomas et al., 2019). Indeed, the lack of consistent terminology, frameworks, and methods for delivery, may also be halting the rigorous evaluation; reflecting a limitation of TIP more broadly (Berger & Martin, 2021a; Emsley et al., 2022).

There is also limited research exploring the experiences of members of school staff in terms of their understanding of trauma and experiences of using TIP (Maynard et al., 2019; Thomas et al., 2019). It appears that when staff perspectives have been

considered, it is often in relation to experiences of a specific type of trauma, or a specific group trauma intervention (for example, Barrett & Berger, 2021; Mayor, 2021), rather than perspectives on whole-school responses more broadly or TI approaches, particularly in terms of literature concerning the UK school context. The majority of research into TIP involving teachers, has been in an evaluative capacity, often to evaluate outcomes or impact *after* the implementation of a specific TI school or professional development programme (Bellamy et al., 2022; Holmes et al., 2015; King et al., 2021; Mahmud, 2022; Post et al., 2020; Rishel et al., 2019) rather than to understand staff perspectives and current experience and practice in informing the development of the approach in the school context (Thomas et al., 2019). Indeed, implementation is rarely informed by the experiences of school staff (Berger, 2019).

1.6. Literature Exploring School Staff Perspectives or Experiences of Trauma-Informed Practice

To further understand what is currently known about staff experiences of TIP, a scoping review of the literature was conducted in accordance with Peters et al. (2020) guidance. The review found five qualitative studies, two mixed methods studies, and one quantitative study exploring staff perspectives on or experiences of trauma and TIP in schools, none of which explore this within the UK context.

The scoping review was conducted between July and August 2022. Databases including CINAHL, Academic Search Ultimate, Scopus and PsychInfo were used for the search. The initial search terms used were (“trauma-informed” OR “trauma informed” OR DE “trauma”) AND (education OR school) AND (teacher OR staff w/3 (perspectives OR experiences OR perceptions). Reference lists of relevant papers were scanned and due to the exclusion of key papers from this search, parameters were broadened to (“trauma-informed” OR “trauma informed” OR DE “trauma”) AND (education OR school) AND (teacher OR staff w/3 (perspectives OR experiences OR perceptions OR attitudes OR views). The search yielded 604 unique results. Initially, titles and abstracts were screened for relevance. Ninety-nine papers were identified as broadly relevant to the research (e.g., relevant to TIP in schools), however not relevant to the perspectives of school staff or efficacy studies. Thirty-seven papers

were read in full to assess for eligibility. This included papers that both seemed relevant to this topic and papers whereby the abstract or title did not provide sufficient information. Of these 37, eight studies of direct relevance were included in the review. Reference lists of these papers were also scanned for any papers that had been missed from the search however no additional papers were of direct relevance. The process of data extraction is presented visually in Appendix A.

1.6.1. Quantitative Studies

1.6.1.1. Williams (2022). This USA study aimed to explore staff perceptions of TIP in a school district. 91 school employees completed the ARTIC-35 scale (Baker et al., 2016). Each participant was given a score of one to seven (whereby one indicates a lower trauma-informed attitude and 7 indicates a higher trauma-informed attitude). Findings suggest that all participants had worked with students who had experienced trauma, and 94.4% had experienced trauma themselves. 84.9% of staff had attended TI workshops. The scores on the questionnaire all ranged above the midpoint of the scale, suggesting favourable perceptions. Williams (2022) addresses a research gap in that the study provides data on trauma prevalence, from a staff perspective. It suggests that there is rationale for TIP in schools in terms of the widespread nature of trauma, and favourable perceptions which is promising for the implementation of TIP in schools. However, the depth of this data is limited due to the quantitative methodology; participants did not have the option to expand on their responses. Data may also be biased in that only those who felt positive about TIP responded to the questionnaire. Finally, this study took place in a small district in the USA and so findings lack generalisability, particularly to a UK context.

1.6.2. Mixed Methods Studies

1.6.2.1. Chudzik et al. (2021). This USA study sought to understand early childhood special education teacher's understanding, experiences, and attitudes about trauma. 25 participants completed the survey, and 18 were interviewed. The survey utilised the ARTIC scale (Baker et al., 2016). The mean ARTIC score was 5.7 suggesting favourable attitudes towards TIP (Chudzik et al. 2021). However, researchers found that scores did not always correspond with qualitative descriptions. For example, participants may have scored lower on the scale, however, they may have reported understandings and practice consistent with TIP. The interviews were semi-

structured and were analysed using Thematic Analysis (Braun & Clark, 2006). Findings highlight how staff currently respond to trauma in terms of prioritising relationships and offering social-emotional lessons. They also suggest that more support is needed for teachers in implementing TIP (e.g., additional staff) and that there are limited opportunities for learning about TIP. This research adds to the literature by highlighting the value in hearing about staff's qualitative experiences rather than relying solely on quantitative measures. A quantitative measure of TIP attitudes may not be reflective of *experiences* or what is done in practice. Limitations include the lack of statistical analysis of findings. Also, findings may be limited to this specific education setting.

1.6.2.2. Hickey et al. (2020). This Irish study investigated 17 teachers experiences of trauma and perspectives on responding to trauma in 'second-chance education' settings. A 'trauma-awareness and practice questionnaire' was used to assess understanding of trauma and use of TIP (Goodman et al., 2016). 86% of participants agreed they had a good understanding of trauma and 76.1% agreed they had a good understanding of the impact on learning and development. Almost 70% of participants reported a lack of training or support in relation to 'secondary traumatic stress'. Open-ended survey questions and focus group findings indicate the perceived importance of developing relationships, gaining trust, and creating a safe environment. Challenges included a lack of training, the impact on staff wellbeing, time pressure and focus on academic outcomes. This was the first Irish study to explore current practice in responding to trauma and barriers according to teachers, and the only to explore this in the specific context of second-chance education. However, it may be critiqued in that focus groups may have led to social desirability bias and concerns around confidentiality, causing reduced reliability and validity. Generalisability may also be limited due to the small, convenience sample. Findings may not be generalisable to education settings more broadly.

1.6.3. Qualitative Studies

1.6.3.1. Luthar and Mendes (2020). This USA study explored the experiences of 10 teachers working in TI schools, including the challenges they faced and ideas about how to manage these, via open ended feedback gathered on social media platforms. The participants worked in a range of education settings. Themes included compassion

fatigue, feelings of inadequacy and fearfulness that they are not doing the right thing in response to distress, academic pressures and evaluative policies. This led to recommendations including prioritising hiring additional staff to focus on mental health needs, continued professional development in relation to trauma, less singular a focus on academic outcomes, and adequate support for teacher wellbeing. This research adds to the qualitative literature particularly as perspectives are not limited to a specific education setting, or the evaluation of a specific TI programme and so can be more reliably used to inform the development of TIP more broadly. However, the sample lacked in heterogeneity and so may represent views from a specific lens. This research involved open-ended surveys rather than interviews, which may have limited the depth of the data as participants were not able to expand on their responses.

1.6.3.2. *Avery et al. (2022b).* This study sought to explore experiences of school staff in the USA working in TI schools, in informing practice in Australian schools. The research investigated participant perceptions of TI core elements, and the barriers and enablers of implementation. Eleven participants took part in interviews or a focus group. Data were analysed using Thematic Analysis. Findings highlighted which elements of a TI school are perceived to be most important from the perspectives of those 'on the ground', for example, safety and trust, encouraging self-regulation, and a focus on staff wellbeing. It also added to the literature in that it highlighted what is important for sustainability of the approach (ownership of change, shared responsibility, whole-school approach), as well as the barriers that need to be overcome (lack of funding, high staff turnover, broader challenges such as poverty). This is also the only staff perspectives study to highlight links between trauma and social inequality and the role that school plays in replicating social inequality. Limitations included a gender homogenous sample, and that most of the sample were individuals supporting to implement TI approaches, which may have created bias. Whilst the intention of the study was to inform international developments, findings may not directly apply to education systems internationally.

1.6.3.3. *Koslouski & Stark (2021).* This USA study explored elementary school teachers' strategies for supporting children experiencing trauma or adversity. Qualitative interviews were conducted with 10 elementary school teachers. Teachers were

interviewed about training received around responding to trauma, their understanding of trauma, and examples of ways in which they have tried to promote wellness for children experiencing trauma. Data were analysed using Thematic Analysis. The findings add to the literature in that they highlight how school staff in the USA are 'organically' responding to trauma and thus can be used to inform developments of TIP (rather than exploring experiences specifically within TI schools). Specifically, findings highlight how teachers prioritise relationships with children and parents, teaching self-regulation and offering choice. They also highlight the importance of cultural responsiveness. Barriers are highlighted in terms of difficulty engaging with parents, inadequate resources and conflicting opinions on responsibility. However, there is potential bias in that findings reflect the views of teachers most enthusiastic about supporting with trauma.

1.6.3.4. *Berger et al. (2021).* This was the first Australian study to explore school staff perspectives on response to trauma. It involved semi-structured interviews with 27 teachers from primary and secondary schools. The research sought to investigate teacher's current experiences, their resources, and any barriers or recommendations. Data were analysed using Thematic Analysis. Findings provide insight into teacher experiences of responding to trauma in the Australian context, (e.g.: creating safety, responding with compassion, pressure on academic outcomes), their current resources for responding (e.g.: varied levels of training and knowledge of school policy), and understanding of TIP (many being unfamiliar), barriers (self-doubt, continuation of care and follow-up) and recommendations (adequate training and funding) and therefore has implications for the development of TIP in schools. Similarly to Koslouski and Stark (2021), this research addresses a gap in the literature in that it did not target TI schools specifically and explored how staff are *currently* responding to trauma in informing TI approaches. It was the first study to do so in an Australian context, where TI schools are not yet widespread. It offers support to many barriers identified in the USA context. However, Berger et al. (2021) reflect on conceptual issues; it was difficult to explore perspectives on TIP when different terminology is used in this field, and the reported discrepancies in understanding may reflect this. It is also acknowledged that the small sample size and lack of existing literature to draw upon makes conclusions difficult, however this exploratory research creates avenues for future research and developments.

1.6.3.5. *Alisic (2012).* This was the first study to explore elementary school teacher's perspectives on working with trauma in the Netherlands. Twenty-one teachers participated in semi-structured interviews. The interview guide included questions around experience and strategies, school protocols, and needs/perspectives on what support or additional information would be helpful. Interviews were transcribed using summative analysis (Rapport, 2010). This research contributes to the very limited literature seeking to understand teacher perspectives on and experiences of responding to trauma, and this is the first to explore this in the context of the Netherlands. Findings highlighted challenges in terms of understanding the role of a teacher in responding to trauma and disagreement amongst teachers around this, how to balance the different needs of children in the classroom, a desire for greater knowledge and 'know how', and guidelines. It also highlighted the emotional burden and the importance of support for staff wellbeing. Findings will have implications for how to support schools particularly in the Netherlands to respond to trauma. However, limitations include a potentially biased sample, in terms of an over-representation of teachers interested in this topic. Whilst the sample is diverse in terms of gender, teaching experience and type of school, other demographics such as ethnicity are not considered.

1.7. Rationale for Current Research

There is increasing emphasis and policy guidance on the role of schools in supporting children's mental health through whole-school approaches (Department for Education, 2021; National Institute for Health and Care Excellence, 2022), and given the prevalence of trauma and research into its impact, there is rationale for schools to adopt a TI approach to this in line with NICE guidance (National Institute for Health and Care Excellence, 2022). However, whilst preliminary evaluative studies indicate positive findings, there has been limited research exploring staffs understanding, perspectives and experiences in informing the development of TI schools. This may be contributing to the lack of a consistent framework or understanding of effectiveness (Thomas et al., 2019). According to TI implementation guidance and implementation science literature broadly, the

involvement of staff ‘on the ground’ is important in increasing the chance of implementation success (Bauer & Kirchner, 2020; Substance Abuse and Mental Health Services Administration, 2014).

The scoping review highlights the handful of research studies that have been conducted in an international context exploring staff perspectives. However, there is no research to the authors knowledge exploring school staff’s current experience of trauma or TIP in the UK. Indeed, the current literature may not generalise to staff’s experience in the UK education system. It is particularly unclear how school staff’s understanding of the concept of trauma informs their practice as the majority of previous research in this area focuses predominantly on *response.* TIP is underpinned by acknowledgement of trauma theory and impact and therefore this is important to explore (Substance Abuse and Mental Health Services Administration, 2014). It is unclear how a TI framework would translate into practice in UK schools which are known to be resource-pressured and to lack adequate funding. It will be important to understand the current experiences of perspectives of staff in informing next steps in the development of TI school approaches in the UK.

As TIP is not yet widespread in the UK, it makes sense to explore how school staff are currently understanding and responding to trauma, non-specific to TI schools, similarly to Koslouski and Stark (2021) and Berger et al. (2021) in an international context. Due to a lack of research in the UK, there is not yet the rationale to focus on a specific education setting or a specific staff group, and instead it will be important to understand perspectives and experiences more broadly. This strategy would also promote a consistent approach across and within schools. In overcoming limitations of previous studies (Williams et al., 2022; Chudzik et al., 2021), it will be important for research to take a qualitative approach in increasing the validity and gathering rich data. Also, the methodological limitations of previous qualitative studies (Hickey et al., 2020; Luthar & Mendes, 2020), highlight the value in using interviews as a means to gather rich data and inform further development and research.

1.8. Implications and Relevance for Clinical Psychology

In the context of increased pressure on CAMHS, which exceeds resource, it will be important for Clinical Psychologists to collaborate with other child services, such as schools, to contribute to the prevention of long-term impacts of childhood trauma on wellbeing (The British Psychological Society, 2018a). Indeed, within the field of Clinical Psychology, there is an increasing focus on the prevention of, as opposed to the treatment of, mental health difficulties (The British Psychological Society, 2020), and with the introduction of MHSTs, there is greater scope for Clinical Psychologists to work in this capacity within the schools. Increasingly, Clinical Psychologists are supporting organisations in the healthcare context to embed TI approaches (The British Psychological Society, 2022), and in preventing mental health difficulties or other long-term impacts of trauma it will be important to understand how this approach may support other community organisations such as schools. Given the current lack of research, it will be important to firstly understand staff's perspectives on TI approaches in schools (for example, how TIP is understood, its potential utility and barriers), and current practice in the context of trauma.

1.9. Research Aims

Exploring the perceptions of school staff on TIP, this research aims to:

1. Present staff perceptions of trauma and its impact
2. Present staff perceptions of TIP
3. Explore current staff experiences of responding to trauma
4. Identify any perceived barriers to TIP in schools and areas for development, with implications for how staff can be supported to implement TI approaches in schools.

1.10. Research Questions

In addressing these aims, this research will focus on the following questions:

1. How do school staff members perceive the impact of trauma?
2. How do school staff members perceive trauma-informed practice?

2. METHOD AND METHODOLOGY

2.1. Ontology and Epistemology

It is acknowledged that the research ontology and epistemology will influence the research at every stage (Willig, 2019). The ontological position of research refers to what exists, or *what* we think we can know. The epistemological position of research refers to the acquisition of knowledge, or *how* we think we can know.

This research adopts a critical-realist position. Critical realism postulates that ontologically, an external reality exists (Pilgrim, 2019) and this can be explored through research. For example, the research assumes that trauma and TIP exist, and it will explore participants understanding and experience of these. In line with critical realism, it will explore both the observable (response to trauma) and the unobservable (what influences this). However, a critical realist epistemology posits that the data collected though research produces perspectives on this 'reality' (Willig, 2019). From a critical realistic perspective, it is not possible to fully know 'reality' as the way we investigate or examine 'reality' is subjective and imperfect. It is influenced by subjective research tools, and the contexts, beliefs and biases held by the researcher and participants (Banister et al., 1994). The data collected can provide us with information about response to trauma in schools, however this will never directly reflect reality (Willig, 2019). This research assumes that participants responses will be shaped by contextual influences, and interpretation of this can form part of this analysis.

2.2. Design

A qualitative design is employed as this is suitable to explore perspectives and experiences, in increasing understanding of a phenomenon to contribute to the knowledge base (Willig, 2019). In taking a critical realist approach to qualitative research, Fletcher's (2017) guidelines recommend collecting in-depth interpretative

data through interviews. Interviews enable a more flexible and detailed exploration of participant perspectives (Fletcher, 2017).

2.3. Participants

2.3.1. Inclusion criteria

Participants were eligible to take part if they were working in a school in the UK at the time of interview. Participants were limited to those *currently* working in a school in order to gain a picture on *current* perspectives and experiences, in increasing the relevance and informing developments in the area.

2.3.2. Recruitment

Participants were recruited initially via a voluntary sampling method. A research advertisement (Appendix B) was posted online on social media networks including Twitter, LinkedIn, and Instagram. Eight participants volunteered having read this advertisement. Following this, the advertisement was shared by a TI schools organisation, to directly target interested participants. Three more participants volunteered to take part. Snowball sampling was also used, whereby interviewed participants recommended the study to others.

A total of thirteen participants volunteered and all met study criteria. Recruitment was capped at 13 as research suggests that approximately 12-15 participants are likely to be sufficient for a degree of data saturation (Guest et al., 2006).

2.3.3. Sample

The sample included 13 members of school staff. 12 participants identified as ‘female’ and one identified as ‘male’. 11 participants identified as ‘White British’, one as ‘White Other’, and one as ‘British Pakistani’. Three participants worked in the West Midlands, one in the East of England, six in London, one in the Northeast, one in the Northwest, and one in Wales.

Table 1

Participant Demographics: Type of School

Number of Participants	Type of School
7	Primary Mainstream
2	Secondary Mainstream
2	Across Schools (Non-Specific)
2	Pupil Referral Unit (PRU)

Table 2

Participant Demographics: Role within School

Number of Participants	Role within School*
9	Class Teacher
1	Deputy Head Teacher
2	Speech and Language Therapist
1	Trauma-Informed Schools Practitioner
1	Mental Health Lead
1	Special Educational Needs Co-ordinator (SENCO)
2	Head of Key Stage
1	PSHE Lead

*Some participants occupy multiple roles which the numbers above reflect.

The participants professional training varied. For example, some were trained as Speech and Language Therapists, and one originally trained as a Clinical Psychologist. Most participants trained as teachers. Some teachers had completed additional training, for example ‘Special Educational Needs’ training.

Table 3

*Participant Demographics: Years of Experience**

Number of Participants	Years of Experience*
4	>10 years
5	6-10 years
3	1-5 years
1	<1 year

*Working in a school.

Table 4

Demographics According to Participant

Participant Number	Type of School	Role within School	Years of Experience
1	Primary	Class Teacher/Deputy Head Teacher	>10 years
2	Secondary	Class Teacher	>10 years
3	Across Primary Schools (Non-Specific)	Speech and Language Therapist	1-5 years
4	Pupil Referral Unit (PRU)	Mental Health Lead and Trauma Informed Schools Practitioner	1-5 years
5	Primary	Class Teacher	<1 year
6	Primary	Class Teacher	>10 years
7	Secondary	Class Teacher and SENCO	6-10 years
8	Pupil Referral Unit (PRU)	Mental Health Lead	6-10 years

9	Across Primary Schools (Non-Specific)	Speech and Language Therapist	6-10 years
10	Primary	Class Teacher	>10 years
11	Primary	Class Teacher	1-5 years
12	Primary	Class Teacher and Head of Key Stage	6-10 years
13	Primary	Class Teacher, Head of Key Stage and PHSE Lead	6-10 years

2.4. Procedure

2.4.1. Designing the Interview

Potential questions arose from reading existing articles and studies exploring TIP in schools. The questions were designed to be open-ended, in leaving space for follow-up questions relevant to participant response, and gathering rich data (Bearman, 2019). In line with the framework of Bearman (2019), a 'conversational' structure was sought, including warm up questions and space for reflection and participant questions at the end. After spending time refining the interview questions (Bearman, 2019), participant feedback was sought (Bearman, 2019) through conducting a pilot interview with a recently retired teacher. The participant fed back that they felt the questions and pacing were appropriate, and that the topic would be very interesting and relevant to teachers. However, they shared that they were initially concerned that they lacked relevant 'expertise'. They shared that they appreciated the relaxed conversational style, the use of alternative phrasing, and reassurance about their responses. This was held in mind during data collection.

It is acknowledged that the design of the interview schedule is not objective and will be influenced by researcher context, beliefs, and epistemological position.

2.4.2. Conducting the Interviews

Individual interviews were arranged via email and were conducted and recorded via Microsoft Teams. Interviews lasted between 30 to 60 minutes. An interview schedule including eight questions based on the research aims was used to guide the interviews (Appendix C). Interviews were semi-structured meaning that there was space for follow-up questions to be asked, and an opportunity for participants to share anything additional to the questions freely at the end.

2.4.3. Transcription

All interviews were transcribed by Microsoft Teams and uploaded onto Microsoft Word. The audio of each interview was listened to alongside reading the transcripts, correcting errors, formatting, and anonymising. The transcripts were reviewed several times in improving the accuracy.

2.5. Analysis

2.5.1. Rationale

Interview data were analysed using thematic analysis (TA) (Braun & Clark, 2006). TA is used to develop, analyse, and interpret patterns across a dataset, which involves a systematic process of theme development (Braun & Clark, 2022). This is compatible with a critical realist epistemology and is useful in investigating subjective experience (Willig, 2013). In line with a critical realist position, TA enables interpretation around the association between the ‘observable’ and ‘unobservable’, and underlying process or influences (Braun & Clark, 2022). This research takes a reflexive approach; an awareness that subjectivity is the primary tool for TA and that analysis is underpinned by theoretical assumptions. It also means that the role of the researcher and the tools used have been continually interrogated and reflected on, in terms of how this influences the research (Braun & Clark, 2022).

2.5.2. The Process

A six phase TA was undertaken according to the practical guide of Braun and Clark (2022). Familiarisation with the data was achieved through listening back to the interviews and reading and editing the automatic transcripts. Initial observations, reflections and ideas for coding were jotted down. Each segment of the data that captured something interesting in relation to the research question was coded. An

open coding strategy was applied and therefore there were no ‘pre-set codes’, and codes were developed and modified whilst the data was being read. This process was done using Microsoft Excel, in line with Bree and Gallagher (2016) (Appendix D). The text segments were re-read to ensure that all relevant data was captured within the codes. The codes were refined and re-organised. Any codes which were capturing the same idea were merged. Codes that did not accurately reflect the meaning of the associated data were re-labelled. An extract of a coded interview segment can be found in Appendix E.

Codes were then sorted into clusters of related ideas to explore potential themes. Some codes fell within a ‘miscellaneous’ theme as they did not appear to fit within the main candidate themes. Thematic maps were employed to create themes and identify connections and sub-themes. Theme construction was guided from the beginning of the process by the research questions, and not necessarily ‘prevalence’ in line with Braun & Clark (2022).

Initial themes and subthemes were shared with the overseeing supervisor and adapted. Each theme was reviewed by checking that the data extracts formed a coherent pattern or whether they did not, and so indicating a problematic theme or misplaced data extract(s). The themes were checked for validity and that they were distinct from one another. Theme definitions were considered at this stage to shed light on over-lapping themes or themes that lacked depth or were too broad, capturing multiple meanings. The entire dataset was re-read to ensure that the final themes accurately represented the conceptual features of the data and that nothing of relevance to the research questions had been missed. The process of theme development is presented in Appendix F.

Themes were defined based on the story that they told (Braun & Clark, 2006). A balance was sought between integration of theoretical ideas, and links to the research question and the data (Braun & Clark, 2022). The narrative of each individual theme was considered in terms of how they fit with the wider story told by the dataset. The final themes are described in Results.

A report was written summarising the results of the thematic analysis and this can be found in Results.

2.6. Ethical Considerations

2.6.1. Ethical Approval

This research received ethical approval from the University of East London (Appendix H). The research was also guided by the BPS Code of Ethics (The British Psychological Society, 2021).

2.6.2. Informed Consent

All volunteering participants were given an information sheet explaining the research (Appendix I). This outlined the researcher background and ethical approval, the research aims, what the research would involve, consent, confidentiality, data management, and dissemination. Participants were encouraged to ask questions however there were no questions after reading the information sheet. The participants were then asked to sign a consent form (Appendix J) and reminded of their right to withdraw at any point up until three weeks after their interview.

2.6.3. Confidentiality and Anonymity

Participant names were replaced with participant numbers in the transcriptions and write up of the interviews. Anonymous participant demographics have been included in the write-up in the form of a broad list. Reviewing and transcription of recorded interviews were conducted by the researcher only. Recordings were deleted once transcribed. During the transcription process, any confidential information shared was anonymised. All data was stored securely, in accordance with the approved Data Management Plan (Appendix L). No volunteering participants had any concerns or questions around confidentiality.

2.6.4. Wellbeing and Debrief

It was recognised that participants may have experienced trauma, and that talking about trauma can be distressing. This was an aspect of the research design that was discussed with members of the University of East London People's Committee. The People's Committee raised concerns about the sensitivity of participants talking

about trauma and offered advice in terms of ensuring a safe and supportive space. Prior to the interview, participants were made aware that they could pause or terminate the interview at any point should they become distressed. During the interview, I adopted a warm, compassionate, and empathetic approach. Participants were given a debrief sheet at the end, including information about services that can offer support in relation to trauma or mental health (Appendix K).

2.7. Reflexivity

2.7.1. Epistemological Reflexivity

This research adopts a critical realist position. Although I am striving to know a reality that exists, through research, it is acknowledged that I will never fully be able to access it due to the subjectivity of data collection and the influence of our personal contexts (Willig, 2013). Through my choice of research questions and the questions that I ask participants, I am assuming that 'trauma' and 'TIP' exist, and that the participants will have perspectives on these concepts. A dilemma was how I asked participants about 'TIP', acknowledging that they may not use this conceptual language. Whilst I used alternative language in the interviews to hopefully elicit richer responses, I acknowledge that by using language such as 'TIP' I may have limited what I could know in terms of experiences and perspectives. This will be explored further in the Discussion.

2.7.2. Personal Reflexivity

A reflexive approach to the research has been sought in that I have considered how my own context and beliefs may influence the research. Through my role as an NHS Trainee Clinical Psychologist, I hold views regarding TIP that I acknowledge will influence the research process. I believe TIP to be a useful approach having observed powerlessness and a lack of control or choice amongst service users in healthcare settings. Particularly having worked in inpatient CAMHS, I perceive prevention and early intervention to be very important and I have wondered specifically about whether a TI approach to community services, such as schools, would have prevented children who have experienced adversity, reaching a point of crisis. However, I have also reflected on the set-up of public services, the lack of resource, and pressure on staff, as potential barriers to this approach. Further,

through my work experiences and attendance at TIP-related conferences I have considered the influence of power in the development of TIP. I am sceptical about how the concept of TIP is used by services and whether it is often misapplied in practice (for example, over-medicalising the approach including conceptualising trauma solely as PTSD). Whilst I acknowledge that implementing a TIP approach requires leadership, I wonder if it is too often applied from the top-down, without an understanding or integration of bottom-up experience leading to a lack of implementation success (Emsley et al., 2022; Sweeney & Taggart, 2018). I am aware that these perspectives may influence each stage of the research. For example, I may focus more heavily on these aspects, or draw conclusions on the data based on these perspectives, potentially missing other interesting perspectives or experiences that differ.

I acknowledge that I hold a position of privilege which will influence the research. I am a White British woman in my twenties, currently employed and completing a doctorate degree. I acknowledge that as a result I will have biases, both conscious and unconscious. I am aware that these biases may influence my research, for example, in terms of the questions I ask and the way I analyse the data through a specific sociocultural lens. My position could lead me to miss perspectives, or not ask certain questions. I am aware that my professional role, my position as interviewer, and the conceptual language that I use may lead participants to make assumptions about me. For example, I may be placed in an expert position. My position and language could influence what participants feel able to share, or how they perceive their expertise.

I have sought to maintain awareness of the influence of my context and background and take a reflexive approach throughout the research by completing a reflexive log (Appendix M). The impact of this will also be considered within the Discussion. However, I acknowledge that taking these steps to be ‘reflexive’ does not make the research ‘objective’ or free from bias.

3. RESULTS

3.1. Chapter Overview

This chapter presents the results of the analysis.

3.2. Final Themes

The process of thematic analysis is described in the Method and Methodology section of the thesis. Illustrative examples are provided in Appendices D and E. The thematic analysis produced three global themes, and eight subthemes. The themes and subthemes are presented in Table 5 below.

Table 5

Final Global Themes and Subthemes of Thematic Analysis

	Global Themes	Subthemes
Theme 1	Theory to Practice: Challenges Defining Trauma and TIP	Trauma Isn't One Size Fits All TIP: *Do I Know What This Is?*
Theme 2	Practice to Theory: Current Response to Trauma in Schools	Building Trusting Relationships Creating Safety Empowerment
Theme 3	The Influence of the Wider Context	Pressures and Priorities A Broken System Covid-19 Affordances and Constraints

Each of the themes are defined and described below in greater detail. In presenting each theme, anonymous extracts from the interviews will be included. Some words are omitted from the extracts to shorten the quotes, and engage the reader, based

on what is perceived to be most relevant in relation to the research questions. Omitted words are replaced with (…). In some cases, further context is required for the reader's understanding and in these cases *[context]* has been integrated into the quotation. Quotes have been tidied up for the purpose of the readability of the report. Themes and subthemes will be both described and interpreted in the analysis; however, most of the theoretical interpretation will be within the Discussion (Braun & Clarke, 2022).

In summary, participants describe conceptual challenges in relation to trauma due to its broad and contextualised nature, which leads to practical difficulties in recognising it. They also describe a lack of familiarity with TIP, and a lack of confidence in their practice in the absence of training or guidelines. However, despite this, the way in which participants conceptualise trauma and practice, is consistent with TIP and its theoretical underpinnings. Although participants recognise the widespread nature of trauma and its impact, and implicitly prioritise TIP, wider contextual factors create barriers to their individual practice and TIP as a whole-school approach. The context of the pandemic is perceived as both constraining and affording.

3.2.1. Theme 1: Theory to Practice: Challenges Defining Trauma and TIP

A consistent theme was that trauma is difficult to conceptualise due to variation in the cause and effect of trauma between individuals. This leads to practical challenges in recognising and responding. Participants were largely unfamiliar with 'TIP', which despite their practical experience, leads them to further doubt their skills.

3.2.1.1. *Subtheme 1: Trauma Isn't One Size Fits All:* Participants discuss variation in the cause and effects of trauma, and the factors that can influence this, leading to practical challenges.

In discussing the causes of trauma, participants highlighted the difference between what is understood to be developmental or complex trauma, and single-event trauma, often associated with PTSD.

It [trauma] is very ambiguous (…) it could be a one-off incident that causes a major effect like sexual abuse. It could be something that was ongoing for a long period of time.

P13

The dilemma around the conceptualisation of trauma in terms of specific categories (e.g., physical abuse), was often highlighted in terms of its reductionism and how it can limit the recognition of other traumas (e.g., poverty, the collective trauma of the pandemic).

It's a tough one. (…) I suppose when people think about trauma, they immediately think about safeguarding child abuse (…), whereas I think what we see as teachers (…), is children who are dealing with trauma due to just living in such poor housing, and that is causing them daily trauma (…) it can't necessarily be pigeonholed into any one thing.

P10

It's [trauma] a really hard umbrella to get your head round because (…) we had this whole conversation and I've only just gone, oh [realising Covid-19 as a form of trauma] (…) and that shows that in your daily life as a teacher, how hard it is to be aware constantly of those things because that's been something we've been dealing with (…) it is staring me in the face and I didn't even mention it.

P10

Participants also discussed the effects of trauma; largely in terms of the impact on behaviour.

Anything that has adversely affected a child (…), that has an effect on them growing up and in turn their behaviour. For example, if you're living in a household where domestic violence has taken place, the impact that has on the child, say coming into school; how they react to different situations in school or how they how they are within themselves. So, just a change in their behaviour.

P1

The impact on behaviour was often understood in a relational context. For example, trauma was understood to impact the way a child relates to adults in order to receive care.

Sometimes the child will like lash out aggressively in their behaviour (…) You know, any attention is attention (…). Even if it's negative, it's still (…) adult attention.

P11

Relational impacts observed through behaviour were also highlighted through participants speaking about response to boundaries set by adults, and trauma impacting on self-concept and leading to a sense of being to blame.

The impact in school was that behaviourally, they found it hard to conform to rules (…). In terms of following rules that we think are easy to follow, children who've experienced trauma will find that a lot more challenging because they think it's a reflection of them rather than a reflection of, I just need to learn how to do this (…) if anything goes wrong, it's on them.

P6

Whilst there was consensus around the impact on behaviour, it was described as varying greatly between individuals. There was resistance to a 'one size fits all' conceptualisation characteristic of the medical model.

I can't say that there's a specific description that you can give to it [trauma], I think it affects different children in different ways (…) so I think it's very individual.

P2

I think this is why I get stuck, because traumas can be all different, I think, I don't necessarily understand it as a whole, just like I wouldn't understand Autism as a whole, because everyone who has Autism is different.

P7

When discussing the varied impact, participants often described a dichotomy between externalised and internalised behaviour.

They're either really withdrawn or completely hyper. (…) I wouldn't necessarily have thought about the ones that are hyper and very bubbly and It's very different depending on anyone.

P12

I'd say it's [behavioural impact] quite different ends of the spectrum.

P11

Participants described the impact as dependent on both individual-level factors (age) and wider contextual factors (access to supportive relationships beyond the primary caregiving relationship). Participants regularly evoked the notion that if a child can turn to trusted others for safety, the impact of the trauma may lessen, highlighting the importance of relationships.

It's the nature of the trauma, the age at which the child experiences it, the number of traumatic incidents, the protective factors (…). But I think it's really hard to quantify impact (…) some children have multiple traumas and do really well because there's other stuff going on. For example, a good relationship with school (…), they might have really good relationships with staff. They might have parents who neglected them (…) but had external family members that were really protective.

P4

Everyone who experiences trauma is different because it depends on what sort of support system you would have, whether you can access therapy, what caused the trauma, when the trauma was. (…) What I learned (…) was all about how if you experience trauma as a child, your development can be interrupted, but if you have the right support (…) then you can work through that trauma to recover.

P7

There was also an implication that some children experience barriers to external support which will increase vulnerability. The extract below highlights the perception that certain forms of trauma are less conducive to help-seeking.

If, for example, your parent dies when you're little, everybody looks after you, everybody knows, so you get support. Whereas domestic violence is hidden, and so I think that would be a very, very different situation (…) (…) and like drug abuse or parental neglect.

P7

Whilst there was resistance to a ‘one size fits all’ conceptualisation due to it being reductionist, participants described practical dilemmas associated with this in terms of responding to trauma.

This is where it becomes so difficult for teachers (….) you have children who are suffering trauma, who can become really needy, really vocal, and never stop talking, but then you can have a child who never talks, and he's really withdrawn (…). We see behaviours (…) that are violent, aggressive, sexually provocative. There is no set behaviour that would make you say, well, this child clearly suffering trauma, and I think that that's what makes it so difficult for teachers.

P10

I think it depends on the trauma as well, what it is that has happened (…) we don't know what the best approach is (…) because each individual trauma is so different, how should we approach that as teachers?

P1

3.2.1.2. *Summary:* Participants describe it as difficult conceptualising trauma due to its broad, context-dependent nature. However, whilst there is resistance to a 'one size fits all' conceptualisation, there are practical challenges associated with this.

3.2.1.3. *Subtheme 2: TIP: Do I Know What This Is?:* Participants describe a lack of familiarity with TIP, or any other guidance in relation to trauma. This leads them to doubt their skill or expertise in responding to trauma.

Most participants (9/13) had not heard of the term 'TIP'. Participants made guesses about its meaning, however there was a lack of certainty.

I'll be honest, I don't have a great depth of knowledge on it. If I was to interpret what that might be, it's how we (…) help in assisting a child that's gone through some sort of trauma. I don't actually know, that's just my interpretation.

P13

I wouldn't say I'd heard that as a term to be able to say this is what it is. I would suggest that trauma-informed practice is looking at ways to help young people that have gone through trauma (…), maybe it's similar to what I'm saying was lacking (…). There doesn't appear to be any (…) guidelines because obviously it's a very broad spectrum of issues (…), but I don't know whether I'm right.

P2

When I saw the words, I was like, do I know what this is? I don't know (…) My guess is that it's about people working with children or young adults, just being aware of trauma, and letting it guide our practice (…). But I genuinely don't know.

P9

Implicit in participant responses is that without knowledge of a specific trauma framework, they lack confidence. Participants frequently questioned whether they do it 'right'.

We just say, you know, you've gotta come in now. What? Classroom or bottle? [specific space for supporting with emotion regulation] Your choice. Which is it going to be? (…) But, (…) are we doing the right thing, reacting the way we do?

P1

However, participants discussed the impact of years of teaching experience. Implicit here is the idea that 'practice-based evidence' is important too, in terms of getting it right for the individual student, shifting the focus from 'evidence-based practice' and getting it right in terms of theory.

It's quite hard, especially as a new teacher, to know how to react, especially because there's children who I know in my class respond really well to more nurturing and caring behaviour if something's going on, but then there's other children, who want their everyday life in the classroom to be the same as everyone else (…). I think that's really hard and I'm not necessarily trained (…). Sometimes something might happen then I'm like, oh, is that a really good way for me to react?

P5

However, it is acknowledged that whilst 'practice-based evidence' is important, this does not necessarily lead to a sense of 'expertise'. Implicit is that fundamentally 'expertise' is associated with formal education, and thus the privileging of certain types of knowledge, leading to school staff feeling that they lack the relevant expertise in the absence of any formal training.

I don't always know if I get it right, it's not my area of expertise, but I think I'd probably have a greater understanding than teachers who first come into the job. You know, 22-year-olds who've done a film studies degree like one of my friends, and came into the job and went 'Oh my God, what is this?'

P10

I have wanted to make sure it [TIP] is in my practice day-to-day, but I've never felt like it's something that I 100% know if I'm doing the right thing or know if it's working for these children (…). I've been teaching a very long time without having anything [training].

P6

3.2.1.4. *Summary:* Most participants described a lack of familiarity with TIP. Despite practical experience, the lack of a conceptual framework in the absence of training leads staff to doubt their practice.

3.2.2. <u>Theme Two: Practice to Theory: Current Response to Trauma in Schools</u>

Whilst participants spoke about the challenges around conceptualisation and theoretical knowledge, this theme highlights that current practice is consistent with

TIP. Participants described prioritising building trusting relationships and creating safety, and the ways in which they empower children who have experienced trauma. This theme is split into three subthemes based on the TI principles reflected in the data (trust, safety, empowerment), however it is acknowledged that there is theoretical overlap between the principles.

3.2.2.1. *Subtheme 1: Building Trusting Relationships:* Participants described the importance of prioritising building relationships and specifically spoke about the importance of trust which reflects the TIP principle of trustworthiness.

> *Because it's [responding to trauma] all about relationships.*
>
> *P1*

> *It is about boundaries and consequences. But trauma-informed boundaries and consequences that include adults and that build on relationships rather than making the trauma worse.*
>
> *P4*

Often, the importance of building relationships on trust was discussed. This was discussed in context of the relational impacts of trauma leading to mistrust in others as people who are there to help them.

> *But it makes it more difficult for us when, when they get to us [specialist provision], there's a lot of distrust. So, we start off with a lot of relationship building before any academic side comes into it.*
>
> *P8*

Relationships have always been hard for them, or not worked out the way they thought they would (…) so responses to adults is challenging. Eventually if you're with them enough, those children form quite good attachments with you (…) but if anybody else tried to deal with the child's behaviour in a way that probably wasn't the same, they would find that really challenging because they don't have that sort of trust that they can apply to everybody. They aren't thinking that every adult is there to help me.

P6

Participants described the importance of trust on a system-wide level, through speaking about building trusting relationships with families.

As a teacher, I feel like I spend most of my time with the children, but I can't be with the children without building trust with the parents.

P12

This was often discussed in the context of families struggling to 'open-up'.

You're there for the sake of the child and you wanna get more information, but the parents aren't giving you anything. They will get defensive and you kind of feel like you're breaching their privacy. It's tricky, because sometimes the trauma is because of the parents so you have to do it really carefully (…) but they don't always open-up.

P12

It's tricky because a lot of our parents won't come directly to us. They are all on Facebook. So that's a challenge (…), we have got a lot of work to do to build that relationship, but it is exactly those parents [of children who have experienced trauma] who don't want to build the relationship.

P1

Participants describe mentalising past relational experiences that may have led families to lack trust. Past experiences with professional systems may have led to a

sense of powerlessness and thus a difficulty trusting others, impacting on their relationship to help.

> *They might have had a terrible experience at school and they are suspicious, they don't want their child to come to us (…). They don't feel like they've had any control over what's happened with the exclusions, relationships have obviously broken down at the previous school.*
>
> *P8*

A participant describes the continuous re-telling of traumatic stories in order receive help, for help to be withdrawn, leading to reluctance to open-up and trust that professionals are here to help.

> *One of our families are on their 5th social worker and the boys have just been put into temporary foster care. They've gotta go through the whole story again, (…) it's back to square one.*
>
> *P1*

One participant discussed the influence of culture on building trust in relationships; highlighting that people from similar cultural backgrounds may relate and build trust more easily. This may also speak to the potential influence of historical and current oppression on the way in which individuals from racially or ethnically marginalised backgrounds may be able to relate to, or trust in the help offered by, professionals or systems of power.

> *I think culture-wise it can be quite difficult for people to open-up (…). I'm able to see that from my experience (…) and I do find that I do have a better relationship with other like diverse parents, I would say (…). I just feel like they're comfortable, and they can talk to me about it.*
>
> *P12*

This process of mentalisation of past relational experiences informs staffs practice in order to break cycles of mistrust and build trust in relationships.

We've tried so many different things. We have parent's days where we'll try and get them to come in, and we pay for taxis. We will do raffles and (…) we've had some really lovely feedback from parents.

P8

When they [child] have made really good choices, (…) we will ring the parents so that we've got something to hook our next phone call on to. It's not only for that but for their parents to also see that they've been brilliant, they've made a really good choice, but that does start to build up that relationship so that you know next time we have to call (…) they're more conducive to answering the phone, because they know we're not just ringing them for the negatives.

P1

3.2.2.2. *Summary:* Participants described the importance of building trusting relationships system-wide, based on difficult past relational experiences leading to mistrust in the context of trauma.

3.2.2.3. Subtheme 2: Creating Safety: Another common theme was the prioritisation of safety in response to trauma.

Participants frequently spoke about how they prioritised psychological safety in their interpersonal interactions, further highlighting an understanding of the relational impacts of trauma. For example, giving children information and preparing them for changes or events.

I speak to children and say we've had to change this now just so that they feel secure in what's happening because every day for children who've had some sort of trouble in their life is challenging. So, to make it them feel as secure as possible is my primary aim.

P6

Participants also spoke about the importance of organisational safety, in terms of a whole-school, consistent approach to behaviour.

Behaviour policies are big one actually for me because I when I was an assistant head, our behaviour policy was very positive, (…) we would use behaviour scripts that, everyone uses to create that safety for children, so children no matter what, know exactly where they stand with all adults.

P10

Safety was frequently associated with consistency and predictability. Implicit here is an understanding that trauma can be associated with unpredictable relationships and environments, leading to a sense of danger. Participants described schools as well placed to provide children with consistency and predictability, highlighting the potential that schools have to mitigate against the long-term effects of trauma.

I taught a little girl, her older brother had severe learning difficulties where he was quite violent and physical at home (…), and this little girl in my class (…) she just absolutely loved going to school just because it was you know a safe place for her because home wasn't (…). Your friends, you know what is expected, the routine.

P11

They've got one classroom, they've got one teacher for the most part, you know, one place that they're gonna go (…), they don't feel that sense of constantly moving around. It's almost like having a bedroom in their house.

P13

In addition to interpersonal and organisational safety providing children with consistency and predictability, participants discussed the importance of creating a safe physical environment so that children can feel in control of their emotions and be protected from harm.

It is creating safe spaces so the physical environment being conducive to supporting traumatised children. (…) We have a sort of a goldfish bowl (…), when the children come out of their classroom, there's this whole big area where they can congregate (…). We're trying to create spaces (…), they can go somewhere quiet, a sensory room (…). So, making the environment safe.

P4

Also, in terms of safe spaces, that's something that we do as teachers, in my career I know that it's incredibly important that children have that place that they can take themselves off to, you know, (…) having those chairs that just have a fold over, so they can't be seen, depending on what the child needs, and we've had all sorts of things, weighted blankets that they can get inside.

P10

3.2.2.4. *Summary:* Participants spoke about prioritising psychological and physical safety. Safety was discussed in terms of interpersonal, organisational, and physical safety, in line with TIP guidelines. Safety was associated with predictability and consistency and schools were perceived to be well placed to provide this.

3.2.2.5. *Subtheme 3: Empowerment:* Participants described a response to behaviour that reflects the TIP guideline 'empowerment'; defined by tuning into what a person needs, validating feelings and experiences, and supporting them to make decisions.

Participants described tuning into a child's needs by understanding behaviour in the context of experiences. There was a resistance to a problem-focused understanding of difficulties and a paradigm shift from 'what is wrong with you?' to 'what has happened to you?', consistent with TIP and a contemporary psychological approach.

So, moving on from what's wrong with you to what's happened to you, kind of conversations, seeing behaviour as a communication rather than just reacting to behaviour with a policy.

P4

Teachers are very aware every behaviour is a means of communication and what's behind that. They want to find out why that behaviour is happening rather than what the behaviour is.

P1

It's kindness and understanding that children might not be always in control of how they react (…). So, say you ask your child to do something and they lose their temper, there's a reason why that child is losing their temper, that child is telling you that they need something, for us to help them.

P7

Participants also described a shift from the historically dominant authoritarian approach in responding to the needs of individuals who have experienced adversity. However, they describe this as at odds with some cultural ideas of parenting which can impact engagement.

I think some parents see the way that we deal with children's behaviour as soft because it's not your traditional sanction-based, obviously there are consequences for poor or dysregulated behaviour, but I think a lot of our parents want to see consequences (…), whereas we understand what's behind the children and the consequences will change depending on the children and the situation.

P1

Participants describe how an authoritarian style could actually worsen difficulties in the context of trauma. Implicit here is a resistance to re-traumatisation in line with one of the TI 'Four R's' assumptions. Whilst school can be a 'safe space' in terms of structure and routine, participants describe that it can re-traumatise in the absence of a whole-school TI approach.

Reprimanding children in front of other children, correcting behaviours in front of other children (…), or trying to deal with dysregulated kids in that context is really unhelpful.

P4

People will react to him [student] differently depending on their role in school. Quite often, the TA's, (…) will shout at him, which will make him worse (…). They don't know how they should react, (…) they're quite old school and they tend to shout.

P1

I believe coming into school becomes traumatic for that child. (…) There is a child in our school, he spends his life sitting outside the office with a book, that's not responding to their needs.

P10

Participants described a shift towards validating experiences and emotions through co-regulation, and a strengths-based approach in terms of recognising the more 'positive' behaviours.

If a child is running out of the classroom, not just simply going out and saying 'you're gonna be excluded if you don't go back in', but taking them somewhere quiet, wondering what's going on, empathising that this is obviously really difficult. Then try to help them regulate because children regulate with other adults that can help them regulate, not in empty rooms.

P4

It [previous behaviour intervention] was called, 'Good to be Green', and in the classroom as used to have a display, and every child had a card which started on green, and if they had a couple of warnings, then you got an amber card. Then one more warning and it went to red. Basically, all that was doing was shame; (…) you've been naughty, you've made the wrong choices (…). So, we changed that to recognition boards, (…) we're putting up children when they're making the right choices.

P1

If we are able to make them feel positive about their themselves (…) emotionally, I think that that would help them. (…) There may be tiny little things which aren't earth shattering, but actually it's something that needs recognising for that student because perhaps their self-esteem is low (…). For example, if it was a student that perhaps had previously poor behaviour but is actually making all-be-it small strides, actually recognising those.

P2

The notion of increased choice and control was also described by participants. Both explicitly and implicitly, responses suggest their practice is informed by an understanding that children who have experienced trauma are likely to feel 'done to' by others and therefore powerless.

Sometimes with trauma the choice is taken away. Giving that back to them through school is really important (…) you can have golden time, you can go and pick whatever you want (…), making them realise they do have a choice.

P12

I am giving children choices (…) you can sit in your special spot or you can come and sit on the carpet, so being under the table is not an option and nine times out of ten they'll be like oh, I'll go to my special spot because I like it there and I feel safe there. I think those forced choices work really well because you're not overwhelming them (…). They feel in control because you're not saying just do this now, you're saying these are your two options.

P6

It's trying to let them take control because a lot of the children don't feel that they have any control when they come to us [specialist provision]. All decisions have been made.

P8

3.2.2.6. *Summary:* Participants describe the importance of empowerment in terms of tuning into a child's needs, and responding through validating their experiences and emotions, positive reinforcement, and offering choice and control. Participants

describe that this should be a whole-school approach to behaviour in resisting re-traumatisation.

3.2.3. Theme Four: The Influence of the Wider Context

Whilst participants discussed their practical experience of applying ideas consistent with TIP and the perceived importance of this, they also described the wider contextual factors that create barriers.

3.2.3.1. Subtheme 1: Pressures and Priorities: Participants describe that wellbeing is not prioritised adequately in education, at odds with the widespread nature of trauma, limiting their capacity to be TI.

Although participants described a drive to do activities which promote mental health and wellbeing, the pressure to meet the demands of the national curriculum often creates a barrier to this.

> *There's a lot of mindful activities (…). I definitely want to create like a really open space to talk about things and I always find that after we've had an afternoon like that, children will come up and tell you something that they haven't told you before. (…) It's so important to have those times because it is very 'go, go, go' in the classroom and it's hard because you feel like you've got to fit all of this stuff in especially with the national curriculum (…) but they need that time.*
>
> *P5*

> *I think because schools are so fast-paced and busy, (…) teachers are so pressured to fit everything into a day, we're sort of like, oh, God, another thing to sort of worry about (…). So, I think that would probably be a barrier for me.*
>
> *P11*

There was an implicit understanding that the TI approach is not solely about implementing specific interventions, but an approach which informs day-to-day practice, and that the pressures create a barrier to this. The pressure leads to compassion fatigue amongst staff which may cause harm or re-traumatise.

I think the expectations make the stress worse and then people don't always react in the right way (…). I think that can create problems when there's an issue with a child, it isn't always dealt with in the right way because people are stressed themselves. (…) if someone is shouting at you, you shout back when you don't mean it.

P7

Participants situated these pressures in the context of the strategic priorities of senior leadership teams (SLT) and regulatory bodies. They described these pressures as leading to tokenistic wellbeing initiatives. Tokenism was distinguished from an investment in the emotional wellbeing of children that actually enables better learning outcomes.

It doesn't necessarily become a priority, and that's (…) the culture of working within a school where you're under so much top-down pressure. Children are not gonna learn unless they're happy, unless they're safe, so actually an investment in the emotional well-being of the children and it not just being an add on, it not just being something we say that we're doing (…); 'we've got this award for this, and we've done this'. They are surface initiatives. It does depend on priorities of the senior leadership team, and I think Ofsted this year threw a huge amount of pressure onto senior leadership teams.

P10

Participants described how SLTs may not be motivated to invest in a cultural shift towards wellbeing if this is not deemed measurable, perpetuating the issue of tokenistic wellbeing initiatives.

You can't put a target, (…) it's not something that's measurable (…) and then seems to be therefore less worthy of time because time needs to be spent on other things which are measurable and which are accountable.

P2

Participants spoke about how, due to the inadequate prioritisation, trauma is not integrated into training or professional development.

> *That's [safeguarding training] every year and it's very much look out for these signs, but there's no training as such as in (…) what do we do on a classroom level day-to-day that's going to support those children? There's nothing.*
>
> *P6*

Participants described that when training has been offered, it has been offered hierarchically, limiting a whole-school approach.

> *It's not consistent across people in different roles (…) so my aim now is to make sure that the teaching assistants and support staff get the same as the teachers.*
>
> *P7*

> *I think only the more important people in school know about these things [responding to trauma] and generally the people that work with a child day-to-day (…) may not know about all of this stuff.*
>
> *P3*

Whole-school training was described as important in ensuring a system-wide approach.

> *The whole staff team needs to be aware, they need to be trained and that can be kinda dripped through so they understand you know, why we're doing what we're doing, why we're not sending kids home for example.*
>
> *P4*

> *It's not just kept within one person whose then very knowledgeable, it's sort of about spreading that knowledge around the staff and making sure that everybody is aware.*
>
> *P6*

Participants described how a lack of prioritisation of wellbeing compared to academic outcomes, also means that trauma is not embedded into whole-school policy, creating a barrier.

> *The policies need to be reviewed in every school, (…) with somebody who's TI trained to then make that policy more trauma-informed. Exclusions need to be reduced.*
>
> *P4*

Participants described a discrepancy between the prevalence of trauma in schools and the way in which it is prioritised in the education context.

> *I think this [trauma] is a huge part of what teachers deal with day in and day out. (…) I don't think that we are adequately prepared for those things when we enter the job, and then when we're dealing with it, I don't think that we are adequately supported.*
>
> *P10*

> *This is major, and people don't understand (…) and these are people that are teaching children, (…) it was just something that we never had direct training on.*
>
> *P6*

3.2.3.2. *Summary:* Participants describe that for schools to be TI, there needs to be a higher-level, strategic shift in priorities. It is important that it becomes a part of staff training and whole-school policy. The lack of prioritisation is at odds with the widespread nature of trauma in schools.

3.2.3.3. Subtheme 2: A Broken System: The lack of funding for public services including schools is also described as a factor impacting school's capacity to recognise and respond to trauma. Participants spoke about this as a worsening situation and implied that schools have previously been in a better position, hence, *'a broken system'.*

Participants frequently described a lack of staff as a barrier to TIP.

> *You can create the safe space for a child in the classroom, but sometimes if I feel overwhelmed, I need to just get away, and you can't facilitate that at school because there's one of you and all of them, and when they're so young, you can't just say, oh, take yourself off to the library. You can do everything in the classroom to help them to regulate their emotions, but I think having extra staff in school would benefit.*
>
> P5

The lack of staff was often spoken about as a worsening situation.

> *Things that we used to do, when we had the staff, like nurture group, like social skills group, that these children need, we don't run them anymore because we just don't have the people (…). We're aware we could be doing more but then I'm not sure that we could even if we wanted to, even if it did even become a priority, because of the lack of people.*
>
> *P10*

> *We did have a SENCO who's no longer with us (…), I'd get regular emails from them with advice (…) but we have nothing.*
>
> *P6*

> *At one stage, I think we had two designated people that were children's mental health specialists and then they both left.*
>
> *P13*

Participants often described how staff adopt additional roles due to the staff shortages. However, this was perceived to not work in practice.

> *We have teaching staff who have extra qualifications and part of their timetable now is to support the children who are suffering with mental health issues, which takes them out of teaching time, but there doesn't seem to be any other solution.*
>
> *P7*

SENCOs are now class teacher's so the role has just changed so much as well as and that's just because of funding, perhaps (…) more and more schools are becoming like that.

P3

It's robbing Peter to pay Paul, really, because they're gonna have to be taken out of classes where they're not spare, so it's a really difficult thing because it is man-power, ultimately, that makes these responses work.

P10

Participants stepped back from the immediate 'micro' context of schools and looked to the wider 'macro' context in terms of a lack government funding, which is often time-limited. They described the onus for change as going beyond members of school staff.

We've got dwindling funds (…), when people leave now, we don't replace them because we don't have the money, so we just kind of claw back that money and put it back into the pot.

P10

We had our own social worker because we're part of a trial, but that's ran out now. If we wanted them to stay, we'd have to pay out of our budget, which we don't really have.

P7

Participants extended the issue of under-funding to children's services more broadly. This was described as impacting communication between services. The word 'broken' implies the system once worked better than it currently does.

It doesn't help that social workers are particularly stretched at the moment, (…) and so any communication takes a long time to get through to us and it just is a bit broken.

P1

It's the follow-up where things are really tricky. Between the schools and other services, whether it be the police service or social services. (…) It just doesn't work, and I don't know if it's time, I don't know if it's resources, but it feels like (…) as a class teacher, I've done my part, (…) but there's never that full follow-through. It's just kind of like ensuring that (…) we're tying up and keeping in contact with other professionals and other agencies and making sure those things are absolutely not falling to the wayside.

P6

3.2.3.4. Summary: In supporting schools to respond to trauma, participants recommend that services (schools and other child services) should be funded so that there are adequate staff numbers and resource enabling them to function as a united system.

3.2.3.5. *Subtheme 3: Covid-19 Affordances and Constraints:* Participants discussed the context of the Covid-19 pandemic as both offering affordances and constraints.

Participants described how the pandemic has been experienced as a form of trauma, increasing the prevalence of difficulties amongst children.

I feel like they're [teachers] still playing catch up. They've [teachers] said to me that they've got children who just can't sit at carpet time or can't put their hand up and wait to answer a question (…), because they've missed that chunk of time, they lack those kind of foundational skills (…). They [teachers] feel the pressure of catching up, and typically older year groups are working on lower year groups stuff (…). They're having to do a lot of differentiating within the classroom.

P9

Post-Covid where children have been so traumatised, you know, some have lost relatives, (…) they missed such crucial social socialisation. This Reception year, they're in a terrible sort of emotional state. There are regressive behaviours (…). There are a huge amount of speech and language needs and behaviours that would be indicative of children who were much younger.

P10

It was highlighted that the impact of this is greater for certain children whose families have less resource, widening the gap in social inequality.

We had a big impact from Covid because lots of our children didn't have the resources to do home-learning (…), and even their social skills were affected.

P5

Participants spoke about the pandemic as just one aspect of the current challenging social climate in the UK impacting children, also referencing the impact of the cost-of-living crisis and poverty.

Families are getting more complex, the country's in a state at the moment, children are gonna be suffering. We've seen children who are hungry. You know that that is traumatic in itself. Parents who've lost jobs and they're worried about money. We had a 200% increase in families who said they would be hungry over Christmas. The impact that has on the children, (…) these children are displaying these behaviours, and that's going to continue with everything we know that is happening in the country at the moment.

P10

Participants highlighted the system-wide impact of the pandemic through describing the impact on building trusting relationships with families.

We didn't have parents in when we started our behaviour regulation policy because of Covid. And we do need to do that, and we need to start building those relationships with those parents again.

P1

Not only are staff managing the systemic impact of the pandemic on children and families with dwindling resource, but also the impact on their own wellbeing.

> *I think staff have experienced trauma as well because obviously staff have had parents die, staff have been shielded, staff have, well, everybody's lives have been different, haven't they? And now things are getting a little bit easier, I think people are finding that it's now starting to bother them. They coped, because they had to, whereas now people seem to be struggling.*
>
> *P7*

One participant spoke about the impact on staff's wellbeing as worsened by neglect of school staff during the pandemic at a wider societal level.

> *Staff sickness is a massive problem (…). I think it's Covid-related and the fact that schools and teachers were neglected in the pandemic (…) it was all like clapping the NHS staff, you know (…). The teachers were going in every day, (…) they were getting sick, they were having to neglect their own families. They were having to move their whole way of working to online, they were working double the hours and they were being criticised for having it easy.*
>
> P4

Participants described how the widening gap between demand and resource since the pandemic and the impact on staff wellbeing has worsened the issue of staff retention. This further emphasises the systemic impact of the pandemic as a barrier.

> *Since Covid hit, we haven't been able to fill them [staff vacancies]. Educational Psychologists are leaving because they've got too many children and they can't look after them (…). Speech and Language Therapists, our Social Workers, (…) a lot of our avenues that we would use to support children who have had traumatic experiences aren't as easily accessible (…). You have to be in crisis to get support now.*
>
> *P7*

So obviously there's CAMHS, that's kind of fallen through, we used to have a really good relationship, but then Covid happened.

P8

However, whilst the pandemic is described as increasing the barriers to a whole-school approach to trauma, they described how the system-wide impact of the pandemic has conversely highlighted the importance of this.

[Covid-19 pandemic] I think there's a whole systemic trauma that's impacted on everyone, it isn't just about looking at the child in the room, it's looking at the whole context around them (…). It's a whole-school approach, it has to include the adults. So, looking after the adults so the adults can look after the children.

P4

Despite the reported lack of prioritisation and dwindling funds, the pandemic may have led to positive organisational growth in terms of a shift in educational priorities.

I think it's going in the right direction, with mental health and wellbeing, and I think that's gonna accelerate, because of Covid.

P8

It's been a heavy push after Covid this whole well-being approach to learning (…) but it's everyone's well-being really, not just the children's.

P12

3.2.3.6. Summary: The Covid-19 pandemic has impacted school's response to trauma both in terms of the systemic trauma impact and increased demand on services. Optimistically, it has also increased the recognition of trauma as widespread and the importance of whole-school approaches.

4. DISCUSSION, EVALUATION, AND IMPLICATIONS

4.1. Chapter Overview

This is the first qualitative study to explore school staff perceptions on trauma and TIP in the UK context, in a non-evaluative capacity. In answering these questions, this study aimed to present staff perceptions on trauma and its impact, to present perceptions on TIP, explore current staff experiences of responding to trauma, and identify any perceived barriers or areas for development in this area. This chapter will seek to answer the research questions and discuss the findings in the context of theory and past literature. Following this, implications will be discussed. The study will be critically appraised, including strengths and weaknesses. Finally, recommendations for future research will be outlined.

4.2. Research Findings: Summary

In response to research question one, findings highlight the broad, contextual nature of trauma in terms of cause and effect, observed in schools. Findings suggest a resistance to a 'one size fits all' conceptualisation of trauma, characteristic of a medical model approach. Indeed, the way in which staff conceptualise trauma aligns with a contemporary psychological approach and TIP. However, without the theoretical language or a conceptual framework, school staff lack confidence in their ability to recognise and respond to trauma. In response to research question two, although findings suggest a lack of familiarity with TIP, both understanding and individual practice is consistent with TIP, and implicit in responses is the perceived importance of this approach in schools. However, findings highlight how the wider context creates barriers to TIP as a whole-school approach. The context of the pandemic was perceived to be both constraining and affording.

Findings are discussed in greater detail below and interpreted in the context of theory and literature. Findings are discussed according to theme in order to not detract from the analytical narrative, in line with Braun and Clark (2022).

4.3. Research Findings: Theme 1: Theory to Practice: Challenges Defining Trauma and TIP

4.3.1. The Causes of Trauma

Findings suggest that school staff perceive there to be large variation in what causes trauma, which makes it difficult to define or understand as a 'whole'. Indeed, participants implicitly and explicitly described both the notion of developmental and complex trauma (van der Kolk et al., 2009), compared to single-event trauma associated with PTSD (American Psychiatric Association, 2013) highlighting the importance of broadening diagnostic criteria beyond PTSD (van der Kolk et al., 2009). The broad nature of trauma in schools supports the limited research exploring staff experiences internationally (Koslouski & Stark, 2021). Findings build upon this and suggest that certain forms of trauma are more difficult to recognise or hold in mind in schools. For example, trauma that is hidden, or caused by *'poor housing'* or the collective trauma of the pandemic. This may reflect dilemmas associated with categorising trauma and specifically the critique of the dominant ACEs framework (Bateson et al., 2020; Felitti et al., 1998) in that the trauma 'categories' overlook other forms of trauma, for example, resulting from social inequality which schools are observing increasingly according to findings. Findings highlight how this framework may perpetuate narrow understandings of trauma and therefore the greater vulnerability to impact based on social inequality (Allen et al., 2014; Bernard et al., 2021; Gauffin et al., 2016). Indeed, findings offer more support to the Ellis and Dietz (2017) 'resilient communities' approach to ACEs and suggest that this would be a more helpful framework for supporting schools to recognise trauma.

4.3.2. The Effects of Trauma

Findings highlight that trauma impact is observed through behaviour in schools, in line with Chudzik et al. (2021). This can be made sense of through drawing upon attachment and mentalisation theory (Ainsworth, 1978; Fonagy, 2006). Children who have grown up in challenging environments where the primary caregiver has been the source of the distress, or too distressed to soothe or co-regulate emotions (Ainsworth, 1978), may experience emotional or behavioural difficulties (van der Kolk, 2014). It also may reflect the way in which a child's brain has developed in the

context of trauma, with a focus on survival, and limited resource for the development of higher-level skills such as emotional or behavioural regulation (Greene et al., 2014). These theories can also be drawn upon to explain the finding that the impact on behaviour is a 'broad-spectrum'. For example, this may reflect the different attachment styles or 'adaptive strategies' that children have developed in the context of trauma (Ainsworth, 1978; Crittenden, 2006). Withdrawn behaviour may be observed in a child who has learned that showing their feelings brings on danger or leads to the withdrawal of care. The more 'challenging' behaviour may be observed in children who have learned that the only way to receive care is to show 'exaggerated' behaviour (Ainsworth, 1978; Crittenden, 2006). This broad-spectrum impact may also reflect differences in a child's physiological response to stress and whether a child is over-aroused or under-aroused (Cross et al., 2017). Indeed, this finding not only makes sense in terms of theory, however also in the context of prior research, highlighting that 'traumatised' children are more likely to be excluded from school due to 'poor behaviour' (Pierce et al., 2022).

According to findings, the way staff understand the reasons for behavioural dysregulation through their practical experience implicitly aligns with relational models (Ainsworth, 1978). For example, participants described children internalising adult boundary-setting or rules as a '*reflection of them'*. This suggests an understanding that childhood trauma can lead to negative self-concept and the perception that others are untrustworthy, which may reflect a child's internal working model of themselves and others, formed by their early caregiving relationship (Ainsworth, 1978; van der Kolk, 2014). Findings also highlight an understanding amongst school staff that children behave in certain ways (for example, *'aggressively')* in order to *'receive adult attention'.* This suggests an understanding of trauma impact on the way a child relates to adults in order to receive care (Ainsworth, 1978; Crittenden, 2006). A relational understanding is also evidenced by the findings in Theme 2, in terms of the school staff prioritising relationships and interpersonal safety. Indeed, findings suggest the way in which school staff understand the impact of trauma aligns with psychological theory and specifically relational models (Sweeney et al., 2018). This supports the ecological validity of the psychological theories that underpin TIP, in the education context.

However, findings suggest the aforementioned psychological frameworks alone would be perceived as reductionist in conceptualising impact in schools. Findings suggest participant perceptions align with Bronfenbrenner's framework, in that a child is affected by the multiple levels of their surrounding environment rather than solely their immediate environment (Bronfenbrenner, 1979). Indeed, findings highlight an understanding that individual-level factors (for example, age) interact with community and societal factors (access to support) to determine vulnerability and therefore impact in schools. Findings suggest that external social support reduces the impacts, and implicit is the notion that relationships beyond those with our primary caregivers are important. This emphasises the critique of dominant models that over-emphasise individual brain development or primary caregiving relationships (Field, 1996). Findings highlight that the wider context and access to support can mitigate against trauma impacts, and therefore how children who experience barriers to support due to stigma, social inequality or discrimination are more vulnerable (Public Health England, 2017), in line with previous research (Morris et al., 2019; Strompolis et al., 2019). This reflects the ideas of the Psychosocial Pathways model (Public Health England, 2017) that posits that both individual-level factors and social determinants influence health outcomes. Again, findings highlight the ecological validity of psychological frameworks and models (Bronfenbrenner, 1979; Public Health England, 2017), and suggest that models such as the Psychosocial Pathways model may useful and meaningful in schools.

4.3.3. Practical Dilemmas

Findings uniquely shed light on how school staff *understand* trauma. Specifically, they suggest resistance to a 'one size fits all' conceptualisation, due to its broad and contextualised nature observed in schools. This further emphasises and supports the critique of the medical model approach (American Psychiatric Association, 2013) in that it is ignorant to context, reductionist and often at odds with lived experience (Summerfield, 2005; van der Kolk et al., 2009). Instead, findings suggest that staff's conceptualisation of trauma aligns with a contemporary psychological approach that de-medicalises, and de-individualises, response to adversity (for example, TIP or the PTMF) (Johnstone et al., 2019; Sweeney & Taggart, 2018). However, it is highlighted that this conceptualisation makes it difficult for school staff to recognise trauma and therefore respond in practice, particularly without awareness of practical

guidelines or having had specific training. This suggests that providing training for staff on the aforementioned frameworks and theories in relation to the causes and impact of trauma, may empower them to make empirically informed choices in their chosen strategies to support children and young people. This conceptualisation also highlights the potential benefits of TIP as a framework to be applied to the whole system, in acknowledging the widespread and broad nature of trauma (Sweeney et al., 2018).

4.4. Research Findings: Theme 2: Practice to Theory: Current Response to Trauma in Schools

In response to research question two, findings highlight that school staff are largely unfamiliar with the framework of 'TIP'. This is consistent with findings of Berger et al. (2021) in an Australian context and makes sense in that TI schools are only just emerging in the UK. Findings suggest a lack of awareness of guidelines or training in relation to responding to trauma leads staff to doubt their practice. This supports findings of previous studies in international contexts, such as Berger et al. (2021), Alisic (2012), and Luthar and Mendes (2020). However, findings suggest that the practice of school staff is TI. Specifically, findings suggest staff prioritise a relational approach emphasising trust, safety, and empowerment in responding to trauma and resisting re-traumatisation, which reflects the TIP guiding principles (Office for Health Improvement and Disparities, 2022). This supports Chudzik et al. (2021), in that although a quantitative measure suggested limited understanding of TIP, qualitative responses suggested practice consistent with TIP. This further highlights the importance of researching both *understanding* of TIP and *experiences* of recognising and responding to trauma and employing qualitative measures.

4.4.1. Building Trusting Relationships

Findings suggest that staff perceive building trusting relationships to be fundamental in responding to trauma and this is informed by the impact of trauma on lack of trust in others, in line with relational theories (Ainsworth, 1978). Findings suggest that building trust with families is also important as there can be resistance to school approaches, also highlighted in previous international studies (Berger et al., 2021; Koslouski & Stark, 2021). Findings reflect a systemic understanding, in that past

experiences of professional help-seeking may impact on a family's relationship-to-help and thus their ability to trust (Reder & Fredman, 1996). This enables them to respond empathetically and informs their practice such that they arrange 'parent's days', social events and informing parents about 'positive' behaviour. This practice aligns with TIP in that it is a system-wide relational approach prioritising the principle of *trustworthiness* (Office for Health Improvement and Disparities, 2022). Findings shed light on current practice that aligns with TIP and supports previous research emphasising the importance of trusting relationships in schools in response to trauma (Avery et al., 2022b; Hickey et al., 2020; Koslouski & Stark, 2021).

4.4.2. Creating Safety

Findings also suggest that staff perceive that the creation of a sense of safety is important. This suggests an understanding that trauma can lead to a chronic sense of danger, in line with neurobiological, cognitive, and attachment theories (Ainsworth, 1978; Cook et al., 2005; Ehlers & Clark, 2000). Participants describe how they seek to provide safety through interpersonal interactions. The emphasis on predictability and consistency of adults in achieving safety further reflects a relational understanding of trauma; childhood trauma is often associated with inconsistent and unpredictable caregiving, leading to a lack of sense of safety (Ainsworth, 1978). Findings also highlight that participants seek to create safe physical spaces that support with emotional or behavioural regulation. Indeed, the creation of safety is perceived to be essential in enabling children to learn and this reflects the theory that children who have had to operate in survival mode will have less capacity for the development of higher-level skills such as emotion regulation, social or cognitive skills (Greene et al., 2014). This practice is consistent with TIP guidelines and the principle of *'safety'* (Office for Health Improvement and Disparities, 2022), and supports previous studies internationally exploring what staff perceive to be important in response to trauma (Avery et al., 2022b; Berger et al., 2021).

4.4.3. Empowerment

Findings suggest that school staff respond to behaviour in the context of trauma through tuning into what the behaviour is communicating, responding with empathy, facilitating self-regulation, and offering choice. This practice aligns with the TIP principle of '*empowerment'. 'Empowerment'* refers to efforts being made to tune into

a person's needs, validate feelings, and share power and give service-users a voice in decision-making (Office for Health Improvement and Disparities, 2022). Ultimately, participants describe a shift from historically dominant styles of responding within schools (authoritarian and punitive responses to behaviour) which is understood to worsen difficulties. Implicit is the notion of resisting re-traumatisation, which is an underpinning assumption of TIP based on the theory that situations that resemble previous trauma, for example those which create a sense of powerlessness or being 'done to', can re-activate trauma and mean that the individual is responding to both past and present trauma (Sweeney et al., 2018). This parallels the shift within mental health settings to de-medicalising distress and understanding difficulties in the context of a person's life experiences rather than through a problem-focused, diagnostic lens (Harper, 2023; Johnstone & Boyle, 2018). Indeed, findings suggest that shift has not occurred solely in a mental health context however also in wider society. It is interesting that people are increasingly 'trauma-informed' in their approach to others, even without awareness of this concept, offering support to the framework and acceptability of it outside of the clinical or healthcare context. The notion of empowerment also supports international findings in terms of how school staff respond to trauma (Berger et al., 2021; Koslouski & Stark, 2021).

4.4.4. Culturally-Sensitive Practice

It is noteworthy that findings also highlighted the impact of cultural diversity on responding to trauma. For example, in terms a difficulty 'relating' to or engaging with families from different backgrounds. Indeed, the 'Circles of Fear' model (Byrne et al., 2017) posits that individuals from racially and ethnically marginalised backgrounds may be reluctant to seek help due to discrimination (historical and current), leading to worsening difficulties and thus more challenging experiences and relationships when they do connect with services and this may be playing out in schools. It is a key finding that only one participant highlighted this as it suggests that schools may need to be further supported to address this, such that it is not something that only school staff from racially and ethnically marginalised backgrounds consider, or that it is solely individuals from White backgrounds that can feel safe and trust. This finding offers support to Koslouski and Stark (2021) and Avery et al. (2022b). In order to prevent schools perpetuating social inequality such that individuals from marginalised backgrounds are more vulnerable to trauma, future research should

seek to include the voices of individuals from racially and ethnically minoritised groups. Policies and training in relation to TIP in schools should pay particular attention to responding to individual cultural, racial, and ethnic needs, in line with guidelines (Office for Health Improvement and Disparities, 2022).

4.4.5. Practice-Based Evidence

This study supports findings of previous international studies in terms of school staff's current practice in responding to trauma. However, it goes beyond this in that it highlights the incongruence between perceived lack of knowledge and expertise, and understanding and practice that is reflective of TIP. Staff feel disempowered and unskilled in the absence of formal training or guidelines, despite their vast practical experience. This may speak to how expertise in this area is defined, and which forms of knowledge are privileged. Indeed, the overall lack of research exploring school staff perspectives, particularly in terms of how they *understand* trauma, may speak to the privileging of academic or theoretical knowledge (Gabbay & Le May, 2010) in relation to trauma. Findings highlight the importance of integrating practice-based evidence with evidence-based practice (EBP), in empowering staff and also best meeting the needs of individuals. Indeed, although EBP is privileged in healthcare, there is often a disconnect between the evidence-base and real-world practice and outcomes, particularly for minoritised groups (Gatera & Singh, 2023). Findings highlight this in that dominant diagnostic conceptualisations of trauma are at odds with lived experience. It can be argued that the privileging of EBP both disempowers staff and is insufficient in meeting the needs of the individual in their specific context (Barkham & Mellor-Clark, 2003). Professional expertise should be integrated with evidence-based practice in the development of TI schools.

4.4.6. A Critique of The Concept of TIP

The discrepancy between perceived expertise and practice consistent with TIP and the privileging of academic or theoretical knowledge may speak to the way in which TIP aligns with the medical model, even though this is at odds with its underpinnings (as a non-pathologising approach to distress). Whilst TIP is underpinned by a broad understanding of adversity (Sweeney et al., 2018), the word 'trauma' commonly applied in a medical context may lead people to associate it with medical expertise or specifically to single-event trauma or diagnoses such as 'PTSD'. Based on

findings, this may lead staff to perceive TIP as less relevant to their practice as it is seemingly medical and associated with a medicalised conceptualisation of trauma which does not align with their lived experiences or the ideas that inform their practice. Johnstone et al. (2019) also highlight this criticism of the use of the word 'trauma' due to its medical overtones and argue that 'adversity' may be a more inclusive term. In empowering staff, attention may be paid to how trauma and TIP are named, defined, and understood by all relevant stakeholders. Indeed, although consistent terminology is preferable, consideration may be given to the most appropriate language for conceptualising 'TIP' particularly in an education context.

4.5. Research Findings: Theme 3: The Influence of The Wider Context

Whilst it is optimistic that findings highlight knowledge and practice amongst school staff that aligns with TIP, contextual factors negatively influence capacity to be TI, and the implementation of TIP as a *whole-school* approach. Drawing upon the ecological systems model (Bronfenbrenner, 1979), school staff look beyond the micro context of their day-to-day practice and towards the macro context of higher-level educational priorities, and the chronic under-funding of public services. This provides support for commonly acknowledged barriers to TI services broadly (Sweeney et al., 2018), and findings of studies specifically exploring school staff perspectives on barriers to TIP in international contexts (Avery et al., 2022b; Berger et al., 2021; Koslouski & Stark, 2021).

4.5.1. Pressures and Priorities

Findings suggest an incongruence between the focus on academic outcomes and the widespread nature of trauma in schools, forming a large part of a teacher's role. This singular focus is perceived by staff to stem from the pressure from senior leadership teams and the regulatory body, Ofsted (2019). Findings suggest this leads staff to feel stressed and experience compassion fatigue, and to lack practical time, which create a barrier to being TI. It also means that there is not an embedded whole-school TI policy, or training which staff perceive to be harmful as inconsistent responses will lead to worsening difficulties, or re-traumatisation (Sweeney et al., 2018). Findings highlight that this is perceived by staff as important, as otherwise learning outcomes will actually be worse, and this aligns with research indicating that

children who have experienced trauma are more likely to be excluded from school and have poorer learning outcomes (Perfect et al., 2016). This reflects a limitation identified by Berger and Martin (2021a) in that a lack of policy reform has meant that schools have been unsupported to shift from a traditional discipline approach to behaviour. Indeed, this offers support to the findings of Berger et al. (2021) and Luthar and Mendes (2020) exploring school staff perspectives in an international context, and further highlights the importance of addressing this barrier.

4.5.2. The Risk of Tokenism

This study does not only offer support to previous findings; however, it uniquely sheds light on how the lack of strategic prioritisation often leads wellbeing approaches to become tokenistic initiatives. This is supported by literature highlighting that existing wellbeing programmes in schools are tokenistic due to a lack of investment from Senior Leadership Teams (SLTs) (Willis et al., 2019). Schools are increasingly required to evidence that they are focusing on wellbeing (Ofsted, 2019; Department of Health and Department for Education, 2017), despite this being difficult to achieve due to academic pressures, leading to unmeaningful implementation. This reflects similar issues in under-resourced NHS mental health contexts (Ocloo & Matthews, 2016). Findings suggest a barrier to SLTs prioritising a 'cultural-shift' towards wellbeing and instead implementing tokenistic initiatives in order to 'meet targets' may be that there is an emphasis on numbers or quantitative data. Indeed, meaningful evaluation has been found to be a barrier to the implementation of TIP in services more broadly (Sweeney et al., 2018). Findings suggest a whole-school TI approach will ultimately require a shift in educational priorities which facilitates SLT investment, as well as a plan for meaningful evaluation.

4.5.3. A Broken System

Further, findings highlight the impact of austerity, under-funding, and a lack of staff. Indeed, findings suggest that this is a worsening situation in terms of the funding for specialist staff within schools such as Special Educational Needs Coordinators (SENCOs), and external staff such as Educational Psychologists or Social Workers. The chronic under-funding of public services and therefore lack of staff means that schools do not feel that they have adequate resource to respond to trauma, and that

communication between services and follow-up is poor. This is at odds with the governments push towards greater mental health resource in schools (Department for Education, 2021). Indeed, the need for better communication between services in enabling a TI approach in schools supports the findings of Berger et al. (2021) in an international context. It will be important to advocate for greater resource within schools, as well as the adequate funding of other child services in enabling these services to work coherently as a united system.

4.5.4. Covid-19: Constraints

This is the first qualitative study exploring teacher perspectives on TIP in the 'post-pandemic era' and findings uniquely highlight the impact of the pandemic on the increased prevalence of trauma, and increased barriers to TIP. Findings highlight the impact of the pandemic on children's development and mental health and wellbeing, in the context of services being unable to meet the demand, widening the gap between demand and resource (Spence et al., 2021). The impact on children's development and wellbeing may reflect the increased exposure to childhood maltreatment, or more limited access to the services that would usually support vulnerable families including schools (Collin-Vezina et al., 2020). Indeed, the pandemic is perceived as increasing the prevalence of trauma, in the context of a particularly challenging social climate including a cost-of-living crisis. Children from vulnerable or socially disadvantaged families will be most affected by this context as highlighted in the findings and in previous research (Collin-Vézina et al., 2020), further putting these children at a disadvantage in schools and increasing the risk of poorer outcomes.

Findings suggest staff are grappling with the pressure to meet the increased demand, with less resource, whilst they manage the impacts of the pandemic on their own wellbeing. Indeed, Statistics suggest that teacher retention is a national concern (National Education Union, 2022), and previous literature highlights the impact of the pandemic on school staff wellbeing (Kim et al., 2022; Robinson et al., 2023). Findings uniquely highlight that levels of staff wellbeing have further decreased due to the lack of acknowledgement of teachers as 'front-line' workers during the pandemic. Arguably, a TI approach in schools is more important than ever due to the collective impact of the pandemic on children, families, and staff.

However, the implementation relies on better resourcing for public services, and support for staff wellbeing.

4.5.5. Covid-19: Affordances

It is promising that despite creating additional barriers, findings uniquely highlight that the systemic impact of the pandemic has shone light on the importance of a whole-school wellbeing approach in schools and may be leading to a shift in priorities. This may be reflective of emerging 'organisational post-traumatic growth', which refers to a process by which organisations are not only restored after experiencing adversity but achieve a higher level of functioning as a result of addressing and learning from the event (Maitlis, 2020; Olson et al., 2020). In line with this theory and the findings of this research, basic needs would need to be met (reduced pressure, adequate resource) in facilitating 'post-traumatic growth' (Olson et al., 2020). However, it provides optimism in terms of a systemic shift.

4.6. Implications of the Research

Whilst staff realise the widespread nature of trauma and its impact, and implicitly perceive TIP as important, they do not feel equipped to practice in this way, nor do they feel that this is a *whole-school* approach, due to wider contextual factors. In preventing psychosocial impacts in the context of trauma, Clinical Psychologists and other mental health professionals have a responsibility to ensure that school staff feel empowered to respond to trauma, and to address the context that creates barriers to this. The implications will be discussed according to the levels of the ecological systems model, including implications for policy and direct work within schools (Bronfenbrenner, 1979). Existing models and frameworks will be drawn upon including NICE guidance for a whole-school approach to wellbeing (National Institute for Health and Care Excellence, 2022), those specific to the implementation of organisational TI approaches broadly (Lancashire Violence Reduction Network, 2020; Substance Abuse and Mental Health Services Administration, 2014; Thrive, 2010; The Institute on Trauma and Trauma Informed Care, 2019) and guidance specific to TI schools (Berger and Martin, 2021b).

4.7. Implications of the Research: Macrosystem

According to the ecological systems model, a child is influenced by the society and culture that they develop in. This includes social norms, political, economic, and legal systems (Bronfenbrenner, 1979).

4.7.1. Addressing the Social Context

Findings shed light on the widespread nature of childhood trauma and the socio-political context both causing and increasing vulnerability to it, in line with the psychosocial pathways model (Public Health England, 2017). As highlighted in the findings, families are under increased pressure, and there is a widening gap in social inequality, in the context of the pandemic and the cost-of-living crisis (Blundell et al., 2022). In preventing the socio-political context both causing and increasing vulnerability to trauma, and therefore decreasing the demand for mental health support, Clinical Psychologists may focus more on community-based and policy work (The British Psychological Society, 2018b; 2020). Indeed, the hierarchy of needs theory (Maslow, 1943) highlights that if basic needs are not met in terms of shelter, food, and safety, children will not have the capacity to develop other skills or have good emotional wellbeing enabling them to succeed in schools. Clinical Psychologists may influence policies (e.g., those relating to housing or refugees) that widen social inequality (for example, poverty, or racism) and cause psychosocial harm. This may involve researching policies, informing oneself on behalf of marginalised groups, and creating networks or activist groups with likeminded individuals such as Psychologists for Social Change (The British Psychological Society, 2018b). Clinical Psychologists may respond to proposed green papers; highlighting the potential psychosocial harm associated with policies and offering psychologically-informed recommendations or amendments.

4.7.2. Influencing a Paradigm Shift in Education

Findings suggest wellbeing is not prioritised compared to the academic curriculum which leads to staff burnout, and a lack of a whole-school approach or training on trauma. Clinical Psychologists may therefore also influence the macro policy context in terms of how schools are regulated. This should involve highlighting to relevant

audiences how the current regulatory approach and associated expectations may cause harm to both staff and students, and particularly those who have experienced adversity or social disadvantage. This is both indicated in this study and supported by previous research (Lefstein, 2013). This is despite changes to the framework in 2019 to better account for health and wellbeing (Ofsted, 2019), suggesting that these were not enough and have only led to tokenistic initiatives. Regulatory frameworks such as Office of Standards in Education (Ofsted, 2019) should be informed by the understanding that investing in wellbeing is essential to enable learning and the desired academic outcomes (Greene et al., 2014; Maslow, 1943; Romano et al., 2015), particularly given the prevalence of adverse experiences highlighted by this research and prior research (Felitti et al., 1998). Particular attention should be paid to the way that regulatory bodies increase social inequality, particularly in light of the impact of the pandemic on vulnerable families, in line with Lefstein (2013). For example, the children most impacted by the pandemic due to limited resource or challenging circumstances will fall further behind unless this is accounted for. Without addressing this, government initiatives may lack effectiveness and perpetuate tokenism at no benefit, and potentially harm, to children and young people.

4.7.3. Accelerating the Implementation of Mental Health Support Teams

Findings highlight that in supporting to embed whole-school TI approaches, it will be important that schools are adequately resourced in terms of staffing, and support from external services. This is also highlighted by models for TI organisational change as essential pre-implementation (The Institute on Trauma and Trauma Informed Care, 2019). Although there is a governmental plan to offer grants for Senior Mental Health Lead (SMHL) training and to embed Mental Health Support Teams (MHST) in schools (Department of Health and Department for Education, 2017), findings suggest there is a way to go in terms of SMHLs and MHSTs becoming widespread in the UK. Indeed, findings actually suggest worsening capacity in terms of less staff to support these approaches, in recent years. This highlights a role in influencing policy and campaigning and advocating for greater funding for mental health in schools. Specifically, Clinical Psychologists may advocate for the government to expand and accelerate the implementation of MHSTs with greater urgency and call for a follow-up to the 2017 green paper

(Department of Health and Department for Education, 2017), particularly in light of the impacts of the pandemic.

4.7.4. Advocating for a Systemic Approach to Mental Health and Wellbeing

School policies and interventions will only go so far without adequate funding of the whole system of public services surrounding children and young people. Highlighted through this study is the lack of communication between services and the barriers to external support and onward referrals due to long waiting times and a lack of staff, worsened by the pandemic. Indeed, a well-integrated system with better communication may reduce overall pressure on services in the long-run. Whilst it is suggested that the implementation of MHSTs in schools will support an integrated approach (Department for Health and Department for Education, 2017), this is reliant on the adequate funding of other public services. Clinical Psychologists may advocate for this through joining with networks to influence policy through campaigning or contributing to briefing papers. Indeed, findings suggest a need to advocate for greater recognition of the importance of an integrated, systemic approach in terms of the outlined plan for mental health support in schools (Department of Health and Department for Education, 2017), with a clear plan for how this is to be achieved through additional funding and resource of public services more broadly.

4.8. Implications of the Research: Mesosystem

A child is also influenced by their mesosystem which comprises of the interactions between a child's microsystem, for example, between a child's school and parents (Bronfenbrenner, 1979). Findings suggest that there is rationale for the implementation of a TI approach in schools, however in preventing barriers to this, schools should be supported to collaborate with the whole community, including families.

4.8.1. Involving the Whole Community

The various TI organisational change models highlight that it is important pre-implementation to listen to and understand the perspectives of all of the relevant stakeholders and ensure sufficient buy-in (Berger & Martin, 2021b; The Institute on

Trauma and Trauma Informed Care, 2019). This study has also highlighted the value in doing so. Whilst findings shed light on the perspectives of school staff broadly, schools should routinely gather qualitative feedback from staff, students, and families. Findings specifically highlight the importance in understanding the experiences of families, in understanding potential barriers to be addressed, and building their understanding and trust in the approach, in line with Berger and Martin (2021b) school TIP policy. Drawing upon behavioural science and specifically nudge theory (Thaler & Sunstein, 2009), understanding the perspectives of the whole system prior to implementation is important in increasing motivation for organisational change.

Based on findings around the importance of building trusting relationships with families and prioritising transparency, families, parents, or carers should also be involved in the implementation of any organisational change. This is also recommended in NICE guidance (National Institute for Health and Care Excellence, 2022) and TI organisational change models (Berger & Martin, 2021b; Substance Abuse and Mental Health Services Administration, 2014). In doing so, it will be important that school publicity and marketing reference or offer information in relation to the whole-school approach, and that feedback is regularly sought during and post-implementation. Mental health professionals working with schools should support and encourage receiving feedback, and a collaborative approach.

4.9. Implications of the Research: Microsystem

A child's microsystem refers to their immediate environment, such as parents, peers, and school (Bronfenbrenner, 1979). If wellbeing is adequately prioritised, and schools are adequately resourced, findings suggest the implementation of a TI approach to wellbeing aligns with the perspectives and experiences of school staff, and that it therefore would be deemed a meaningful and acceptable approach in empowering them to respond to trauma. Implications will be discussed in terms of how mental health professionals, working as part of MHSTs for example, may support schools to embed a TI approach.

4.9.1. Investment from Senior Leadership Teams (SLT)

Firstly, findings suggest embedding TIP relies on investment and commitment from the SLT. This is consistent with TI organisational change models that propose that leadership is essential (The Institute on Trauma and Trauma Informed Care, 2019). With reduced pressure on academic outcomes and increased funding, mental health professionals working within schools should support the integration of TIP into strategic planning documents (The Institute on Trauma and Trauma Informed Care, 2019). Mental health professionals may also support with the creation of specific TI working groups to assist leadership (Thrive, 2010). Ultimately this may support the integration into whole-school training and policy, enabling staff to practice accordingly.

4.9.2. Whole-School Policy and Training

With adequate resource, whole-community involvement and buy-in, including leadership investment, findings highlight the importance of mental health professionals supporting to embed a TI whole-school policy to guide practice and ensure a consistent approach to prevent worsening difficulties resulting from a policy informed by traditional discipline. This is emphasised in TI organisational change models (The Institute on Trauma and Trauma Informed Care, 2019; Thrive, 2010). Berger and Martin (2021b) offer a template for an evidence-based TI policy that may be used and adapted in schools. In line with findings, the policy template emphasises the importance of providing access to whole-school training, of which mental health professionals may support with. Berger and Martin (2021b) suggest that training is guided by the TIP assumptions; supporting staff to realise, recognise, respond to trauma, and resist re-traumatisation (Substance Abuse and Mental Health Services Administration, 2014). Berger and Martin (2021b) also emphasise that existing TIP in school models such as the ARC framework may be drawn upon to inform behaviour policy (Blaustein & Kinniburgh, 2017). This model focuses on relationships and strengthening the caregiving system surrounding children, supporting with emotions, and addresses resilience through increasing choice and empowerment (Blaustein & Kinniburgh, 2017). Findings suggest that this model would be easy to implement and would attract buy-in in that it aligns with current thinking and practice. However, further more rigorous and controlled research should

be conducted in exploring the effectiveness of specific models and building the evidence-base (Maynard et al., 2019).

Of note, findings highlight the value in understanding the current experience of staff in informing whole-school training and policy. For example, findings suggest it will be important to employ a framework that adopts a broad definition of trauma, including recognising social trauma, and the varied impact observed in schools, in line with guidance such as the Trauma Informed Organisational Development Framework (Lancashire Violence Reduction Network, 2020). Findings suggest the Ellis and Dietz (2017) Resilient Communities approach to ACEs may be drawn upon, as well as frameworks that emphasise contextual factors such as the Psychosocial Pathways Model (Public Health England, 2017), and ecological systems theory (Bronfenbrenner, 1979).

Findings also suggest the importance of not assuming lack of knowledge. Indeed, it may not necessarily be about embedding TIP as an entirely new concept, but rather supporting staff to recognise that what they are doing is TI, and to strengthen their knowledge and practice, in line with Koslouski and Stark (2021). Findings suggest that strengthening practice should involve a specific focus on the principle of cultural competence (Office for Health Improvement and Disparities, 2022) such that support for trauma does not discriminate or further increase social inequality. Findings also highlight the importance in integrating evidence-based practice with the professional expertise of school staff, in line with Berger and Martin (2021b). Indeed, school staff currently prioritising a TI approach may be involved in supporting the delivery of training and implementing policy, drawing upon their practical expertise. In line with behavioural science and specifically nudge theory, this positive reinforcement may be effective in creating change (Thaler & Sunstein, 2009).

4.9.3. Staff Wellbeing

Findings also suggest that in schools becoming TI, there will need to be greater support for staff wellbeing. Staff can feel hopeless in responding to trauma with such little support, and staff morale is generally poorer since the pandemic where school staff were largely neglected. In line with TI organisational change models (Lancashire Violence Reduction Network, 2020), mental health professionals

working within school contexts may support in establishing a reflective practice model for staff. Indeed, the ARC model is a TI framework that can be used in schools that promotes adult self-regulation and self-care so that staff can better support children (Blaustein & Kinniburgh, 2017).

4.9.4. Sustained Change and Evaluation

Mental health professionals working within schools to embed TI whole-school approaches should consider how they can be evaluated meaningfully in the context of TIP as a cultural shift. Indeed, this is an essential part of the implementation process in line with TI organisational change models (The Institute on Trauma and Trauma Informed Care, 2019). Evaluation could involve employing a range of methods which prioritise co-production. For example, utilising both questionnaires and focus groups gathering information from the various stakeholders (children, parents, teachers), on various aspects of school (learning, relationships, ethos). The Institute on Trauma and Trauma Informed Care (2019) propose a trauma-informed climate scale questionnaire that may be drawn upon in evaluation. Existing guidance for whole-school approaches to wellbeing such as the Nurturing, Empowering, Safe, Trusted (NEST) framework (2021) could be used to guide the evaluation of a whole-school TI approach (Welsh Government, 2021). Ultimately, however, the way in which regulatory bodies evaluate mental health and wellbeing approaches needs to be adjusted to enable this.

4.10. Critical Evaluation

This section critically evaluates this research. As part of assessing research quality, the frameworks of Spencer and Ritchie (2012) and Tracy (2010) will be drawn upon. The guiding principles include research contribution, credibility, defensibility, and rigour. Within this, research limitations are discussed.

4.10.1. Research Contribution

This is the first qualitative study to explore school staff perspectives on TIP in the UK. This is of particular relevance with the increased guidance around whole-school wellbeing approaches in schools (Department for Education, 2021) and specifically TI approaches (National Institute for Health and Care Excellence, 2022). This study

differs to TIP evaluation studies in that it explores *current practice* in informing the TI approach. The prevalence of evaluative studies may reflect the 'top-down' implementation of TIP, in that school staff are consulted *after* implementation. Indeed, according to implementation science literature, understanding potential barriers is essential prior to implementation (Bauer & Kirchner, 2020). Although a handful of similar qualitative studies have been conducted internationally, it is difficult to apply findings to a UK education context. Further, this is the first in this field to shed light on the impact of the pandemic. Findings are discussed in the context of research questions and existing literature in Research Findings, and the implications are discussed in Implications of the Research. The exploratory nature of the study has been helpful in both enabling nuanced analysis and highlighting avenues for future research, discussed in Areas for Future Research.

The value of the research was also anecdotally reflected on by participants within the interviews. For example, participants described this area of research as very 'interesting' and 'important' and an area that should be thought about more within the school context. Participants asked about how the research would be disseminated and what the implications of the research would be. For example, *"will this be something coming into schools?"*, *"will you come into schools to talk about this?"*.

As part of assessing the contribution, limitations should also be discussed (Spencer & Ritchie, 2012). A limitation of this research is the potentially biased sample. The voluntary recruitment approach may have attracted members of school staff most interested in TIP or supporting with trauma or mental health within schools. The findings may therefore not be representative of *all* members of school staff and rather represent the views of a select group of individuals more interested in this area. However, it is nonetheless promising that there are individuals who share this interest and would advocate for this approach, in terms of the implementation of TIP. Further, the sample was racially and ethnically homogenous in that there was only one participant who did not identify as White. This means that this research largely represents perspectives from a White cultural lens. It is noteworthy that the influence of 'cultural difference' was reflected on by the only participant in the sample who was not from a White cultural background, perhaps reflecting the Whiteness of the sample. An additional limitation in relation to the sample is the lack of information

gathered in terms of school socioeconomic context. Indeed, the small sample in the context of a dearth of existing literature to compare to, as well as the sample diversity in terms of professional orientations and types of schools, makes it difficult to draw conclusions and generalise to specific groups. However, the intention of the research was to gain a rich understanding of experiences and to highlight avenues for further research, as opposed to generating generalisable findings.

In terms of the study design, is acknowledged that both the title of the research and the questions asked employed the terminology 'TIP'. This may have impacted the recruitment in that participants may have felt they did not have the knowledge around this topic. When volunteering for interviews, participants would ask *"do I need to know what TIP is?"* which implies this may have been a recruitment barrier to many. The fact that this was unfamiliar language may have also influenced the data collected during the interviews, for example in terms of how the participants perceived their 'expertise'. Participants may have felt less confident in sharing their understandings in this context and therefore Theme 1 may be an under-representation of participants 'knowledge'. It is interesting that participants implied greater knowledge around theory and impact whilst discussing the way that they respond to trauma in practice. Indeed, TIP is also described as *'trauma-sensitive'* or *'trauma-responsive*' and there is an overall lack of consistency in terminology in research and practice which may have contributed to the reported lack of knowledge and reflects a limitation of research in this field (Berger et al., 2021).

4.10.2. Research Defensibility

Defensibility refers to how well the research strategy addresses the research questions (Spencer & Ritchie, 2012). The research aimed to address the gap in the literature in terms of understanding staff perspectives and experiences of trauma and TIP in schools particularly in the UK context, and therefore there was rationale to employing a qualitative approach involving semi-structured interviews. The rationale for the study and methodology including the analysis have been described in detail, in the context of the aims of the study and previous literature. There has been a discussion of the limitations of the research in terms of design and methodology and the implications of this, in line with Spencer and Ritchie (2012).

4.10.3. Research Credibility

Credibility concerns the trustworthiness and plausibility of research findings (Tracy, 2010). In striving to achieve credibility, the rationale in terms of the research aims and methodology have been considered in the context of existing research and theory, and so too have the findings of the study. The methodological and analytic processes have been described in detail. Further, quotations from the participant interviews have been included to back-up the claims made in terms of the findings, and so that the reader understands why certain conclusions have been made. The research rationale, design, data collection, findings and conclusions have all been discussed with the research supervisor. Whilst it is acknowledged that triangulation does not necessarily improve accuracy in qualitative research or make it 'correct', it still improves the quality. It can improve the quality in that it deepens understanding, allows different facets to be explored, and encourages consistent interpretation (Tracy, 2010). It has also been considered how researcher subjectivity has influenced the research at the various stages as outlined both in Method and Methodology and Researcher Reflexivity in Discussion, Evaluation and Implications. A reflexive log was also kept during the research and for transparency an extract of this can be found in Appendix M.

4.10.4. Research Rigour

This evaluative aspect concerns the richness of the data gathered and the care and practice of data collection and analysis (Tracy, 2010). The research was designed in such a way to allow for the gathering of rich data. For example, the research questions are broad, and a semi-structured, flexible interview design was employed. The interview schedule was employed as a guide, and questions were kept broad and open, with space for follow-up questions based on what participants shared. Research care and practice is evidenced through thorough description of the analytic process including the processes of transcription, data coding and theme development. Transcriptions were read, and re-read, and the process of data coding was repeated multiple times. The process of theme development involved the creation of multiple thematic maps and continued adjustment and re-defining, in order to best reflect the data gathered. Transparency adds to the rigour of research and has been sought through the inclusion of coded data segments (Appendix E),

the process of theme development (Appendix F) and the reflective log (Appendix M) (Spencer & Ritchie, 2012).

4.11. Researcher Reflexivity

4.11.1. Personal Reflexivity

Reflexivity concerns the relationship between the research and the researcher and should be considered throughout each stage of the research process (Willig, 2013).

I have reflected on the power I held during the interviews and the influence of this on the data and the conclusions made. During the interviews, participants would often ask '*is that right?*' after responding. Whilst I felt that I was coming from a 'not knowing' stance and interested in participants *experience* (for example, commenting *'there is no right or wrong'* or *'I'd just like to hear about your understanding and experience'*), I realised that there was an inevitable power imbalance and assumption of expertise associated with my position as a doctoral researcher and Trainee Clinical Psychologist. This may have led to an under-representation of knowledge or practice, and an over-emphasis on lack of confidence, not necessarily reflective of reality. As I became aware of this power dynamic, I attempted to reduce any feelings of inadequacy amongst participants, which may have led me to probe less or ask fewer follow-up questions, again potentially contributing to an under-representation of knowledge or experience. I have also been acutely aware that the language that I was using (TIP) was unfamiliar and as previously discussed, perhaps perceived as medicalised, likely contributing to this power dynamic. Although I sought to minimise this as a barrier to gathering rich data through adjusting the language that I used (for example, *"what is your experience of TIP, or responding to trauma within schools?"*), I am aware that this may have still contributed to under-represented knowledge or confidence in practice.

I have also reflected on how my own cultural background and privilege may have influenced the questions that I asked or the way in which I analysed the data. For example, there were likely opportunities where I could have asked a follow-up question around the impact of being from a White vs. a racially or ethnically minoritsed background, or where I could have interpreted data in light of social

inequality, however due to my social privilege and unconscious bias, I may have missed these avenues. This context may mean that findings under-represent the impact of Whiteness or social inequality on trauma or school's response to trauma.

4.11.2. Epistemological Reflexivity

I wonder whether the way that I understand TIP has limited or biased my interpretation of the data. I am conscious of how I may have conceptualised aspects of what the participants shared, for example, as 'empowerment' due to my own understanding. This epistemological standpoint may have led me to miss key findings that did not fit with what I understand to be TIP. I am also mindful that due to the understanding that I have of concepts such as 'complex trauma', 'mental health', 'wellbeing', or 'safety', I did not always ask participants how they defined these, assuming that our understanding is the same. Therefore, the findings may have been influenced by my own epistemological assumptions.

4.12. Areas for Future Research

This was the first study to qualitatively explore staff perceptions of TIP within a UK context and therefore a broad, exploratory approach was taken to the research. Findings have highlighted avenues for further research which could provide a greater understanding of TIP within the school context.

It is important that future research samples a more diverse group of participants in terms of ethnicity so that findings are more representative of voices from ethnically and racially minoritised backgrounds. This should extend to diversity in gender identity, as well as sexuality in increasing representation. This is particularly important given that research suggests the prevalence of trauma, and the impact of trauma, is greater amongst individuals from marginalised backgrounds, and in preventing the development of an approach that discriminates and further widens this inequality. Future research also should seek to reduce bias within the sample towards individuals particularly interested in supporting with trauma. This could involve recruiting participants as part of mandatory training days or offering other incentives to participating.

A further potential area for future research could be exploring the perspectives of specific groups, for example, members of the Senior Leadership Team or Teaching Assistants, based on the findings around the differing priorities or training received across staff groups and in informing successful implementation. The perspectives of students or parents could also be explored, especially in ensuring that the approach is collaborative and supports schools building trusting relationships with families.

Future research should pay greater attention to school staffs understanding of the concept of trauma rather than solely focusing on response to trauma. It will be interesting to understand if findings generalise or differ depending on specific school settings or professional orientations. This is important in understanding how trauma presents in schools, integrating practice-based evidence, and enabling the development of a framework that is meaningful in this context.

Ultimately it is important that further research is conducted to continue to improve and evaluate school approaches to wellbeing and specifically trauma given its increasingly widespread nature broadly and within schools, which creates a barrier to learning and thus poorer long-term outcomes. There is a need for further, more rigorous studies into the effectiveness of specific TI models or frameworks, and further qualitative research particularly in the UK. It will be interesting to understand through research how TI whole-school approaches develop over the next few years in the UK, especially with the new government guidance and funding for MHSTs.

4.13. Conclusion

To the authors knowledge, this is the first qualitative study to explore school staff's perceptions of trauma and TIP within the UK context. This is important based on what is known about the prevalence of childhood trauma, and in preventing barriers to education and long-term impacts on health and wellbeing. This research is particularly relevant in the context of the increasing focus and guidance on early intervention and specifically whole-school approaches to mental health and wellbeing, particularly since the Covid-19 pandemic (Department for Education, 2021; National Institute for Health and Care Excellence, 2022).

Findings uniquely highlight that although staff report a lack of knowledge and expertise in relation to trauma, their understanding of trauma and their individual practice is consistent with the concept of TIP. This suggests that the TIP framework is likely to be perceived as relevant and meaningful in this context. This finding also suggests that it is not necessarily about training school staff on TIP as an entirely new concept, but instead empowering them through offering it as a framework to conceptualise and strengthen their current practice. Importantly, findings highlight that the barrier to a *whole-school* TI approach actually lies in the wider context.

Implications highlight the importance of advocating for wider systemic change. This includes advocating for an education paradigm shift towards wellbeing, and for greater resource in schools, so that staff feel equipped to respond to trauma, which is experienced as increasingly widespread. With greater resources or utilising the current Mental Health Support Team (MHST) resources, a collaborative approach should be taken to supporting schools to embed a whole-school TI framework that involves strategic buy-in, whole-school policy and training, support for staff wellbeing, and involvement of the wider community. This research uniquely highlights how the pandemic has both increased the barriers to TIP and provided hope for a systemic shift. Further research is essential in the development of TIP in schools.

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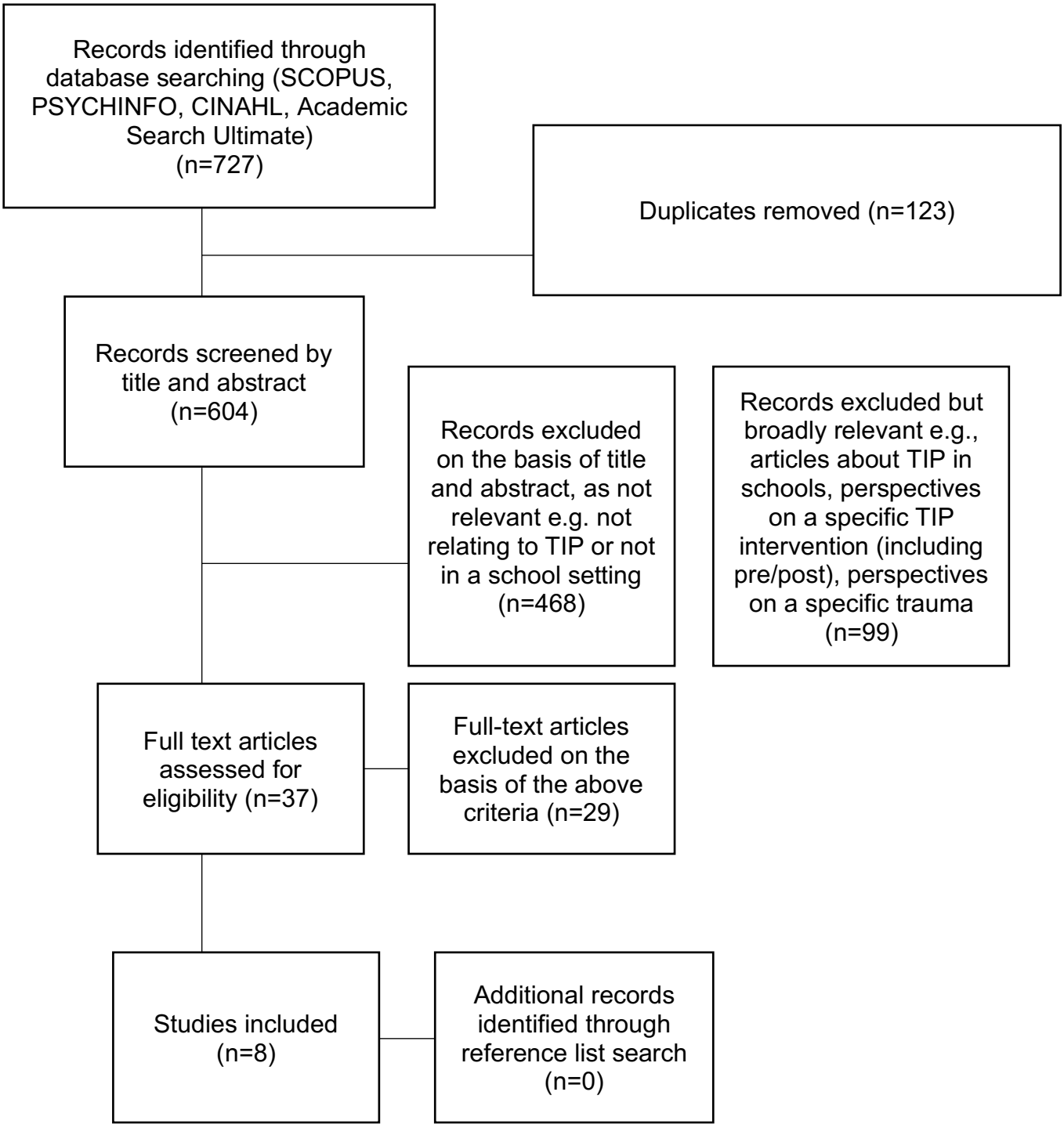
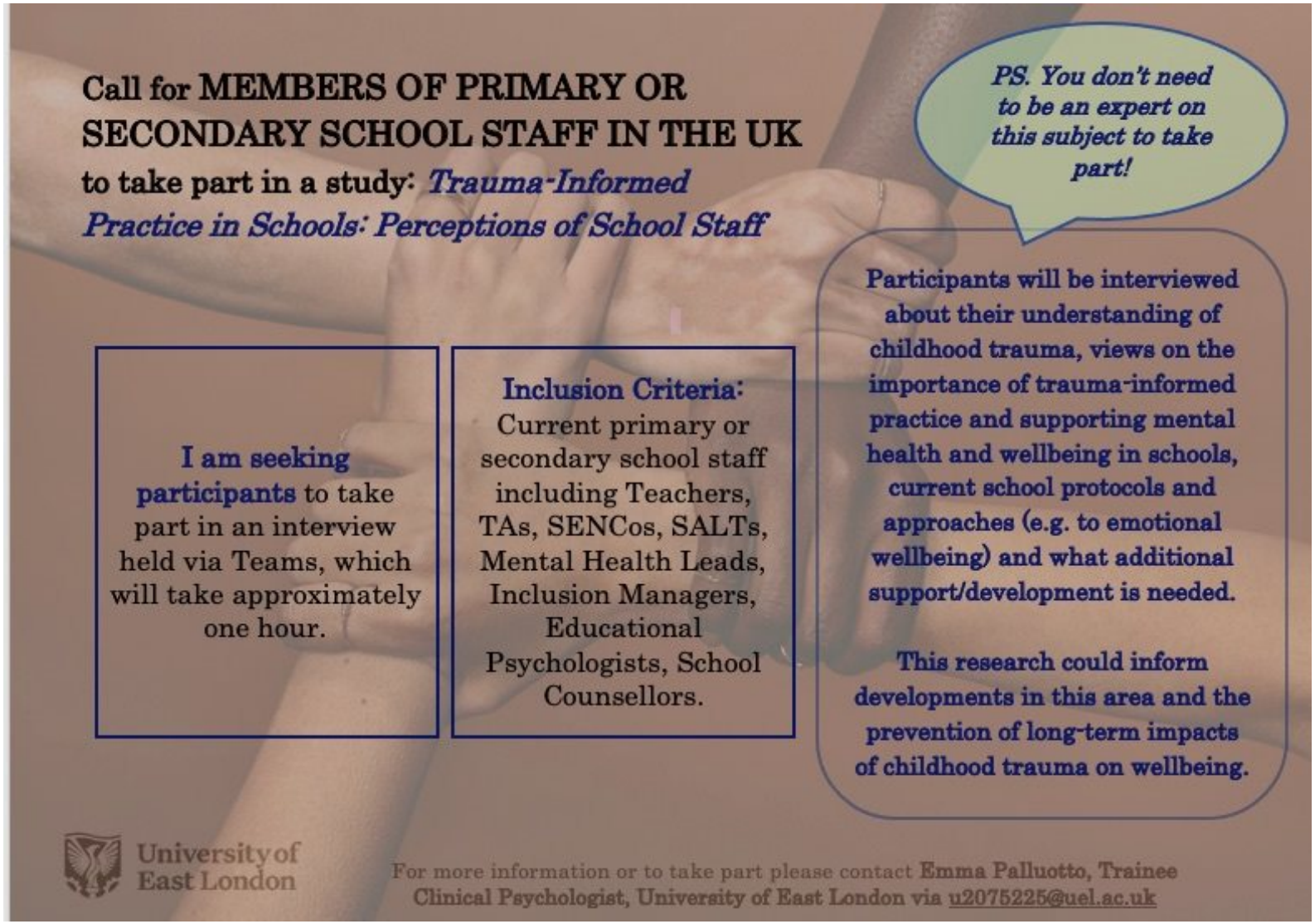
APPENDIX A: Process of Data Extraction




Call for MEMBERS OF PRIMARY OR SECONDARY SCHOOL STAFF IN THE UK
to take part in a study: Trauma-Informed Practice in Schools: Perceptions of School Staff
PS. You don't need to be an expert on this subject to take part!
I am seeking participants to take part in an interview held via Teams, which will take approximately one hour.
Inclusion Criteria: Current primary or secondary school staff including Teachers, TAs, SENCos, SALTs, Mental Health Leads, Inclusion Managers, Educational Psychologists, School Counsellors.
Participants will be interviewed about their understanding of childhood trauma, views on the importance of trauma-informed practice and supporting mental health and wellbeing in schools, current school protocols and approaches (e.g. to emotional wellbeing) and what additional support/development is needed.
This research could inform developments in this area and the prevention of long-term impacts of childhood trauma on wellbeing.
University of East London
For more information or to take part please contact Emma Palluotto, Trainee Clinical Psychologist, University of East London via u2075225@uel.ac.uk

APPENDIX C: Interview Schedule

Demographic Questions

- **What age range do you fall under?**
  18-25 / 26-35/ 36-45 **/** 46-55 / 56-65 / 66-75 / 76-85 / 86+ / prefer not to say

- **How would you describe your ethnic background?**
  Specify: / prefer not to say

- **How would you describe your gender?**
  Male / female / non-binary /prefer to self-describe: / prefer not to say

- **What region of the UK do you work in?**
  London / North East / North West / Yorkshire / East Midlands / West Midlands / South East / East of England / South West / Wales / Scotland / prefer not to say

- **What type of school do you work in?**
  Primary Mainstream / Secondary Mainstream / Primary SEN / Secondary SEN / Primary PRU / Secondary PRU / Specify: / prefer not to say

- **What is your role within the school?**
  Deputy or Head Teacher / Teacher / TA / SENCo / Mental Health Lead / Inclusion Manager / School Counsellor / SALT / Specify: / prefer not to say

- **(If relevant) what year group do you teach?**
  Specify: /prefer not to say

- **(If relevant) Have you done specific training?**
  Specify: /prefer not to say

- **(If relevant) What year did you do this training?**

- **How long have you worked in this role/at this school?**
  <1 year / 1-5 years **/** 6-10 years / 10+ years / prefer not to say

Research Q: How do school staff members perceive the impact of trauma?

Interview Questions

1. How would you describe what is meant by childhood trauma?
   Pr. What informs this? Can you elaborate?
2. How do you understand the impact of childhood trauma?
   Pr. What informs this? First-hand experience? Any examples?

Research Q: How do staff members perceive trauma-informed practice?

Interview Questions

3. What do you understand by trauma-informed practice in schools?
   Pr. Why/where did the understanding come from?
4. Could you tell me about any experiences of trauma-informed practice in school?
   Pr. Or supporting emotional wellbeing or trauma generally, If example – what did you do, how did you feel? Impact? Can you elaborate?
5. What do you think are the advantages of trauma-informed practice and supporting emotional wellbeing in schools?
   Pr. What influences this? Can you tell me more?
6. What do you think the disadvantages or barriers are to trauma-informed practice or promoting emotional wellbeing in schools?
   Pr. Can you tell me more about this? What could help with that?
7. How could schools and staff be supported to respond to childhood trauma or use trauma-informed practice?
   Pr. Can you tell me more? What might help with that? What would be needed? Anything specifically? Has Covid-19 impacted your view?

Is there anything else that you would like to add or share about your views on TIP or the promotion of emotional wellbeing in schools?

APPENDIX D: Excel Coding System

P1 INTERVIEW	Importance of parental support and engagement	Issues with parent engagement	Consistency	Behaviour protocol
P1: Erm, I think some parents see the way that we deal with children's behaviour as soft because it's not your traditional sanction-based, obviously there are consequences for poor behaviour or, you know, dysregulated behaviour, but I think a lot of our parents want to see consequences and, and the more severe the the better for them, whereas what we go for is, you know, we understand what's behind the children, and the consequences will change depending on the children and the situation. But it's about the consistency rather than severity of the consequence, and I think we have a bit of a battle on our hands explaining that to parents.		1	1	1
Interviewer: Okay, yeah				
P1: We have been able to well, we didn't have parents in when we we sort of stated our behavior regulation policy because of COVID, and we do need to do that and we need to start that building those relationships at those parents again.	1	1		1
P1: And it tends to be our most dysregulated chidlren, not always, but it tends to be that our most dysregulated children have the parents that want the firmer consequences.		1		
Interviewer: OK. And can you just tell me a bit more about kind of what like, I know you're talking about consequences so just any sort of examples of what consequences might be and how they might differ to what you did before? You mentioned a soft approach, but if you can tell me a bit more?				
P1: Well, so in terms of what we used to work with was, it was called, Good to be Green and in the classroom as used to have a display, and every child had a card which started on green, and then they'd have a card if they misbehaved, had a couple of warnings, and then you got to an amber card. So you changed the card on the wall to Amber. Then one more warning. Then it went to red and basically all that was doing was shame. And the children, they were up there, you know, big and				

APPENDIX E: Coded Interview Transcript

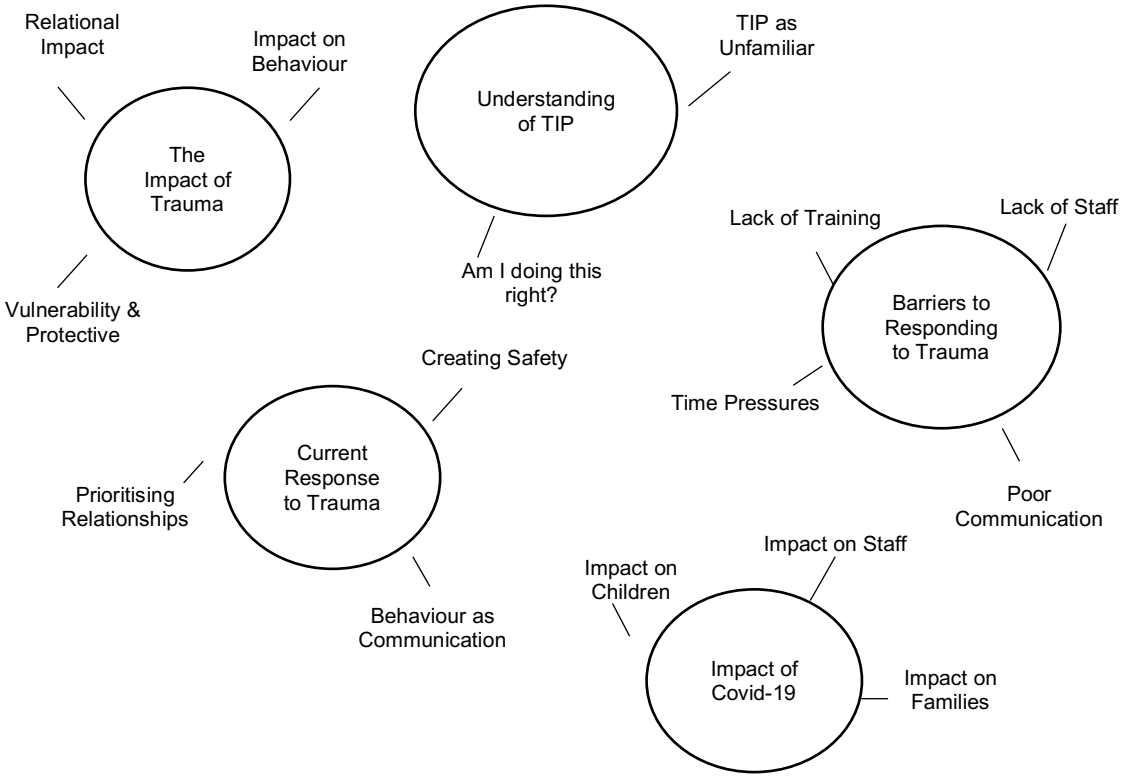
Interview Extract	Codes
Interviewer: Yeah. No, absolutely. I imagine that is really really hard, and do you think staff or teachers can be better supported?	
Participant: I think so yes, but I don't know what the answer is in terms of how we support them. It doesn't help that social workers are particularly stretched at the moment, so the social workers that we have dealing with a lot of our families are either off ill or have moved to another area or are no longer working, and so any communication takes a long time to get through to us and it just is a bit broken.	Social Work Less Support from Services Communication with System Lack of Staff Support for Staff
Interviewer: Ah OK I see, so the communication with other services is broken?	
Participant: Yeah, communication, but the system as a whole really. So, one of our families are on their 5th social worker and the boys have just been put into temporary foster care. Parents have just asked for them back, and they're now on their 6th social worker. They've gotta go through the whole story again. Those children have had so much trauma over their little lives, and it's back to square one.	Communication with System Children in Care Social Work Re-telling Stories
Interviewer: Mmm OK.	
Participant: Time scales are reset and it feels like you you're going nowhere, but as a teacher or a DSL, you spend a lot of time chasing, looking out for these children that nobody else seems to be.	Hopelessness
Interviewer: OK, yeah. It's really interesting to hear you talk not just about school, but actually all the other systems around the child as well. So, you've mentioned social work there	
Participant: Yeah, I mean all the multi-agency, I just did my refresher Level 3 safeguarding which was to do with multi-agency work. I mean in theory it should work, but the social work side of it, and it just doesn't seem to be working at the moment.	Social Work Less Support from Services Communication with the System
Interviewer: Mhmm OK.	

Participant: We have such a high percentage of children, that, yeah, I think that's the heads whole life at the moment, but we are looking to employ a social worker to come and work in school.	Social Work Need for more Staff
Participant: Well, they can't really afford it, but we can't really afford not to anymore either.	Lack of Funding Need for more Staff
Interviewer: Yeah, it sounds like a really difficult situation that you are in in terms of the system not working as it should and the impact that it has on you in schools. And I mean, thank you so much for everything that you've shared with me so far. It's so interesting to hear about your experiences. I just wonder if there's anything else before we finish, that I haven't asked you about that you think would be helpful to share in relation to supporting well-being, trauma-informed practice, or mental health in schools?	
Participant: Well, I think it would be really helpful to have a bank of strategies to draw on, you know something that you know could dip into, that one for that situation, dip into that one for that situation and, we don't want to do the wrong thing because we feel that sometimes if you react in a way we think is right, but it's actually counterproductive that actually makes matters worse, and as I say, we're just, we're trying to educate rather than, understanding traumatic needs of the children.	Are we doing the right thing? Making things worse Need for strategies
Interviewer: Yeah, no, absolutely. And if I could just ask you, because you just mentioned being counterproductive, is there anything in particular that you're kind of referring to there?	
Participant: Well, we got a little boy in year four that he is being tested for Autism at the moment, but regardless of whether he's diagnosed with autism or not, we wouldn't really change how we deal with him. He's not as bad now, but he used to punch himself and then he'd just shout kill me, I wanna die, I don't want to live. And you know, I talked to the lady at the mental health team the other day. I'm saying, you know, it's constant, it's been for 18 months now and we sort of say, you know, we leave it and then just say you know you've gotta come in now. What? Classroom or Bottle Dream, your choice. Which is it going to be? And you know, we're quite firm with them about that.	Choice Mental health Autism Mental health support team Self-harm Current interventions

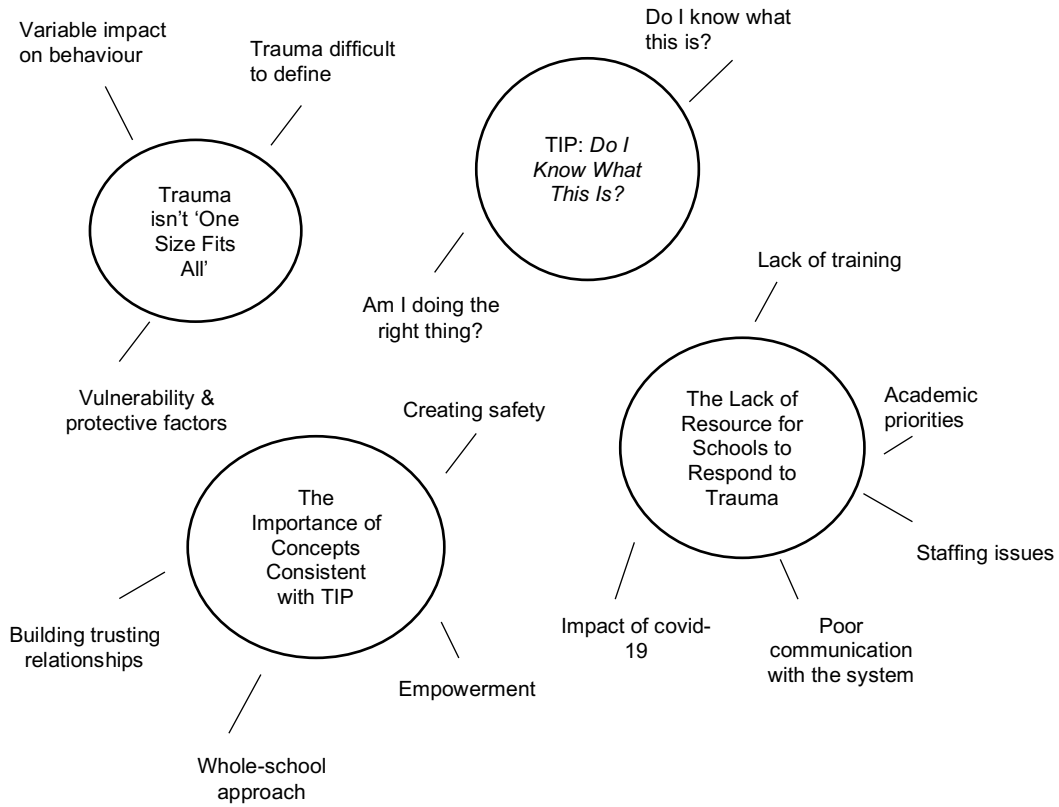
Participant: But are we doing the right thing you know, by just acknowledging it but not going any further into it. And his parents are very supportive, separated but very supportive, but, you know, we don't know if we're doing the right thing by doing that, or should we be talking about it in more depth?	Are we doing the right thing?

APPENDIX F: Development of Thematic Framework

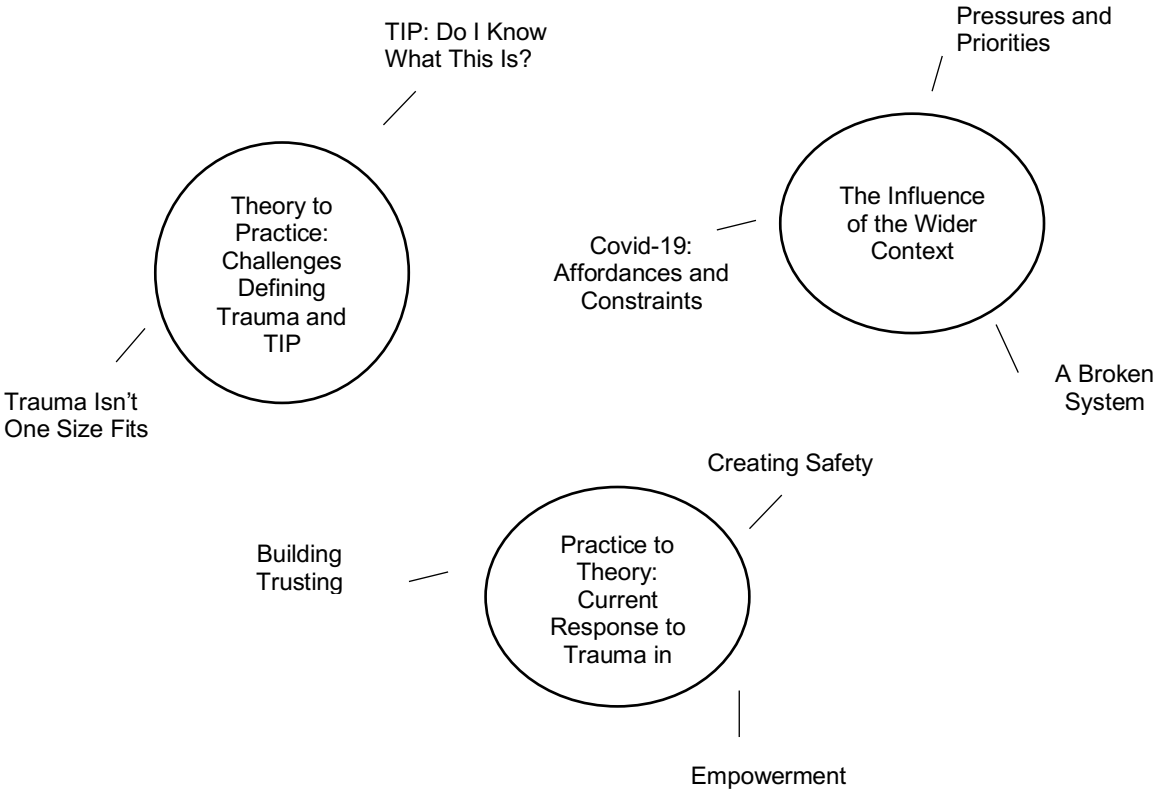
Thematic Map 1



Thematic Map 2



Final Thematic Map



APPENDIX G: Ethics Application

University of East London

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: ▪ 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: ▪ 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/ ▪ 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	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 You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service
1.7	Checklist, the following attachments should be included if appropriate: ▪ 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:**	**Emma Palluotto**
2.2	**Your supervisor's name:**	**Christina Trigeorgis**
2.3	**Name(s) of additional UEL supervisors:**	**David Harper** 3rd supervisor (if applicable)
2.4	**Title of your programme:**	**Professional Doctorate in Clinical Psychology**
2.5	**UEL assignment submission date:**	**02/05/2023**

		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:** Please note - If your study requires registration, the title inserted here must be the same as that on PhD Manager	Trauma-Informed Practice in Schools: Perceptions of School Staff
3.2	**Summary of study background and aims (using lay language):**	Childhood trauma is associated with long-term impacts on wellbeing and mental health. In the school context, research suggests trauma or adverse childhood experiences can affect engagement, learning, behaviour and peer relationships. Trauma-informed practice (TIP) in schools is a newly emerging area and research and evidence is currently limited, particularly in the UK context. According to existing literature, TIP refers to schools building a shared understanding of trauma and the impacts, consensus for trauma-informed principles, training and organisational change including modifying disciplinary policies and building staff resilience. The proposed study will interview school staff to explore their understanding of trauma-informed practice, the extent to which they use it and perspectives on its impact, and their ideas about further support and development. The aim is to inform further research, policy and practical developments in this area, to better support children who have experienced trauma and prevent long-lasting impacts of trauma or adverse experiences on mental health and wellbeing, including having a better understanding of how psychologists can support TIP in their roles in schools.
3.3	**Research question(s):**	How is trauma-informed practice understood by school staff? To what extent do school staff use trauma-informed practice and what has been the impact? What additional training, support, or development is needed?

3.4	**Research design:**	The research design with apply a qualitative approach, using individual semi-structured interviews to gather information about the participants' subjective experience and perceptions of TIP in schools. Data will be analysed using a thematic analysis method (Braun & Clarke, 2006).
3.5	**Participants:** Include all relevant information including inclusion and exclusion criteria	7-12 primary or secondary school staff in the UK (teachers, teaching assistants, SENCos, school counsellors, mental health leads etc). Excluded if not a current/recent member of school staff. Inclusion criteria will be over 18 years of age and English language proficiency. Participants will be self-selecting volunteers. I may also access publicly available information from school websites, for example their mental health policies that may related to TIP in schools.
3.6	**Recruitment strategy:** Provide as much detail as possible and include a backup plan if relevant	Participants will be recruited via advertisements (Appendix D) on social media sites and online forums, including LinkedIn, Facebook and Instagram. The researcher's personal contact details/profile won't be used for advertising on social media. Using convenience sampling, I will also ask teachers that I am connected with to post the advert on teacher-specific groups on Facebook and Whatsapp, and relevant websites. Once a participant volunteers, they will be provided with information (Appendix A), consent forms (Appendix B) and a form for their personal contact information (Appendix E). Within this participants are made aware that they can withdraw from the study without consequence.
3.7	**Measures, materials or equipment:** Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	With consent, Microsoft Teams will be used to audio/video record interviews and will produce a transcription.

3.8	**Data collection:** Provide information on how data will be collected from the point of consent to debrief	Following consent, data will be collected using semi-structured interviews (Appendix F) with myself online via Microsoft Teams (with option of telephone call or face to face on UEL campus if there are issues with accessing Teams). Interviews will last about 60 minutes. A debrief will be provided after the interview, including ways for participants to access support should they wish to (Appendix C).	
3.9	**Will you be engaging in deception?**	**YES** ☐	**NO** ☒
	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** ☐	**NO** ☒
	If yes, please detail why it is necessary.		
	How much will you offer? Please note - This must be in the form of vouchers, not cash.		
3.11	**Data analysis:**	Data will be analysed using Thematic Analysis (TA) (Braun & Clarke, 2006), compatible with critical realism. Analysis will involve data familiarisation, generating codes, searching for themes, reviewing these and then defining and naming them and producing a report (Braun & Clarke, 2006).	

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** ☐	**NO** ☒
	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** ☒	**NO** ☐
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	All identifiable information will be removed or anonymised on the transcripts, including name and contact details, and participants will each be allocated a pseudonym.	
4.3	**How will you ensure participant details will be kept confidential?**	Personal data will be collected prior to the interview, including names, email addresses and telephone numbers for the purposes of consent and arranging the interview. The real names of participants on consent forms and any other personal data will be stored separately in encrypted and password-protected files, on the UEL OneDrive, on the researcher's private password-protected. All identifiable information in the interviews will be removed at the point of transcription and pseudonymised for the write up, with video/audio recordings being destroyed following transcription.	
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	Interview data (audio/video files and transcripts) and all forms will be stored confidentiality according to the Data Protection act 2018. These will be secured on the UEL OneDrive for business cloud, in encrypted folders, with identifiable information separate from all other data, accessed via the researcher's password protected laptop. Full details on how data will be saved is described in the data management plan. The interview data and consent forms and personal contact information will be stored on the researcher's and supervisor's secure accounts so that there is back up. Audio/video files will all be destroyed once transcribed. All personal data and forms will be destroyed once the thesis has been examined, however anonymised transcripts will remain on the research supervisor's OneDrive for another three years.	

4.5	**Who will have access to the data and in what form?** (e.g., raw data, anonymised data)	All data will be obtained and stored by the researcher. The researcher will share access to anonymised transcripts with their supervisor and examiners, but this will not include the original audio/video file (raw data) – only the researcher will have access to this. Access to consent forms will only be granted if necessary and with participant consent.	
4.6	**Which data are of long-term value and will be retained?** (e.g., anonymised interview transcripts, anonymised databases)	Audio files will be destroyed once transcribed. All personal data and forms will be destroyed once the thesis has been examined. Transcripts will be stored for three years on UEL OneDrive and then will be deleted.	
4.7	**What is the long-term retention plan for this data?**	See above.	
4.8	**Will anonymised data be made available for use in future research by other researchers?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐
4.9	**Will personal contact details be retained to contact participants in the future for other research studies?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐

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** ☒	**NO** ☐
	If yes, what are these, and how will they be minimised?	The researcher recognises that participants may have experienced trauma and that talking about trauma could be distressing. Participants will be	

		made aware before the interview that if they become distressed, they are able to terminate the interview at any point. I will take a compassionate and sensitive approach to the interview and will use my clinical judgement to pause/stop an interview if it seems too distressing. All participants will be given a debrief support and information sheet prior to the interview which will include information about trauma and available support.		
5.2	**Are there any potential physical or psychological risks to you as a researcher?**	**YES** ☒	**NO** ☐	
	If yes, what are these, and how will they be minimised?	It is acknowledged that hearing participants talk about trauma could also be distressing for the researcher, and therefore I will use supervision to manage this and prevent any impact on the research.		
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** ☒		
5.4	**If necessary, have appropriate support services been identified in material provided to participants?**	**YES** ☒	**NO** ☐	**N/A** ☐
5.5	**Does the research take place outside the UEL campus?**	**YES** ☒	**NO** ☐	
	If yes, where?	Interviews will take place online, from the researcher's home in a private space.		
5.6	**Does the research take place outside the UK?**	**YES** ☐	**NO** ☒	
	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	**YES** ☐		

	(available in the Ethics folder in the Psychology Noticeboard). Please confirm a Country-Specific Risk Assessment form has been attached as an appendix. 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.	
5.7	**Additional guidance:** ▪ 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	**Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?** If yes, you will require Disclosure Barring Service	**YES** ☐	**NO** ☒

	(DBS) or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project		
	* You are required to have DBS or equivalent clearance if your participant group involves: (1) Children and young people who are 16 years of age or under, or (2) 'Vulnerable' people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, 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.		
6.2	**Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?**	**YES** ☐	**NO** ☐
6.3	**Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the duration of the research project?**	**YES** ☐	**NO** ☐
6.4	**If you have current DBS clearance, please provide your DBS certificate number:**	Please enter your DBS certificate number	
	If residing outside of the UK, please detail the type of clearance and/or provide certificate number.	Please provide details of the type of clearance, including any identification information such as a certificate number	
6.5	**Additional guidance:** ▪ 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	**Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?**	**YES** ☐	**NO** ☒
	If yes, please provide their details.	Please provide details of organisation	
	If yes, written permission is needed from such organisations (i.e., if they are helping you with 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.	**YES** ☐	
7.2	**Additional guidance:** ▪ 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** ☒
8.2	**Student's name:** (Typed name acts as a signature)	**Emma Palluotto**

8.3	**Student's number:**	**U2075225**
8.4	**Date:**	**16/05/2022**
Supervisor's declaration of support is given upon their electronic submission of the application		

APPENDIX H: Letter of Ethical Approval

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:	Marita Morahan
Supervisor:	Christina Trigeorgis
Student:	Emma Palluotto
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.)	☐	☒	☐
Detailed account of participants, including inclusion and exclusion criteria	☒	☐	☐
Concerns regarding participants/target sample	☐	☐	☐
Detailed account of recruitment strategy	☒	☐	☐
Concerns regarding recruitment strategy	☐	☐X	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☒	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	☐X	☐	☐
Clear and detailed outline of data collection	☒	☐	☐
Data collection appropriate for target sample	☐X	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☒
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☒	☐	☐
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☒	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☒	☐

Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☒	☐
If required, General Risk Assessment form attached	☐X	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐X	☐	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☒	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☒
If required, a DBS or equivalent certificate number/information provided	☐	☐	☒
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☐	☐	☒
All relevant information included in the participant information sheet (PIS)	☒	☐	☐
Information in the PIS is study specific	☒	☐	☐
Language used in the PIS is appropriate for the target audience	☒	☐	☐
All issues specific to the study are covered in the consent form	☒	☐	☐
Language used in the consent form is appropriate for the target audience	☒	☐	☐
All necessary information included in the participant debrief sheet	☒	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☒	☐	☐
Study advertisement included	☒	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☒	☐	☐

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	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. 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.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	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. 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 project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study

Please indicate the decision:	APPROVED - MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES

Minor amendments
Please clearly detail the amendments the student is required to make
Please complete 5.5, is the study going to be conducted on MSTeams?

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 ☒	NO ☐
	If no, please request resubmission with an adequate risk assessment.	
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.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☐

LOW	Approve and if necessary, include any recommendations in the below box.	☒
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature	
Reviewer: (Typed name to act as signature)	M. Morahan
Date:	12/06/2022
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)	Emma Palluotto
Student number:	U2075225
Date:	14/06/2022
Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required	

APPENDIX I: Participant Information Sheet

PARTICIPANT INFORMATION SHEET (27.06.22)

Trauma-Informed Practice in Schools: Perceptions of School Staff

Contact person: Emma Palluotto
Email: u2075225@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?

My name is Emma Palluotto. I am a doctoral student in the School of Psychology at the University of East London (UEL) and I am studying for a Professional Doctorate in Clinical Psychology. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?

Childhood trauma is associated with long-term impacts on wellbeing and mental-health, and research suggests Covid-19 has led to higher rates of traumatic childhood experiences and that it has worsened pre-existing mental health difficulties amongst children.

With referrals to Child & Adolescent Mental Health services (CAMHS) increasing, and wait-lists subsequently increasing, especially since the pandemic, fewer children are receiving help on time. The school environment has the potential to play a key role in intervening early and reducing the long-term or mental health impacts of trauma.

Increasingly, schools are linking up with CAMHS services and trauma-informed school schemes are being piloted, with more teaching and training being offered. However,

currently, little is known about trauma-informed practice in UK schools due to limited research. As such, my research aims to explore, for example, how school staff perceive trauma and trauma-informed practice, experience of trauma-informed practice and support for wellbeing in schools, perceived barriers and areas for development. This research could contribute to the prevention of long-term impacts of child trauma on mental health.

Why have I been invited to take part?

To help address the study aims, I am inviting primary and secondary school staff in the UK to take part in my research. If you are currently working within a primary or secondary school setting in the UK and are either a Teacher, Teaching Assistant, SENCo, Mental Health Lead, Safeguarding Lead, Inclusion Manager, Specialist Staff, Educational Psychologist, Speech and Language Therapist, or School Counsellor, you are eligible to take part in the study.

I am not seeking for experts on the topic but rather want to hear about your understanding and experiences of supporting children's mental health and well-being in schools. It is entirely up to you whether you take part or not, participation is voluntary.

What will I be asked to do if I agree to take part?

If you agree to participate, you will be asked to provide contact details including your email and phone number, and take part in an informal individual interview with me, Emma, the researcher. The interview will last approximately 30 minutes to one hour. I will firstly ask demographic questions, for example, about your age, gender, ethnicity, how long you have been in the role for, and the region of the UK and type of school you work in. I will then ask questions relating to your understanding of childhood trauma and trauma-informed practice, experience of trauma-informed practice and supporting emotional wellbeing in schools including perceived barriers, and what support or development you feel is needed.

The interviews will take place online via a video-call software called Microsoft Teams and will be video recorded via Microsoft Teams for transcription purposes. Once interviews have been transcribed, these recordings will be deleted and there is more information on this below. If it is not possible to carry out the interview via Teams, a telephone or face to face interview could be an alternative and would be recorded using an audio-recording device.

The interview is not an examination of expertise and should feel like an informal chat. There is no need to prepare for it in advance.

Can I change my mind?

Yes, you can change your mind at any time and withdraw without explanation, disadvantage or consequence. If you would like to withdraw from the interview, you can do so by either telling me at the time of the interview, or sending me an email beforehand. If you withdraw, your data will not be used as part of the research.

Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?
The interview is not designed or intended to cause distress. However, it is acknowledged that talking about trauma can be distressing, particularly if you have worked with children who have experienced trauma, or if you have experienced trauma yourself. I will be sensitive and compassionate during the interview to ensure that you feel supported. Please let me know if at any point you feel distressed and would like to pause or terminate the interview. You will not be penalised for this. Please note, I will not be able to provide therapy, however you will be offered information for supporting agencies at the end of the interview, or if you decide to withdraw, as part of the debrief process.

How will the information I provide be kept secure and confidential?
Your personal information will not be identifiable through any of the data collected or in any of the write-up of the research. Your real name will be replaced with a pretend name to maintain confidentiality. The transcription of the interviews will be anonymous, as well as any short quotes from the interview that are used in the final write up of the project. Only anonymous transcripts will be shared with the researcher's supervisor and examiners.

All interview data will be stored in separate and secure password-protected folders, on an encrypted UEL OneDrive, on a secure password protected laptop. The interview data will not be identifiable as it will be saved separately to all identifiable information. Only I, Emma, the researcher, will have access to video recordings, consent forms and contact information.

All video recordings will be destroyed immediately after transcription. Consent forms and contact information will be destroyed following examination of the project (September 2023). Anonymised interview transcripts will be destroyed three years in a secure location after completion of the project, for potential publication purposes. Your contact details will only be kept if you report that you would like to receive a summary of the findings in the consent form. If you consent to this, your contact information will be stored securely and then destroyed once findings have been sent. Otherwise, this information will not be kept and you will not be invited to participate in future studies.

If there are serious concerns about yours or others' safety raised during the interview, I will need to discuss this with my supervisor and consider if support from external services may be needed. I would discuss this with you first and keep you informed.

For data protection purposes, 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.

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 may also be published through journal articles or presentations. In all material produced, your identity will remain anonymous - it will not be possible to identify you personally as pseudonyms will be used.

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

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 about my research or have any questions or concerns, please do not hesitate to contact me - Emma Palluotto, Trainee Clinical Psychologist, u2075225@uel.ac.uk.

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Christina Trigeorgis, School of Psychology, University of East London, Water Lane, London E15 4LZ, Email: c.trigeorgis@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)

APPENDIX J: Participant Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Trauma-Informed Practice in Schools: Perceptions of School Staff

Contact Person: Emma Palluotto

Email: u2075225@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated 27/06/2022 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 I have 3 weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be recorded using Microsoft Teams	
I understand that my personal information and data, including audio recordings from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
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 data may be used in 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 (BLOCK CAPITALS)

……

Researcher's Signature

……

Date

……

APPENDIX K: Participant Debrief Sheet

PARTICIPANT DEBRIEF SHEET

Trauma-Informed Practice in Schools: Perceptions of School Staff

Thank you for participating in my research study Trauma-Informed Practice in Schools. This document offers information that may be relevant now you have 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, talks, magazine articles, blogs. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally as pretend names will be used and any other identifiable information will be removed from any extracts included in the write up.

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 for a maximum of 3 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 – or its after-effects – 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, as well as accessing support through your support systems, GP, family and friends:

Trauma-Specific Support Services:

- **ASSIST Trauma Care:** *Information and specialist help for people who've experienced trauma or are supporting someone who has.*
  - Website: assisttraumacare.org.uk
- **The National Association for People Abused in Childhood (NAPAC):** *Supports adult survivors of any form of childhood abuse. Offers a helpline, email support and local services.*
  - Tel: 08088010331
  - Email: Support@napac.org.uk
  - Website: Napac.org.uk
- **One in Four:** *Offers advocacy services, counselling, and resources for adults who have experienced trauma, domestic or sexual abuse in childhood.*
  - Website: https://oneinfour.org.uk/
- **The Survivors Trust:** *Lists local specialist services for survivors of sexual violence, including advocates and Independent Sexual Violence Advisors (ISVAs).*
  - Tel: 08088010818
  - Website:Thesurvivorstrust.org
- **Victim support:** *Provides emotional and practical support for people affected by crime and traumatic events.*
  - Tel:08081689111
  - Website: Victimsupport.org.uk

General Mental Health Support Services:

- **NHS Improving Access to Psychological Therapies services (IAPT):** *IAPT services offer talking therapies, such as cognitive behavioural therapy (CBT), counselling, other therapies and guided self-help for common mental health problems, like anxiety and depression. You can use the NHS website to find your local IAPT service*
  - https://www.nhs.uk/service-search/mental-health/find-a-psychological-therapies-service
- **British Association for Counselling and Psychotherapy (BACP):** *Professional body for talking therapy and counselling. Provides information and a list of accredited therapists.*
  - https://www.bacp.co.uk/
- **EMDR Association UK:** *Professional association of EMDR clinicians and researchers in the UK and Ireland. Provides lots of information about EMDR. Includes a search tool to find EMDR-accredited therapists.*

    - https://emdrassociation.org.uk/
- **Samaritans Help Line:** *Samaritans are open 24/7 for anyone who needs to talk. Samaritans also have a Welsh Language Line on 08081640123 (7pm-11pm every day).*
    - 116 123 (helpline)
    - Samaritans.org
- **Mind:** *Organisation providing advice and support to empower anyone experiencing a mental health problem. Helplines and local mind service details can be found on the website linked below.*
    - https://www.mind.org.uk

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

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me. My name is Emma Palluotto, I am a Trainee Clinical Psychologist, and my email is u2075225@uel.ac.uk.

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor, Christina Trigeorgis, Clinical Psychologist, School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: c.trigeorgis@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 my study!

UEL Data Management Plan

Completed plans must be sent to researchdata@uel.ac.uk for review

If you are bidding for funding from an external body, complete the Data Management Plan required by the funder (if specified).

Research data is defined as information or material captured or created during the course of research, and which underpins, tests, or validates the content of the final research output. The nature of it can vary greatly according to discipline. It is often empirical or statistical, but also includes material such as drafts, prototypes, and multimedia objects that underpin creative or 'non-traditional' outputs. Research data is often digital, but includes a wide range of paper-based and other physical objects.

Administrative Data	
PI/Researcher	Emma Palluotto
PI/Researcher ID (e.g. ORCiD)	0000-0001-9006-4806
PI/Researcher email	U2075225@uel.ac.uk
Research Title	Trauma-Informed Practice in Schools – Perceptions of School Staff
Project ID	NA
Research start date and duration	May 2022 – October 2023
Research Description	Childhood trauma is associated with long-term impacts on wellbeing and mental health. In the school context, research suggests trauma or adverse childhood experiences can effect engagement, learning, behaviour and peer relationships. Trauma-informed practice in schools is a newly emerging area and research and evidence is currently limited, particularly in the UK context. The proposed study will interview school staff in the UK to explore their understanding of trauma-informed practice, the extent to which they use it and perspectives on its impact, and their ideas about further support and development. Data will be analysed using thematic analysis.

	Research questions are: • How is trauma-informed practice understood by school staff? • To what extent do school staff use trauma-informed practice and what has been the impact? • What additional training, support, or development is needed? The aim is that this will inform further research and effective policy and practical developments in this area in the UK, to better support children and prevent long-lasting impacts of trauma or adverse experiences on mental health and wellbeing.
Funder	N/A, part of professional doctorate
Grant Reference Number (Post-award)	N/A
Date of first version (of DMP)	February 2022
Date of last update (of DMP)	28 March 2022
Related Policies	Research Data Management Policy, UEL Data Backup Policy, GDPR, UK Data Service, BPS Practice Guidelines
Does this research follow on from previous research? If so, provide details	N/A
Data Collection	
What data will you collect or create?	Personal data will be collected before-hand including names (on consent forms) and email addresses and telephone numbers prior to the interview for purposes of arranging this (participant contact information). Consent forms and participant contact information will be saved as word documents in .docx format. The interview recordings will be saved in .mp4 format. At the start of the interview, the interviewer will also ask the participant for their job title, how long they have been in the job for, the region of the country that they work in, when they trained as a teacher and these participant demographic details will be saved as word documents in .docx format. Teams auto-transcriptions will be created as .vtt format.

How will the data be collected or created?	8-12 school staff will be interviewed by the researcher. The interviews will be individual and semi-structured and approx.. 40-60 minutes. They will be video recorded and transcribed via Microsoft Teams (using auto-transcribing software). Video recordings will be saved initially in Microsoft Stream Library, and then downloaded and saved in an encrypted folder. They will then be deleted from Microsoft Stream Library. The transcriptions will also be saved initially on Microsoft Stream Library, and then as word documents in a separate encrypted folder on UEL OneDrive Cloud for analysis by the researcher (then deleted from Microsoft Stream Library). All identifiable information will be removed on the transcripts and participants will each be allocated a pseudonym. All local copies of videos and auto-transcriptions will be deleted from the downloads folder on the researcher's personal laptop and will not be synced to a personal Cloud storage such as iCloud. Consent forms, participant information sheets and debrief forms will be emailed to participants prior to the interviews and will be emailed again at the time of interview. See storage section for information on storage.
Documentation and Metadata	
What documentation and metadata will accompany the data?	A blank consent form, blank personal info form (for contact details – email and telephone number), template participant information sheet, interview schedule guide, participant debrief form, study advertisement/recruitment poster.
Ethics and Intellectual Property	
Identify any ethical issues and how these will be managed	UEL ethical approval will be sought prior to recruitment. Participants will be provided with an information sheet explaining the project and they will have the opportunity to ask questions. Participants will also be emailed a consent form prior to the interview, and will be given this again via Teams at the time of interview. This form will ask participants to tick a list of statements to ensure that they understand what they are consenting to, in terms of their participation, the data collection, storage of the data, and how the data will be used.

	Participants will be reminded that they have the right to withdraw from the study, and that there are no negative consequences to this. If they agree to participate, they are made aware that they can change their mind without needing to give a reason. Participants will be reminded that they have until three weeks after the interview to request to withdraw. Participants are also made aware that they can stop/pause the interview at any time, and will be given the names of services that they can contact should they become distressed, prior to and after the interview. As discussed above, interview transcripts will be pseudonymous. As discussed above, these will be stored securely and separate from any identifiable information. In line with the UK Data Service recommendations, any other identifiable information, or information that increase the risk of re-identification post-anonymisation, shared in the interview will be removed from the transcripts, and will be replaced within the text, for example, by using [brackets]. Any statements where there is an increased risk of harm or disclosure will be redacted. Only the researcher, their supervisor and examiners will have access to anonymised transcripts. Interview data and all forms will be stored confidentially according to the data protection act 2018 and GDPR. Data stored on UEL OneDrive are encrypted, and secured on the University of East London managed Cloud storage. Audio recordings will be deleted following transcription, and consent and personal contact information will be destroyed following examination, in compliance with GDPR. Anonymised transcripts will be kept for 3 years and then destroyed. Participants will be made aware of all of this prior to consenting.
Identify any copyright and Intellectual Property Rights issues and how these will be managed	No issues are foreseen.
Storage and Backup	
How will the data be stored and backed up during the research?	Interview data (audio/video files and transcripts) and all forms will be stored confidentiality according to the data protection act 2018. These will be secured on UEL OneDrive for

	business cloud, accessed via the researcher's password protected laptop. Data will be stored within a larger folder titled 'Data' within a folder titled '[ProjectCode]-Project. Within this folder titled 'Data', data will be stored as follows: Interviews conducted and recorded remotely using Microsoft Teams will be installed on the interviewer's laptop, with the resulting .mp4 files transferred to OneDrive. There will be an encrypted, password-protected folder titled 'VideoRecordings' and within this, recordings will be stored in encrypted sub-folders labelled with pseudonyms, following the file-naming convention: [ProjectCode]-[InterviewerInitials]-[Pseudonym]-[Location]-[Date]-Video.mp4 These will be destroyed once transcription is finished. There will also be a separate encrypted folder for transcripts, titled 'InterviewTranscripts' and within this each participant will have an encrypted sub-folder for their transcript titled with their pseudonym, and the file will be labelled as: [ProjectCode]-[InterviewerInitials]-[Pseudonym]-[Location]-[Date]-Transcription.doc. All local copies of videos and auto-transcriptions will be deleted from the downloads folder on the researcher's personal laptop and will not be synced to a personal Cloud storage such as iCloud. There will be a separate encrypted folder titled 'Documentation'. Within this, there will be a password-protected subfolder titled 'ConsentForms' including consent forms, documents titled: [ProjectCode]-[ResearcherInitials]-[ParticipantRealNameInitials]-[Date]-ConsentForm.doc, and a separate password-protected subfolder titled 'ContactInfo' including the contact information sheets (name, email, number), documents titled: [ProjectCode]-[ResearcherInitials]-[ParticipantRealNameInitials]-[Date]-ContactDetails-.doc. There will also be an encrypted folder titled 'ParticipantDetails' including the demographics obtained at interview, each document will be titled [ProjectCode]-[ResearcherInitials]-[Pseudonum]-[Date]-ParticipantInfo.doc. There will also be a separate encrypted subfolder for the information sheet, titled 'InformationSheet' (document titled: [ProjectCode]-[ResearcherInitials]-InfoSheet.pdf), a separate encrypted subfolder for the debrief form titled 'DebriefForm' (document titled: [ProjectCode]-[ResearcherInitials]-[Date]-Debrief.pdf), a separate encrypted folder for the study advert titled 'StudyAdvertisement' (document titled: [ProjectCode]-[ResearcherInitials]-[Date]Advert.pdf) and a separate encrypted folder for the interview schedule titled

	'InterviewSchedule' (document titled: [ProjectCode]-[ResearcherInitials]-[Date]-interviewschedule.doc). There will also be an encrypted folder titled 'ParticipantSpreadsheet' including a password-protected Microsoft Excel spreadsheet linking pseudonyms to real names, this document will be titled '[ProjectCode]-[ResearcherInitials]-[Date]-ParticipantSpreadsheet.xls. Versioning will be included within file names where appropriate, e.g. adding 'Version [VersionNumber]' to the document name. The interview data and consent forms and personal contact information will be stored on the researcher's and supervisor's secure accounts so that there is back up. Audio/video files will all be destroyed once transcribed. All personal data and forms will be destroyed once the thesis has been examined, however anonymised transcripts will remain on the research supervisor's OneDrive for another three years.
How will you manage access and security?	All data will be obtained and stored by the researcher using UEL managed systems accessed via their personal laptop (password protected) . Access to UEL systems and storage is via multi-factor authentication, and data stored will be encrypted. The researcher will share access to pseudonymous transcripts with their supervisor and examiners, but this will not include the original Teams audio file/transcription – only the researcher will have access to this. Sharing will take place via secure links on UEL OneDrive. File names will be labelled with pseudonyms and identifiable information (consent forms, contact details, participant name spreadsheet) in a separate folder to pseudonymous transcripts, and all password-protected. Access to consent forms will only be granted if necessary and with participant consent.
Data Sharing	
How will you share the data?	Short extracts of transcripts will be included in the final write-up of the research and any publications following this. There will be no identifiable information in these extracts. The final project write up will be uploaded onto UEL repository, the pseudonymous transcripts will not be uploaded onto UEL repository, as it will not be useful to other researchers so will be unnecessarily sharing too much information.

Are any restrictions on data sharing required?	Only the researcher and supervisor will have access to the data.
Selection and Preservation	
Which data are of long-term value and should be retained, shared, and/or preserved?	Audio and video files will be destroyed once transcribed. All data and consent forms will be deleted once the thesis has been examined and passed.
What is the long-term preservation plan for the data?	Transcripts will be stored for three years on UEL OneDrive for business by the research supervisor and then will be deleted. They will be retained for three years to allow for the work to be written up for publication.
Responsibilities and Resources	
Who will be responsible for data management?	Emma Palluotto and Christina Trigeorgis
What resources will you require to deliver your plan?	Laptop, access to secure UEL portal.
Review	
	Please send any amendments to your plan to researchdata@uel.ac.uk
Date: 07/04/2022	Reviewer name: Penny Jackson (Assistant Libraria

Guidance

Brief information to help answer each section is below. Aim to be specific and concise. For assistance in writing your data management plan, or with research data management more generally, please contact: **researchdata@uel.ac.uk**

Administrative Data

Related Policies

List any other relevant funder, institutional, departmental or group policies on data management, data sharing and data security. Some of the information you give in the remainder of the DMP will be determined by the content of other policies. If so, point/link to them here.

Data collection

Describe the data aspects of your research, how you will capture/generate them, the file formats you are using and why. Mention your reasons for choosing particular data standards and approaches. Note the likely volume of data to be created.

Documentation and Metadata

What metadata will be created to describe the data? Consider what other documentation is needed to enable reuse. This may include information on the methodology used to collect the data, analytical and procedural information, definitions of variables, the format and file type of the data and software used to collect and/or process the data. How will this be captured and recorded?

Ethics and Intellectual Property

Detail any ethical and privacy issues, including the consent of participants. Explain the copyright/IPR and whether there are any data licensing issues – either for data you are reusing, or your data which you will make available to others.

Storage and Backup

Give a rough idea of data volume. Say where and on what media you will store data, and how they will be backed-up. Mention security measures to protect data which are sensitive or valuable. Who will have access to the data during the project and how will this be controlled?

Data Sharing

Note who would be interested in your data, and describe how you will make them available (with any restrictions). Detail any reasons not to share, as well as embargo periods or if you want time to exploit your data for publishing.

Selection and Preservation

Consider what data are worth selecting for long-term access and preservation. Say where you intend to deposit the data, such as in UEL's data repository (https://repository.uel.ac.uk) or a subject repository. How long should data be retained?

APPENDIX M: Reflexive Journal Extracts

Below are extracts from a reflexive journal kept throughout the research process.

03/09/2022

I have now recruited and interviewed 11 participants. I am acutely aware that all participants recruited so far have been of White ethnicity. I have been reflecting on why this might be. I have considered that the study advertisement clearly shows that I am a White researcher. This may lead individuals from racially or ethnically minoritised backgrounds to not volunteer perhaps due to feeling unsafe talking about topics such as trauma, with White people, in the context of experiences of systemic racism and discrimination. I am aware that this bias in the sample will impact on the research findings in that they will not reflect the perspectives of individuals from minoritised backgrounds.

07/07/2022

Whilst conducting interviews, I have occasionally felt a sense of discomfort when participants have asked me questions such as 'is that right?' in the context of trauma or TIP. This discomfort may stem from being positioned as someone with more knowledge or expertise. Whilst I am really interested to hear about, and learn from the experiences of the participants, they are inevitably positioning me as someone that knows more than them despite me not actually having the first-hand experience. This has led me to reflect on the power associated with my position as a Trainee Clinical Psychologist, conducting doctoral research, and the potential influence of this on the research. I wonder whether the reported lack of confidence in terms of conceptual understanding or daily practice, is a reflection of the power imbalance felt between us in the interviews. I try to put participants at ease and reinforce their responses both verbally and non-verbally. However, I wonder if this discomfort has led to a reluctance to prompt participants in terms of their understanding, as to not make them feel as though their response or understanding is lacking. This could mean that the data is not as rich or reflective of 'reality' as it otherwise would be.