Experiences of Care following a Road Traffic Collision: A Phenomenological Study of Injured Individuals in Italy

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Abstract

This study aimed to explore the experiences of care amongst severely injured individuals in Road Traffic Collisions (RTCs) in Italy, focussing on a phenomenological and idiographic understanding of the experiences of these individuals.

The large amount of evidence showing that RTC injuries often can lead to psychological comorbidities with prolonged recovery periods, and the paucity of qualitative studies on the experiences of care amongst these individuals, informed the rationale for the research question: "What are the experiences of hospital care received by individuals who have had severe injuries following an RTC in Italy?" To explore this research question semi-structured interviews were conducted in Italian with four Italian participants. Participants' ages ranged from 24 to 55 years. Participants were two females and two males who were severely injured in a RTC within the last two years and consequently hospitalised for at least two days.

Interviews were transcribed and analysed using Interpretative Phenomenological Analysis (IPA). Four Group Experiential Themes (GETs) emerged from the analysis: 'Life-changing experience', 'Negative impact on emotional state', 'Inability to connect with emotions' and 'Meaningful connections matter'. Each of these GETs consisted of two or three sub-themes.

A key finding was the intense life-changing impact that the experiences of care can have on the lives of participants. Some of whom experienced powerlessness and anger whilst others saw it as an opportunity to change their lives. Additionally, participants explored those aspects of their care experiences that negatively impacted their emotional state. This was also related to their inability to connect with their emotions. Another key finding included the importance of being cared for in a holistic way, underlining the importance of receiving consistent emotional support as a result of the intense impact that the experiences of accidents often involve.

Findings of this study enhance current knowledge about the care experiences of RTC-injured individuals. Recommendations for clinical practice and future research are made, which take into account the experiences of RTC-injured individuals and the care they receive in hospital.

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Abbreviations

CoP: Counselling Psychology

BPS: British Psychological Society

RTC: Road Traffic Collisions

RTI: Road Traffic Injuries

WHO: World Health Organisation

IPA: Interpretative Phenomenological Analysis

UEL: University of East London

UK: United Kingdom

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Introduction

Chapter Overview:

In this chapter, I will outline the context of the doctoral research I have undertaken about the experiences of care amongst severely injured individuals in RTCs in Italy. I will discuss my personal context, my philosophical positioning in research and the relevance of my research to Counselling Psychology (CoP).

Personal Context

In Interpretative Phenomenological Analysis (IPA), the researcher plays an active role in the interpretation of the data. Therefore, it is important to consider how my previous experiences may influence and predispose me to interpret certain phenomena.

Having been severely injured in a road traffic accident as a teenager, I had the opportunity to become aware of the hospital environment and the diverse aspects of care that patients often encounter during their stay in hospital. During my experience of care, I recall interacting with multiple patients in hospital who shared my experience of finding the hospital environment to be overwhelming and often emotionally unsupportive. This experience raised in me the desire to explore further the aspects of care provided in hospitals and the experiences of patients.

As an adult, during my job as a support worker in ICU and A&E, I had the opportunity to observe the quality of care provided to patients, especially those presenting with severe injuries. I noticed how there is not always a standard protocol to follow in regards to the mental health of these patients and I became curious about the patient’s thoughts and experiences of this. In my undergraduate research, I therefore explored the experiences of hospitalisation amongst undergraduate students and I continued to conduct literature reviews on the experiences of care of patients. Time after time, I noticed the lack of qualitative research on patients and I became passionate about understanding and providing support to patients in physical health settings.

Positioning as a Researcher

Qualitative approaches range from a realist to a relativist ontology where the view of reality can vary from a single and observable reality to co-existing multiple realities. Ontological concerns are considered fundamental because they respond to the question: "what is there to know?". Therefore, based on their view of reality, qualitative researchers will be able to choose their epistemology which consequently will determine what kind of knowledge will be produced through methodology (Willig, 2013).

The scientist-practitioner model is considered the cornerstone for the current practice and professional development of counselling psychologists (Milton, 2010). Within this model, trainees are encouraged to become familiar with research methods and use scientific methods to assess the effectiveness of their practice (Vespia & Sauer, 2006). For a long time, research in counselling psychology has been dominated by the positivist paradigm (Blair, 2010). The *Positivist Paradigm* subscribes to a realist ontology which assumes that there is one reality that is knowable and objective (Blair, 2010). Epistemologically, positivism sustains that human experience can be systematically observed and verified through quantitative methodologies to establish cause and effect relationships (Willig, 2013). Axiologically, positivist research does not aim to include the researcher's values (Ponterotto, 2005).

As a researcher, I subscribe to the humanistic values underpinning the therapeutic practice of CoP, which maintain that at the heart of therapy is the individual experience (British Psychological Society, [BPS], 2021). My own epistemology differs from positivism as I am interested in the experiences of participants and the meanings attributed to them. I subscribe to a critical realist ontology based on the idea that the reality of RTCs, severe injuries and quality of care can shape in different ways the experiences of care of my participants.

I acknowledge that my role as a researcher is influenced by my personal experiences; therefore, I engaged in personal reflexivity throughout the whole process of completing this research in order to monitor my participants' and my own triggers. In addition, my engagement with reflexivity allowed me to examine my own assumptions, beliefs and judgements whilst thinking critically about their influence throughout the whole research process. This allowed me to question the utility, ethics and value of my research whilst gaining insight into successful and insightful qualitative work (Olukotun et al., 2021).

Health care and RTCs

Universal care is a health care system in which all residents of a particular country or region are given access to health care (WHO, 2018). Universal care systems started to be set up around the world after World War II, including in the UK, where the National Health Service was introduced in 1948 and in Italy, where the 'Servizio Sanitario Nazionale' (National Health Service) was introduced in 1978 (Giorgi, 2023). One of the goals of these health care systems is to provide medical resources of high quality to patients, in order to improve the quality of care delivered to patients (WHO, 2018).

When looking at the literature related to RTC-injured individuals, research has stressed the importance of how treatment provided in hospitals should consider the psychological and physical states of RTC-injured individuals simultaneously. This is because the physical and psychological recovery of individuals after an RTC has been found to be interdependent, highlighting the need to implement improvements in the quality of care delivered to such individuals (Peden, 2005). However, research has also shown that there is a lack of resources available worldwide to understand and improve the quality of care provided to such individuals (Sabet et al., 2016a). This points to the importance of taking into consideration RTC individuals' experiences of care in order to increase the awareness and understanding of healthcare professionals concerning how to improve the quality of care provided to this population (Craig et al., 2016; Mayou & Bryant 2002; Papadakaki et al., 2017).

Theoretical Frameworks

Shame and Stigma

Recent research unveiled how in Italy, the stigma in healthcare settings is notable amongst Italian healthcare workers especially towards individuals with mental health difficulties, causing patients to experience shame (Cerino et al., 2024). Stigma in healthcare has been linked to a range of negative outcomes such as delays in treatment seeking, avoidance of clinical encounters and increased mental health distress. In particular, health-related stigma can reveal how a patient experiencing ill health may be subjected to discrimination, judgement, social exclusion, labelling, prejudge and unfair treatment among others (Link and Phelan, 2001). Davidoff (2002) showed how when a person lives with stigma, they are most likely to live with shame, fear of being shamed when their stigmatised condition is noticed. This can lead patients feeling unworthy and perhaps avoiding seeking medical help when in need. Shame can be easily exacerbated during interactions with healthcare professionals due to: unequal power relationships, worry about being judged and exposure to aspects of self that may be 'shameful'. If one is living with stigma, and then healthcare encounters where shameful exposure may feel inevitable due to physical injuries or illnesses, this can become particularly threatening to one's feeling of psychological safety (Link and Phelan, 2001). An accessible way for clinicians to understand how stigma is experienced and how it interferes with healthcare is the focus on the emotional dimension of patients. However, it remains a frequently neglected aspect of clinical encounters in healthcare. Therefore, a research focused on the care experiences of RTC-injured patients in Italy, contributes to understand their subjective experiences in a context where shame and stigma is often experienced. This is due to both the physical and psychological distress that these individuals are often subjected to experience as a result of their RTCs and injuries.

The Biopsychosocial model of healthcare

For centuries the biomedical model of clinical practice has influenced healthcare and it continues to be utilised in systematically address health concerns in illness. This model guides physicians' assessments, diagnosis, treatment, critical thinking and decision making to ensure best patients outcomes. This model focuses on purely biological factors excluding psychological, environmental and social influences. Even more, the medical model views mental distress as biological abnormalities of the brain, emphasising pharmacological treatment to target such abnormalities (Deacon, 2013). This view has been found to imply that the person is no longer whole because it attributes psychological problems to a sick mind or body, causing stigma (Lahey, 2021). For this reason, patients may experience high levels of shame in relation to their experiences of care and their emotional distress and may fear to disclose their difficulties to a medical professional (Peter et al., 2021). As such, patients at high risk of emotional distress may be difficult to identify and reach, limiting the support that they could receive for their distress (Shulze et al., 2020).

Over the last four decades, the concept of health has transformed from the biomedical model to a more encompassing concept rooted in a more psychosocial understanding of health and illness (Farre & Rapley, 2017). George Engel (1977) criticised the biomedical model for leaving no room within its framework for social, psychological and behavioural dimensions of illness. Engel proposed to broaden the biomedical approach to include the psychosocial aspects without sacrificing the advantages of the biomedical approach. In this way, health professionals would be able to evaluate all the factors contributing to illness in the care process of patients by taking into account their subjective experiences.

The biopsychosocial model of healthcare is considered both a philosophy of clinical care and a practical clinical guide. This model allows to understand how suffering, disease and illness are affected by multiple levels. At practical level it is a way of understanding the patients' subjective experience as an essential contributor to diagnosis, health outcomes and humane care. Therefore, because most of the literature on RTCs have focused on the biomedical view of health of injuries and psychological distress, a qualitative research focused on the subjective experiences of care provides a contribution to the biopsychosocial understanding of health of these individuals.

Trauma Informed Care

Previous research has shown how patients with a history of traumatic life events are subjected to experience increased distress or re-traumatisation in response to healthcare experiences. Research has shown that exposure to trauma can negatively affect the mind and the body by adversely impacting normative functioning, cognition, social and emotional well-being and the experience of sensation (Yeager et al., 2013). A trauma-informed care (TIC) approach aims to understand how to apply the understanding of trauma impact in providing services in order to accommodate needs and vulnerabilities of trauma survivors facilitating patients' participation in treatment. TIC is a framework that recognises the multidimensional impact of trauma incorporating that understanding into services and treatment approaches. It is defined as a strengths-based framework that emphasises the physical, psychological and emotional safety of patients and care providers. According to this model the responses to trauma are unique to each trauma survivor on a physical and experiential level, therefore, treatment must be individualised. This makes it important to understand care experiences from a subjective viewpoint of patients. Therefore, a study with a specific focus on the care experiences of severely injured RTC individuals may help in increasing the knowledge of the individualised needs of these individuals.

Counselling Psychology Context and Rationale

An in-depth understanding of how RTC-injured individuals experience the hospital care in Italy contributes to our awareness and understanding of the needs of such individuals. More specifically, increasing our knowledge of patients' feelings and sense-making of their experiences of care would allow us to improve the quality of care provided in hospital with potential implementation of additional psychological support to physically traumatised individuals. Such implementations would be cost- and time-effective as they would address potential drawbacks and delays in the overall recovery of these patients whilst preventing the possible worsening of symptoms or relapse that may take place after hospital discharge. Furthermore, patients at risk of potential mental health complications such as anxiety, depression and PTSD may be identified and approached early on (e.g., during hospital admission) and therapy may be used as a preventative tool. Although my chosen methodology does not permit for generalisation due to its idiographic and phenomenological nature, it justifies transferability conclusions because it offers insights into how a person makes sense of a given situation (Pietkiewicz & Smith, 2014). As Smith and Osborn (2003) maintain, IPA ought to be considered in terms of theoretical generalisability so that readers can draw links between IPA findings, the existing literature, and their own personal and professional experiences (Noon, 2018). Therefore, my results could inform the quality of care and therapeutic interventions for individuals with similar experiences to those reported in my research.

Chapter Summary

The aim of this thesis was to explore the experiences of care of severely injured individuals in RTCs in Italy. In this introduction, I outlined the relevance of this exploration to my personal context, my position as a researcher and CoP practice.

Literature Review

Chapter Overview

In this chapter I will present an overview of the key constructs of this study, which is followed by a review of the literature on the experiences of care amongst individuals with a severe road traffic injury. I will then provide a methodological and epistemological critique of the literature findings. Finally, I will provide a rationale for the current study and its relevance to counselling psychology.

Key Constructs

The following section offers an overview of the key constructs of this study: Health care, Road Traffic Collisions (RTCs), Road Traffic Injuries (RTIs).

Health care

Health care is defined as the improvement of health through prevention, diagnosis, treatment or cure of disease, illness, injury and other physical or mental impairments and it plays a role in promoting physical, mental and well-being of people around the world (World Health Organisation [WHO], 2019). Quality of care is defined as the degree to which health care services increase the prospect of desired health outcomes; it takes into consideration the needs, values and perspectives of every patient (WHO, 2022a). Research, sustained that quality of care in health care services should be effective, safe and people-centred, which means providing care that responds to individual patients' preferences, needs and values (Campbell et al., 2000). Quality of care is improved through research, which forms the basis for evidence-based practice in care delivery. Therefore, exploring the experiences of patients can help to identify what really matters to them, and thereby lead to a quality improvement in the delivery of care (Kaufman et al., 2023; Pope et al., 2002). However, research has found that there is a lack of resources concerning how patients experience and perceive care during their recovery (Rios-Diaz et al., 2016). For the purpose of this study, 'care experience' will refer to the health care participants received by any health care professional in hospital after their traffic collisions. I will also use the term 'patients' to refer to individuals who have been hospitalised.

Road Traffic Collisions (RTCs)

Road Traffic Collisions (RTCs), also called Road Traffic Accidents, are defined as "any accident involving at least one road vehicle in motion on a public road or private road to which the public has right of access" (International Transport Forum [ITF], 2019). Research has established that by 2030 RTCs will be the seventh leading cause of death globally (Ahmed et al., 2023). RTCs are considered to be a significant health burden worldwide, with 1.35 million deaths and 50 million individuals being injured on the roads annually (WHO, 2018). In particular, statistics have shown how in 2023, 133,443 road collisions were registered in the UK and 166,525 were registered in Italy (Department for Transport [DfT], 2024; Italian National Institute of Statistics [ISTAT], 2024).

RTCs are considered to be the cause of major health problems and research has established that the impact of RTCs on individuals can include the initial shock of the crash, some degree of threat to life, related economical and financial hardships and potential loss of property or amenity which can all affect individuals in many ways (Másilková, 2017). In particular, research showed how individuals are highly subjected to experience psychological consequences such as a deterioration on their mental health and physical consequences such as Road Traffic Injuries (RTIs) (Alharbi et al., 2019). For clarity, I will use the terms RTC, collision or accident to refer to road traffic collisions throughout this chapter and the rest of this thesis.

Road Traffic Injuries (RTIs)

According to the eleventh of the International Classification of Diseases (ICD-11), the term ‘Injury’ is defined as “physical or physiological bodily harm resulting from the interaction of the body with energy (mechanical, thermal, electrical or radiant or caused by extreme pressure) in an amount, rate or transfer that exceeds physical or physiological tolerance”(WHO, 2022b). Injury has a repaid onset in response to a well-defined event, for example a traffic collision. Injuries can vary in severity and can occur in any part of the body, causing immediate physical stress or bodily changes (Vincent et al., 2018).

RTIs are defined as “fatal or non-fatal injuries incurred as a result of a road traffic crash” (WHO, 2023). With this type of injuries, the psychological consequences that survivors may suffer increase substantially (Kovačević et al., 2020). This is because the traumatic impact of an RTC and the experience of a sudden physical injury is a complex experience that causes patients to experience multiple psychological consequences (Marasini et al., 2022).

Literature Review Findings

Search Strategy

In order to find relevant literature for this topic, literature was identified through the use of electronic databases and engines: Google Scholar, EBSCo and PubMED between 2021 and 2024. In order to identify relevant literature relevant search terms were used i.e., ‘Road Traffic Collision’ ‘Road Traffic Accident’ ‘Injury’ ‘Severe injury’ ‘Road Traffic Injury’ ‘Healthcare’ ‘Quality of care’ ‘Hospitalisation’. The choice of these search terms was based on the definitions chosen for this research on severe RTI and care experiences. Additionally, as there appears to be a paucity of literature on the experiences of care amongst RTC-injured individuals, other search terms such as ‘Motor Vehicle Accidents’ ‘Motor Vehicle Collisions’

‘ICU’ ‘Lived experience’ ‘Trauma’ ‘Physical Trauma’ were also used as articles using these terms also contained some relevant information about care experiences. Lastly, other relevant articles were identified from reference lists of relevant scoping or systematic reviews and other articles on RTI and care experiences. The choice of relevant articles was based on quantitative and qualitative studies which focused on RTC injured individuals in particular. The choice of qualitative articles was based solely on studies that focused on the hospital care experiences of individuals injured in RTCs. This is because studies which focused on either experiences of RTCs or RTIs exclusively, were not included due to the lack of focus and information on the experiences of care of participants which therefore were not relevant to the purpose of this literature review.

Quantitative Studies

Previous reviews have focused exclusively on quantitative studies that aimed to measure the comorbidity of psychological distress as a result of physical injuries in RTCs (Alharbi et al., 2019; Craig et al., 2016; Marasini et al., 2022).

Two previous reviews on RTC have focused on quantitative studies that aimed to measure the comorbidity of psychological distress and RTIs (Alharbi et al., 2019; Marasini et al., 2022). Alharbi et al. (2019) and Marasini et al. (2022) conducted a scoping literature review and systematic literature review respectively, of studies from the past 20 years which focused on identifying the presence of psychological disorders in individuals who had been involved in RTCs. These included RTCs involving motorbikes, cars, road debris and pedestrians. Studies selected in these reviews were mainly based on diverse quantitative methods and standardised statistical tests which focused on the comorbidity of psychological distress and RTCs.

The two reviews reported similar findings: psychological distress after RTCs is substantial and it can have detrimental effects on the recovery of individuals, regardless of the type of accident encountered. Specifically, individuals appeared to experience symptoms of psychological disorders such as anxiety, depression and post-traumatic stress disorder (PTSD). Furthermore, amongst injured participants, these psychological disorders were found to be most prominent in individuals who had encountered a severe physical injury. However, both the reviews included studies which focused on either different type of injuries (e.g., minor or severe injuries), different locations of the injuries (e.g., lower extremity or musculoskeletal injuries), or no injury at all. The reviews focus on the overall impact of traffic accidents and lack a specific focus on which types of injuries can have an effect on the mental health of the individuals concerned. Therefore, this makes it difficult to draw clear and definite conclusions regarding the effects of injury severity on the psychological state of RTC-injured individuals.

Severe RTIs and psychological consequences. Injuries can be classified as minor, moderate, severe or critical . The severity of an injury can be measured with an Injury Severity Score (ISS), which is the internationally recognised medical score to assess the severity of injuries (Baker et al., 1974; VanDerHeyden & Cox, 2008). Severe physical injuries can involve intense physical pain, body image distress and body disfigurement, and can have a negative impact on the functional capacity of the injured individuals, with subsequent implications for their daily mobility (Baecher et al., 2018). All of these factors can have a negative influence on the thoughts of individuals, who may develop negative beliefs about their capacity to cope and recover, and on the likelihood of physical and emotional recovery, which consequently will affect these individuals’ adjustment and their mental health state (Glynn et al., 2010; Weaver et al., 2014).

The effect of injury severity on the psychological distress of RTC individuals has been evaluated by previous literature. It is well established that severe RTIs are a key factor in causing negative psychological consequences on injured individuals. Indeed, findings from previous literature suggest that the severity of injuries is the most frequently mentioned risk factor in the development of psychological distress (Chossegros et al., 2011; Hours et al., 2010). Specifically, research has suggested that severe RTIs predict psychological distress, such as symptoms of anxiety, PTSD, depression (Dickov et al., 2009; Frommberger et al., 1998; Kovačević al., 2020).

Furthermore, individuals with severe physical injuries tend to experience longer Hospital Length of Stay (HLS) compared to those with minor and moderate physical injuries (Lee et al., 2016). The hospitalisation experience is often linked to an increased feeling of fragility in individuals, as they can be negatively affected by a lack of communication, separation from loved ones, noisy equipment and harsh lighting exposure which increase patients' risk of experiencing psychological distress (Holbrook & Hoyt, 2004).

For this reason, a large amount of literature has emphasised that comorbidity of injuries and psychological distress of patients is an important factor that needs to be considered in their recovery process whilst in hospital. This is because psychological comorbidity predicts poorer quality of wellbeing, greater pain and disability, and negative outcomes in physical function and social activity, which may explain prolonged recovery periods in hospital (Mayou & Bryant, 2002; Ottosson et al., 2005; Sterling et al., 2011). Therefore, taking into consideration the recovery of individuals with severe RTIs would expand our knowledge of the factors affecting both the physical and the emotional wellbeing of such individuals whilst addressing their needs (Sabet et al., 2016a).

Recovery from Severe RTIs. Previous research has stressed the importance of how treatment provided in hospitals should consider the psychological and physical states of RTC injured individuals simultaneously. This is because the physical and psychological recovery of individuals after an RTC has been found to be interdependent, highlighting the need to implement improvements in the quality of care delivered to such individuals (Kovačević et al., 2020; Peden, 2005).

This has been further explored by Papadakaki et al. (2017), who assessed a group of RTC survivors and the impact of their injury on their psychological and physical recovery. The study recruited 120 patients from hospitals in Greece, Germany and Italy. Patients were interviewed three times: at one month, six months and twelve months. Findings concluded that the predictors of long-lasting disability and psychological distress included past emotional reaction to distress and the type and severity of injury. Therefore, the study concluded that there is a need for a comprehensive and holistic understanding of the impact of injury and the psychological comorbidities after an RTC, regardless of the country where the care is delivered. The above literature demonstrates that the psychological consequences from RTCs and severe physical injuries are interrelated, and they can influence each other and have a direct impact on the recovery of patients. For this reason, previous research has highlighted the need to improve and understand the care delivered in hospital to RTC-injured individuals (Franzén et al., 2006).

However, although the experiences of RTC-injured individuals can help to identify key quality of care components in relation to their needs, not much research has explored the experiences of care of individuals following a severe RTI (Sabet et al., 2016a).

Qualitative Studies

Most of the research to date on RTCs has been based on quantitative approaches focused on the psychological comorbidities after an RTI lacking in-depth information about how individuals experience the quality of care provided in hospitals (Alharbi et al., 2019; Franzén et al., 2006; Marasini et al., 2022). This means that most of the research available subscribes to a positivist ontology that maintains the existence of an objective reality that is discovered through empirical testing. This would imply that the experience of RTIs can be understood objectively. However, RTIs are subjective experiences involving both physical and psychological consequences whose impact can influence individuals in unique ways whilst also having an impact on their recovery (Franzén et al., 2006). Hence, qualitative research that focuses on the subjective experiences of participants can provide a subjective understanding of injured RTC individuals' experiences of care, whilst strengthening our understanding of the factors affecting emotional wellbeing following an injury (Franzén et al., 2016). This is in line with Counselling Psychology values that underline the importance of qualitative research methods to adequately explore the depth and complexity of the subjective experience of participants (Morrow, 2007).

A small amount of qualitative research has begun to research the experiences of RTCs reporting that participants disclosed experiencing negative physical, psychological and financial consequences (Cagnetta & Cicognani, 1999; Hasselberg et al., 2019; Sabet et al., 2016b; Wilson et al., 2020). However, none of these studies have focused on the care experiences of these individuals. To my knowledge, six qualitative studies have explored the experiences of care among RTC-injured individuals. These studies focused on participants who presented with different types of injuries, such as orthopaedic, oral and maxillofacial, upper and lower extremities, and non-minor injuries. Nevertheless, the severity of such injuries was not specified. Hence, none of these studies focused specifically on severe injuries, despite previous evidence suggesting that affected individuals may have a higher likelihood of experiencing psychological disorders and negative recovery outcomes compared to those having other less severe injuries (Mayou & Bryant, 2002; Papadakaki et al., 2017; Sterling et al., 2011). These six studies are presented below.

The earliest qualitative study was conducted by Franzén et al. (2006), who used narrative interviews and qualitative content analysis to explore experiences of care and rehabilitation among nine individuals with non-minor RTC injuries in Sweden. Findings showed that on one hand, participants experienced a sense of trust and security when healthcare providers treated them as individuals with unique needs. On the other hand, participants reported feeling unsupported and insecure when healthcare providers did not listen or explain the course of treatment to them. These findings suggest that such individuals may have mixed experiences when receiving care after an RTI. This is important because it shows the uniqueness of their experiences and how injuries can be experienced differently among individuals. However, the use of narrative interviews in this study follows a social constructionist epistemology, which would imply that participants' experiences of care would shift based on the context in which they are spoken (Willig, 2013). However, physical injuries are defined as embodied experiences that are unique to the person who experiences them, and whose feelings and behaviours are grounded in the individual's own sensory and bodily states (Lo et al., 2023; Smith et al., 2009). This means that participants experience events through their physical bodies in a subjective way (Bloom, 2018). This suggests that such experiences should be understood through a methodology that views participants' experiences as 'real' to them. This would include methods like Interpretative Phenomenological Analysis (IPA), instead of narrative interviews, which suggest that participants' experience would keep shifting from context to context.

Sabet et al. (2016a) and Tan et al. (2008) used semi-structured interviews and qualitative content analysis to investigate the experiences of RTC-injured individuals. Sabet et al. (2016a) investigated the experiences of returning to normal life for eighteen participants with disabilities involving the upper and lower limbs caused by RTCs in Iran. Results revealed that returning to normal life was complex and difficult for participants who expressed the need for treatment support by the hospital team and social and peer support during their recovery. Tan et al. (2008) instead explored the experiences of six individuals with musculoskeletal injuries from the moment of the accident to discharge from hospital in Singapore. Mixed findings were reported for the quality of care delivered to participants. For example, quality of care was described as a failure when there was a lack of understanding, concern, and support from healthcare providers. Other participants expressed positive encounters with nurses with whom they could share their worries and concerns, which consequently improved their recovery process. In contrast to narrative interviews, the use of semi-structured interviews in these studies allowed the researchers to promote the sharing of personal experiences with a degree of control over the interview. This is considered important because the researcher is able to focus the direction of interviews to specific topics, whilst allowing participants the freedom to convey their subjective experiences in a safe environment (Richards & Morse, 2012).

The data analysis of the three studies mentioned so far was based on qualitative content analysis (Franzén et al., 2006; Sabet et al., 2016a; Tan et al., 2008). This analysis is known to highlight the expression of participants' feelings, thoughts and actions that are described throughout the text (Drisko & Maschi, 2016). Although this can be helpful in reaching the depth of participants' experiences and their related feelings, it limits the interpretation of the results and the meaning behind them (Elo & Kyngäs, 2008). This is because it often disregards the context that produced the text and instead focuses on words or phrases in isolation, which can be reductive when analysing complex texts and topics such as physical pain or injuries (Elo et al., 2014; Smith et al., 2015). Other methods such as IPA, which have an idiographic lens, would have offered an in-depth understanding of an individual case before highlighting similarities throughout cases (Smith et al., 2015). This would have allowed for a deeper understanding of the uniqueness of RTC injuries.

Haghparast-Bidgoli et al. (2013) used semi-structured interviews and grounded theory to explore the perceptions and experiences of trauma care among twenty individuals with motorcycle injuries treated in orthopaedic departments and fifteen healthcare professionals in Iran. The aim of their study was to identify factors that influence care delivery in emergency departments. Their findings indicated that hospital environments were poorly organised in delivering care, and lacked provision of supportive communication with patients. These factors resulted in ineffective trauma care and highlighted the necessity of strengthening both training and continuing education for healthcare professionals. However, the focus of this study was exclusively given to identifying the barriers to delivery of trauma care, and the study lacked information on the subjective experiences of participants. This study used the positivist version of grounded theory to analyse the data collected from semi-structured interviews. The positivist version suggests that there is one objective reality that can be known and measured through systematic methods. It does not explore the subjectivity of the participants' experiences (Denzin & Lincoln, 2011). This limits the subjective understanding of the care received by individuals, which can be crucial because injuries are experienced uniquely (Smith et al., 2015).

The two most recent studies have explored the experiences of individuals after an RTC by using semi-structured interviews to collect data and thematic analysis for analysing this data. Yadav and Shrestha (2017) examined the experiences of twenty individuals with oral and maxillofacial injuries consequent to RTCs in Nepal. Participants expressed the need to receive more emotional support and assistance, better personalised care and more information about their diagnosis. Nutbeam et al. (2022), on the other hand, aimed to explore individuals’ experiences of entrapment and subsequent extrication from deformed vehicles caused by an RTC. For this study, eight participants who have been trapped following an RTC in the UK were selected. For the purpose of participants’ selection the definition of ‘trapped’ relied on participants’ self-identification instead of being explicitly defined. This study found that participants’ extrication experience could be improved by positive communication, companionship, explanations of events and planning post-incident follow-ups with healthcare professionals. Furthermore, findings showed that participants experienced distress when they encountered failures in communication with healthcare providers, loss of autonomy, poor pain management and delayed communication with family.

The use of thematic analysis for both studies resulted in a flexible method that allowed a wider range of analytic options for the data, compared to the use of content qualitative analysis by Tan et al. (2008), Franzén et al. (2006) and Sabet et al. (2016a). However, thematic analysis may not be helpful as it can be limiting for the researcher, who has to decide what aspects of the data to focus on (Braun & Clarke, 2006). Additionally, thematic analysis can have a limited interpretative power beyond mere description when compared to IPA (Braun & Clark, 2021). Interpretation in analysis is important because topics such as pain and injury are considered complex psychosomatic interactions often difficult to articulate (Reid et al., 2005). Therefore, IPA would be a useful methodology that would allow one to analyse complex, ambiguous and emotionally laden topics such as physical pain, illness or injury (Smith et al., 2015).

Epistemological and Methodological Critique

A large amount of literature on RTC injuries has been dominated by a positivist paradigm that holds on to the ontological position of a single, measurable and observable reality. A positivist paradigm involves a quantitative and systematic inquiry that establishes the cause-effect relationships of a phenomenon. Thus, these quantitative studies have aimed to demonstrate the connections or cause-effect relationships between RTC injuries, their severity, the related psychological consequences and relevant treatment. However, these studies have not captured details of the individual experiences which are required to improve the quality of care delivered to these individuals (Docteur et al., 2004).

The use of qualitative research in RTC instead, has provided us with a detailed description of the first-person experiences of participants. This has provided a counterpoint to previous quantitative research (Marasini et al., 2022), which has not provided sufficient information regarding how participants experience the care received after an RTC injury (Peden, 2005). The small number of qualitative studies available have begun to address the experiences of care among individuals injured in RTCs. However, the aims of these studies focused on different aspects of RTC injuries, such as the experiences of entrapment and extrication, experiences of maxillofacial and oral trauma, returning to normal life, aspects that influence care delivery, and experiences of the accidents. Only one study (Franzén et al., 2006) has focused exclusively on the experiences of care received by individuals with RTC injuries. This highlights the lack of relevant research in this field. Moreover, none of these studies have focused on the experiences of individuals with severe injuries only, despite their higher likelihood of experiencing significant psychological distress (Hours et al., 2010).

The majority of these qualitative studies reported that the experience of RTC injuries among participants can be different between studies, and at times, contrasting experiences were reported from participants in the same study. This evidenced the uniqueness of the subjective experiences of RTC-injured individuals. However, data analysis for these studies involved either content qualitative analysis, constant comparative analysis or thematic analysis, which all resulted in limited interpretative power compared to IPA. The analytical choices of these studies show how the paradigms of the available research have drawn on either a social constructionist epistemology or a positivist ontology. This suggests that the available literature has left a gap in the research that may be filled by gaining a phenomenological and idiographic understanding of care experiences amongst individuals with severe RTIs. Specifically, none of the studies in the available literature have explored the subjective experiences of participants by using IPA despite its usefulness in the analysis of complex topics such as those pertaining to physical injuries (Smith et al., 2015).

RTCs and quality of care in Italy

As the researcher of this study, I acknowledge my Italian background and upbringing, which exposed me to the statistics of road traffic collisions in Italy and influenced my decision to study this topic in greater depth. In 2023, 224,634 injured individuals were registered in Italy whereas, 130,418 injured individuals were registered in the UK (DfT, 2024; ISTAT, 2024). This means that there is a larger number of individuals in Italy that have been subjected to a long hospital stay and an extended recovery process compared to the UK (DfT, 2024; ISTAT, 2024).

Furthermore, previous research has identified how Italian healthcare professionals report being uncertain about the experiences of care of patients and how to integrate psychological and emotional aspects of physical pain into practice (Montali et al., 2011; Varrassi et al., 2008; Zangoni & Thomson, 2017). Therefore, conducting research in Italy is important because considering WHO’s (2022a) guidelines on quality of care, healthcare services should be equitable, meaning that quality of care should be fair and equal regardless of gender, ethnicity, geographic location or socio-economic status. Therefore, a piece of qualitative research focusing on the experiences of care in Italy, a country that follows WHO’s public health guidelines, would not only provide professionals with an insight into the experiences of patients with severe RTIs, but also potentially contribute towards fulfilling

WHO (2022a)'s guidelines on quality of care. Furthermore, research conducted in Italy contributes to Counselling psychologist's knowledge of social and cultural explanations of distress which is needed to deliver psychological interventions more broadly and to raise the issue of inequality and discrimination in the society (Kagan et al., 2010). In addition, previous research has highlighted the need to increase healthcare professionals' awareness in relation to the physical and psychological recovery experiences of RTC individuals (Mayou & Bryant, 2002). Conducting my research in Italy would shed light on these experiences, as the number of RTC-injured individuals is not only higher than that in the United Kingdom, but hospital stays and recovery times are also longer. This would greatly expand our body of knowledge on this important but relatively neglected topic.

Implications of the review and research gap

A survey of the existing literature points to a research gap concerning the experiences of hospital care received by individuals with severe RTIs. Specifically, there is a lack of in-depth, subjective, and phenomenological knowledge of how these individuals experience the care received in hospital. It is interesting how relevant literature has explored experiences of the accidents, psychological comorbidities, experiences of entrapment and extrication, maxillofacial and oral trauma, returning to normal life, aspects that influence care delivery. However, a direct focus on the care experiences after a severe RTI remains missing, despite the large evidence that individuals with severe RTIs are subjected to psychological comorbidities and prolonged recovery times.

It is also noteworthy that findings about care experiences in qualitative studies emerged to be diverse and contrasting amongst individuals with severe RTIs. Such findings may suggest the uniqueness of the subjective experiences of these individuals. Considering physical pain is seen as a complex psychosomatic interaction that is difficult to articulate, IPA would be considered a particular useful methodology for it because it enables participants to portray as full an account as possible of their experience (Smith et al., 2015). Therefore, the present research aims to focus on the subjectivity of how individuals experience care after a severe RTI.

An in-depth understanding of their care experiences during their recovery would be instructive, and potentially also inform future research and practice in the UK. This research will be transferrable and useful in understanding the subjective experiences of recovery and care, known to have an influence on the physical and mental wellbeing of participants (Craig et al., 2016). Finally, my familiarity with the Italian culture and language provides me with useful knowledge as to how to approach recruitment and data collection. More importantly, conducting interviews in Italian provides me with an opportunity to explore Italian participants' experiences whilst entering their world in the way they experience it. This is in line with phenomenological research and its interest in the content of the data and how the participant's account explains the phenomenon of interest (Willig, 2013).

Rationale for the Study

My proposed research aims to contribute to the understanding of individuals with severe RTIs and their experiences of care received in Italy. Exploring the experiences of care in individuals who were severely injured in RTCs may be useful for clinical practice in Counselling Psychology and allied disciplines for multiple reasons. Severe Road Traffic Injuries can have a detrimental impact on the psychological wellbeing of patients who are subjected to prolonged recovery periods in hospital. Although injuries are rooted in physical health, the multi-modal training in Counselling Psychology allows counselling psychologists to work in physical health settings (BPS, 2024) and therefore, with individuals with severe RTIs.

Moreover, an exploration of the care experiences of these individuals may provide a unique psychological viewpoint on physical health, which can inform other healthcare professionals involved in physical injuries treatment (Kaufman et al., 2023). The study would provide an insight into the impact of various aspects of the treatment provided to these individuals, who are likely to experience both physical and psychological consequences from RTIs. This aligns with the Division of Counselling Psychology guidelines (2020), which focus on the primacy of both the physical and mental wellbeing of individuals.

Research Aims

In conclusion, the primary aim of my research is to explore the experiences of care among individuals in Italy who have been involved in an RTC and consequently suffered a severe physical injury.

Additionally, my research aims to expand our understanding of the care knowledge of providers by taking into account both the physical and mental wellbeing of Italian individuals. This contributes to increasing counselling psychologists' breadth of knowledge concerning explanations of distress across different cultures and countries.

Research question

What are the experiences of hospital care received by individuals who have had severe injuries following an RTC in Italy?

Methodology

Chapter Overview

I describe the methodology of my study and provide a rationale for my choices. Methodological choices will then be related to the underlying philosophical stances of ontology and epistemology as well as my positioning. Validation of quality in research will then be considered by outlining the process of the applied methodology.

Ontological and Epistemological Position

All research in Counselling Psychology is underpinned by diverse paradigms that conceptualise the nature of reality and how knowledge can be gained (Willig, 2013). A research paradigm refers to a framework that shapes the entire process of research and includes the concepts of ontology, axiology, epistemology and methodology (Willig, 2013). ‘Ontology’ refers to the nature of reality (Ponterotto, 2005). ‘Epistemology’ focuses on the theory of knowledge i.e., ‘how’ knowledge can be gained and the ‘way’ in which reality is understood by a researcher which will determine the methodology that will be used to approach the research topic (Ponterotto, 2005). ‘Axiology’ refers to the researcher’s values and their role in the research process; and ‘Methodology’ consists of the procedures and methods used in the research (Morrow, 2007).

Within the field of counselling psychology, the dominance of positivist research introduced tensions as counselling psychology prioritizes the subjective experience of individuals and focuses on meaning-making (Blair, 2010). As a result, counselling psychology has started embracing the different epistemological positions to manage the tensions between the objective and subjective way of seeing the world (Harper & Thompson, 2012). Therefore, Counselling Psychology allows practitioners to shape their knowledge from diverse research paradigms as researchers attempt to answer the question ‘How can knowledge be gained?’ in different ways (Harper & Thompson, 2012; Ponterotto, 2005).

Ontologically, I recognise the reality of RTC and severe injuries and I acknowledge that this reality can shape the experiences of care which such individuals receive (Lee et al., 2016). Therefore, critical realism was chosen as my ontology. It suggests the pre-existence of an external reality that is experienced by individuals differently (Willig & Rogers, 2017), and can offer an understanding of biopsychosocial phenomena whereby the biological, social and psychological dimensions of health, illness and healing are taken into consideration to inform and improve understanding in healthcare settings (Clark, 1998). To answer my research question ‘What are the experiences of hospital care received by individuals who have had severe injuries following an RTC?’ I take an interpretative phenomenological epistemological stance (Smith et al., 2022). An interpretative phenomenological view focuses on the quality and texture of participants’ experiences and the meanings that they attribute to them (Willig, 2013). This is suitable for my topic because previous research has established that the experiences and perceptions of RTC-injured individuals need to be understood in depth, to improve the quality of care provided to meet their needs (Pope et al., 2002).

Further, RTIs are considered complex and emotionally laden experiences which need to be understood and interpreted from the first-person point of view due to the interrelated physical and psychological impacts on the recovery of individuals (Heron-Delaney, 2013; Smith et al., 2015). Interpretative phenomenology focuses on how individuals make sense of their experiences (Smith, 2004). Meaning-making of RTIs is important because victims can suffer from different types of injuries and disabilities that can have an impact on their quality of life in different ways (Másilková, 2017; Wilson et al., 2020). For example, individuals might experience numerous limitations on physical and psychological health, finance, work or education (Butcher, 2009). These aspects are considered to be unique to each individual

(Riva et al., 2011), and so it is important to understand how each individual would make sense of it in their unique way (Milton, 2010). Additionally, interpretative phenomenology acknowledges bodily and physical sensations as embodied experiences which are considered to be subjective to each individual (Smith et al., 2009). This aligns with my research, as RTCs usually involve physical injuries, which can be experienced by individuals in unique ways depending on the severity of such injuries (Vincent et al., 2018).

Furthermore, an interpretative phenomenological position embraces Heideggers' consideration that bracketing of foreknowledge in phenomenology can only be partially achieved through reflexivity (Smith et al., 2022). As an Italian citizen myself, and my personal experiences with RTCs in the past, I acknowledge that I bring some knowledge to the research process. As a result, I understand the importance of personal reflexivity throughout the research process, for increasing my awareness towards potential biases and expectations towards the data (Kasket, 2012). I aimed to do this by using personal therapy and supervision to monitor my progress and to identify any triggers and biases throughout the whole process of my research starting from conducting a literature review, developing a research proposal, conducting interviews and in particular during the analysis process.

Rationale for Choosing IPA

Exploring different epistemologies and methodologies has helped me reflect on the ontological, epistemological and methodological choices of my research.

For example, Content Qualitative Analysis was considered because it can highlight participants' expression of feelings, thoughts and actions that are described throughout the text (Drisko & Maschi, 2016). However, although this analysis allows the researcher to reach the depth of experiences and feelings of participants, it limits the interpretation of the meaning behind such results (Elo & Kyngäs, 2008). This is because focusing only on the words/phrases of participants in isolation may not capture the experience of the participant in a holistic manner, which is crucial for understanding complex topics such as physical pain and injuries (Elo et al., 2014; Smith et al., 2015).

Another analysis that was considered was Thematic Analysis (TA), which has previously been used in studies on RTIs. Thematic analysis is considered to be a flexible method that allows the researcher to look at a wide range of analytic options for the data (Braun & Clarke 2022). However, in TA, the researcher begins to find patterns across the dataset at an earlier stage compared to IPA. For this reason, there is more focus given to finding patterns across the dataset and sometimes the unique experiences of participants may be lost in this process. In contrast, IPA goes into great depth for each individual case, before starting to find patterns across different cases. As a result, the uniqueness of each individual case is retained (Braun & Clarke, 2021). Furthermore, using interpretation instead of mere description is considered important to address both the physical and psychological aspects of injuries that are physical in nature (Arvinen-Barrow et al., 2010). This is important because doing so can provide valuable insights in relation to the care provided to injured individuals (Hours et al., 2010).

The majority of the studies in the literature review focused on different aspects of RTIs, pointing to a gap in the experiences of care following a severe RTI. Moreover, findings from the available studies showed that participants talked about their experiences of care in a contradictory way which indicated how a subjective understanding of the experiences of participants could help elucidate these contradictions. However, the analytical choices of the available literature suggest that there is a gap in the phenomenological and idiographic understanding of care experiences of individuals with severe RTIs.

Considering the gap in the literature and my interpretative phenomenological epistemology, I chose Interpretative Phenomenological Analysis (IPA) for my methodology (Smith et al., 2022). IPA is considered helpful for topics such as physical pain and injury, as they are considered to be emotionally laden and complex psychosomatic experiences that are often difficult to express (Reid et al., 2005; Smith et al., 2015). IPA has an idiographic lens that offers an in-depth understanding of an individual case before highlighting similarities across cases (Smith et al., 2022). Moreover, IPA-based researchers are encouraged to engage with the data in a reflective and rational way, to understand the participant's way of making sense of their experiences (Smith et al., 2015). Exploring how individuals make sense of their experiences can provide a nuanced understanding of the experiences of care/hospitalisation following a severe RTI, which can help to improve the emotional wellbeing of such individuals (Pope et al., 2002; Smith & Osborn, 2015).

Overview of IPA

Theoretical Foundations of IPA

IPA emphasises the individual's lived experience of a phenomenon. It values the subjective experience of participants by interpreting the phenomenon and making meaning out of such an experience. The underlying foundation of IPA involves phenomenology, hermeneutics and ideography.

Phenomenology. Phenomenology is a philosophical approach aimed to produce an account of lived experiences in its own terms instead of one established by pre-existing theoretical preconceptions. Phenomenology was rooted on Husserl's ideas which focused on the identification of the essential qualities of experience by engaging in a process of methodological reduction to basic core structures (Tuffour, 2017). Husserl's work establishes the importance and relevance of focusing on experience and its perception. Heidegger, Merleau-Ponty and Satre developed Husserl's work into a view of the individual as embedded and immersed in a world composed of objects, relationships, language, culture, project and concerns (Heidegger, 1962; Smith et al., 2022). This view moves away from the descriptive commitments of Husserl, towards a more interpretative position focused on understanding our involvement in the real world. Thus, the complex understanding of experience invokes a lived process, an unfurling of perspectives and meaning that are unique to the individual's embodied and situated relationship to the world (Smith et al., 2022). Therefore, in IPA the focus is to understand other people's relationship to the world whilst focusing on a particular event, relationship or process in that person's world. This approach recognises the analyst to have a central role in making sense personal experiences and is thus, related to the second foundation of IPA, Hermeneutics.

Hermeneutics. Hermeneutics is the theory of interpretation which is considered the central concept of IPA. The researcher assumes a central role in the analysis and interpretation of participants' experiences because he/she aims to understand their sense-making. However, when engaging in close interpretation, the researcher may not be aware of his/her preconceptions before the analysis. This means that the interpretation of the researcher is inextricably linked to his/her experience and background. Consequently, the researcher is required to engage in repeated interpretation, in an attempt to probe the surface meaning of the participants' narratives by reading between the lines for a deeper interpretation. This is called double hermeneutics where the researcher is considered to be in a complex position because his/her experiences and knowledge have a bearing on the research process and the data itself.

Idiography. IPA has an idiographic lens that offers an in-depth understanding of an individual case before highlighting similarities across cases (Smith et al., 2022). IPA acknowledges the uniqueness of participants' experience. Therefore, IPA-based researchers are encouraged to engage with the data in a reflective and rational way in order to understand the participant's way of making sense of their experiences (Smith et al., 2015). That is conducting analysis by identifying similarities and differences between cases only after each account is interpreted individually. This results in a detailed analysis that represents the patterns of meaning across cases whilst capturing idiosyncratic nuances.

Characteristics of IPA

In this section, I will now outline the characteristics of IPA that align with my research topic: epistemological basis, focus on embodied experience and role of language.

Epistemological basis. Ontologically, IPA is closely matched with critical realism, which claims that a single external reality exists independently, but that this reality is experienced and explained differently based on the subjective experience of participants (Willig & Rogers, 2017). Epistemologically, IPA is based on the idea that the meaning-making of an experience is contingent upon the individual's existence in the world; hence, it is unique to each individual (Milton, 2010).This fits well with my research because ontologically, I acknowledge there is a reality composed by road traffic collisions and severe injuries that exists independently of my perceptions and theories whilst epistemologically, I believe that I do not have immediate access to this reality, as it can be understood differently by each participant. However, I am aware of my ability of engaging in a reflective and relational way, in which I attempt to understand and make sense of my participant's way of making sense of their experiences.

Focus on embodied experience. IPA fits well with the aim of my research to explore the experiences of care amongst RTC-injured individuals. This is because physical pain and injury are considered difficult experiences to express and not visible to an outsider, therefore, it is important to understand them through the person who is experiencing them (Smith &

Osborn, 2015). IPA is seen as a popular tool that facilitates in-depth exploration of the illness or injury meaning for participants because it considers the physical sensations of participants as part of their subjective experiences (Reid et al., 2005; Smith et al., 2015).

Role of language. IPA focuses on participants' choice of words, syntax, intonations and the meanings behind them, as well as emotional and psychological states that can be interpreted from these (Willig, 2013). Although phenomenological research is mainly interested in the content of the data and how participants explain their experiences, IPA considers the subjectivity of participants as part of the experience that they are reporting. The role of language is important as it is through this medium that participants' experiences are transmitted to researchers (Willig, 2012). This aligns with my research because as interviews were conducted in Italian and then translated, I focus on language and translation choices in order to capture my understanding of the participants' meaning-making evoked in Italian.

Methodological Changes and Reflexivity

I originally aimed to conduct data collection in the UK through the use of advertisements on different charities' websites. During recruitment, I received responses from two participants, who changed their minds after reading the information sheet. Around that time, I was approached by two Italian individuals who were happy to talk about their experiences of care following a severe RTI in Italy. As an Italian myself, I reflected on my bilingual skills and my social network and the possibility of recruiting Italian participants in my country of origin. I therefore compared the statistics between the UK and Italy and found that there is a higher proportion of the Italian population who have suffered severe injuries from RTCs compared to that of the UK. As a result, I concluded that recruiting participants from my country of origin might provide an opportunity to reach the right population for my research.

In conducting research on a topic that is prevalent across multiple countries, notably more so in Italy than in the UK (DfT, 2024; ISTAT, 2024), I believe that my research is of relevance to CoP. It is hoped that future practitioners will be better equipped to work with RTC-injured individuals, whose experiences of care are known to be key aspects of both their physical and mental wellbeing. Furthermore, considering reflexivity and my position as a researcher in IPA, my familiarity with the Italian language provides me with an opportunity to explore Italian participants' experiences whilst entering their world in the way they experience it (Willig, 2012). As a phenomenological researcher, I focus on language in terms of the meanings communicated in Italian, and the translation choices in interpreting participants' accounts. Therefore, not only would I have the advantage of knowing how to communicate in my participants' first language, but I would also be better able to interpret their narratives (Temple & Koterba, 2009). However, I am aware that the impact of translating transcripts from Italian into English might present obstacles such as the loss of meaning in translation (Squires, 2019; Van Nes et al., 2010). Therefore, I have made sure to engage in reflexivity before and during the translation process; instead of translating word for word using a dictionary translation, I have retained the language features of Italian and made notes concerning their meaning during transcription (Temple & Koterba, 2009).

Procedure

Ethics

Ethical approval for the current project was obtained through UEL Research Ethics Committee with relevant ethics amendments in order to recruit participants in Italy and conduct the research in Italian (Appendix A). An information sheet containing my details, the purpose and nature of the research, risks and relevant contact details confidentiality and contact details of both me and my research supervisor was sent to participants (Appendix B).

Participants were asked to sign a consent form to confirm having read and understood the information sheet(Appendix C). Interviews were conducted via UEL Teams meetings and they were audio recorded. Audio-recorded materials were stored in a password-protected and encrypted UEL One Drive account and immediately transcribed and translated. Virtually signed consent forms and completed questionnaires were also stored in UEL Drive account, ensuring security and data protection. Confidentiality was maintained by using pseudonyms during both transcription and translation. In line with security and confidentiality protection, consent forms did not include participants' names or contact details. Participants' full names were only used for arranging interviews and only I had access to them.

Sampling Method

Recruitment criteria included participants who had been involved in any type of RTC. This is because previous literature has found that psychological distress among RTC individuals is present regardless of the type of accident that they were involved in (Marasini et al., 2022).

Considering average ages involved in an RTC in Italy ISTAT (2024), overall age distribution of individuals involved in an RTC would range between 20-29; 45-59; 75-84. Therefore, 20-84 years old was set as the age range for my sample. This is because to my knowledge, in the available literature no current studies states that specific age ranges would differ in the way adult participants experience care after a severe RTI.

Participants must have been hospitalised for at least two days in order to identify individuals with a wider range of care experiences. Furthermore, no maximum time of hospitalisation was set. This is because no research evidenced that hospital care experiences would differ on the basis of hospital stay length. Moreover, as homogeneity was achieved through recruitment of severely injured individuals whose average length of hospital stay is found to be similar, no maximum time of hospitalisation was considered to be necessary for recruitment (Lee et al., 2016).

Participants' RTC must have happened at least three months and at most two years from the moment they were interviewed, as autobiographical memory is likely to be less reliable beyond that length of time (Gunasekara et al., 2020; Roediger et al., 2017). Only participants with severe physical injuries were included in the study. This is because individuals presenting with these types of injuries tend to be subjected to longer hospital stays and therefore are likely to have a wider range of care experiences (Lee et al., 2016). Injury severity was screened using the Abbreviated Injury Scale (AIS) and the highest scores were then summed to calculate the Injury Severity Score (ISS), (Appendix D) (Baker et al., 1974). ISS scores range from 1-8 (minor injury), 9-15 (moderate injury), 16-24 (severe injury), 25> (critical) (VanDerHeyden & Cox, 2008). Participants who had Traumatic Brain Injury (TBI) were not included in the study. This is because participants' awareness needed to be as little affected as possible for the purpose of my study and TBI involves transient diminished consciousness resulting from an insult to the brain (Sbordone & Liter, 1995).

Participants with current mental health diagnoses were also not included in the study. This is because such individuals have a higher tendency to be triggered by traumatic memories and flashbacks when discussing possible distressing events during interviews (Labott et al., 2013). Therefore, mental health screening was conducted using the Patient Health Questionnaire (PHQ-9) and Generalised Anxiety Disorders scale (GAD-7) (Kroenke et al., 2001; Spitzer et al., 2006) (Appendix E). PHQ-9 scores range from 0-4 (none), 5-9 (mild), 10-14 (moderate), 15-19 (moderately severe), 20-27 (severe). GAD-7 scores range from 0-4 (minimal), 5-9 (mild), 10-14 (moderate), 5-21 (severe). People with a PHQ-9 score above 10 (moderate depression) and GAD-7 score above 10 (moderate anxiety) were excluded from the study. Finally, participants were required to understand the English language, as the relevant Injury Severity Score Questionnaires, PHQ-9 and GAD-7 were in English (Baker et al., 1974; Kroenke et al., 2001; Spitzer et al., 2006).

Sampling Size

Purposive sampling included two males and two females participants who had been involved in a road traffic collision with consequent severe injury in Italy. Purposive sampling is a technique widely used in qualitative research because it allows researchers to identify and select participants and facilitate the homogeneity of the sample (Langdridge, 2007). Creswell (2012) suggests that the selection of participants in phenomenological research should be such that the sample is homogeneous. This is so the researcher may have a better estimate of the overall perceptions of the participants in order to understand the phenomenon of interest. I initially aimed to recruit a minimum of five participants. This is because the sample size used in phenomenological research can range between four and ten participants which, following Smith et al's (2009) guidelines, should provide an adequate range of data. I recruited five participants; four took part in the interview.

Recruitment

Initially, recruitment was attempted by posting a research poster (Appendix F) on different RTC charities' websites in the UK (such as Aftermath support). Two individuals from the UK showed interest in participating however, they did not follow up in contacting me after receiving the information sheet. As a result recruitment changes were made, and ethical approval was received to recruit participants in Italy and for interviews to be conducted in Italian. A translated research poster (Appendix G) was emailed via a UEL secure email address to friends, family and colleagues to share with their appropriate social networks. Interested participants made contact with me via email. The information sheet, consent form and questionnaires were shared via secure UEL email. A suitable date and time for the interview was then agreed and a unique Microsoft Teams meeting link was created and sent to the participants. No individuals asked to withdraw from the study. One interested participant was deemed unsuitable to participate due to reporting Traumatic Brain Injury after their accident. All interviews were conducted in Italian via Microsoft Teams meeting over videocall and all were audio recorded. The interviews lasted between 45 and 60 minutes.

Participants

Four participants aged between 24 and 55 took part in the study. Their demographics are presented below (Table1). Participants were given pseudonyms for confidentiality purposes. Although my initial aim was to recruit 5 participants, my sample of 4 provided sufficient depth regarding each unique experience of care after a road traffic collision. All participants were involved in a traffic collision between 18 and 20 months ago: two were in car accidents, one was on a motorcycle and one was a pedestrian. As homogeneity in sampling should provide the researcher with a better estimate of participants' perceptions in order to understand a phenomenon of interest, different types of collisions were considered to be homogenous. This is because no previous research was found to indicate that different types of collisions influenced the way participants experienced care in hospital. Moreover, the purpose of the study was to explore RTC-injured individuals' care experiences instead of how the type of their collisions influenced their experiences. Therefore, participants involved in any type of RTC were included in the study. All participants reported severe physical injuries (ISS score between 18 and 24) and the time they spent in hospital was between three weeks and two and a half months. All participants completed PHQ-9 and GAD-7 questionnaires with a total score of 0. All participants scoring zero in the questionnaires may have indicated possible shame towards experiencing any emotional distress which is a common aspect identified by previous research in Italy which underlined the presence of stigma towards mental health in healthcare settings (Cerino et al., 2024). Therefore, participants may have felt reluctant to answer questions honestly or they may have perceived the nature of the questions as not relevant to their experience of emotional distress.

Table 1

Demographics of Participants

Participants	Age	Gender	Type of collision	Time since collision	Time spent in hospital	ISS	PHQ-9	GAD-7
Michael	55	male	Motorcycle	21 months	1 month	24	0	0
Christina	40	female	Pedestrian	20 months	3 weeks	18	0	0
Rebecca	24	female	Car	12 months	2.5 months	23	0	0
Anthony	31	male	Car	19 months	1.5/2 months	22	0	0

Data Collection

Interview schedule. The interview schedule was created following Smith et al's (2012) guidelines and then revised. The interview questions were originally written in English (Appendix H) and then translated into Italian (Appendix I). It was created following guidelines from Smith et al. (2022) and revised during research supervision. The interview was followed as a guide instead of dictating the interview. This was done with the aim of facilitating a meaningful and individualised discussion of experience with participants (Adams, 2015). The schedule of the interview was structured, starting with the most general questions : “Tell me about your accident, do you remember what happened?”. To follow, more specific questions were asked in order to explore participants’ experiences of care consequent to their RTC: “Do you remember what thoughts you had during your hospitalisation?” “Why do you think that was?”. Some questions were also asked following the participants’ responses, e.g., “In what way was limiting?” “And I wonder how did you feel in that environment that kept you alive?” in order to allow them to engage in a dialogue where I could probe important areas that might emerge in relation to their experiences of hospital care. The main questions that related most to the research question were: “Do you remember how you felt when you were in hospital?” and “What kind of support did you receive?” Lastly, participants were asked if there was anything else they wished to add.

Pilot interview. Following the development of the interview schedule, an Italian-speaking acquaintance who had been involved in an RTC in the past was asked to take part in a pilot interview. Pilot interview was not included in the data. This was with the aim of allowing me to practise the interview schedule and to identify any repetition, unclear questions or obstacles to the flow of the interview. These were then taken into consideration and added to my reflexive journal.

Conducting the interviews. Interviews were carried out between December 2023 and April 2024 via Microsoft Teams Meeting. Due to participants’ medical appointments, I remained flexible for rescheduling some interviews. Although participants did not have to travel to take part in interviews, I made sure to take into account any possible pain or discomfort they might have been experiencing during the interviews. This helped them to open the discussion as to how their accident had impacted their lives. Prior to commencing the interviews, participants were asked if they had any questions or if they needed clarification on any aspect of the topic. Participants were reminded of the confidentiality of their participation in the interview and their right to withdraw if they wished to (at the onset and the end of interviews). Furthermore, participants were reminded that interviews were recorded and were notified when recording started and ended. The formulation of the questions took into consideration any possible triggers, physical or emotional pain that the participants might experience, in an attempt to minimise the likelihood of emotional distress. During the interview, I took into account the non-verbal communication, use of words and tone of voice of participants whilst they answered questions, in order to assess their physical and mental states and offer them pauses where I felt it was necessary. This also allowed me to check-in with participants whether they felt comfortable to continue. Furthermore, the interview schedule allowed me to focus and ground myself in my role as a researcher without feeling anxious or confused about my other position as a trainee counselling psychologist. After the interviews, I informed participants that they would receive a debrief letter (Appendix J) via email, containing relevant details of Italian crisis lines if they needed further support.

Data preparation

Data was prepared according to guidelines by Smith et al. (2009). Demographic information was collected prior the interview in order to ensure that participants met the inclusion criteria. Questionnaires were created in .docx format and sent to participants from a UEL email account. Questionnaires and demographic information were kept on the UEL OneDrive account. Data were collected via interview audio recordings in .mp4 format via UEL Microsoft Teams on a UEL-managed laptop. Following this, transcripts were created and translated using Microsoft Teams (on a UEL-managed laptop) and converted into .docx files. From the transcripts, codes were created, and they were stored in a separate document on the UEL OneDrive account. Translated transcripts were repeatedly compared with the original transcripts in order to ensure accuracy. Notes were also made during the translation process regarding Italian terms and their meanings and the non-verbal communication of the participants (Smith & Shinebourne, 2012). I aimed to keep the meanings of Italian turns of phrase by translating them as closely as possible into the English language whilst avoiding dictionary translations (Temple & Young, 2004; Van Nes et al., 2010).

Analytic process

Data analysis was conducted following Smith et al's (2022) guidelines. The process was started by individually reading each transcript (original and translated version) and listening to its corresponding recording. This was done with the aim of immersing myself in the data. Notes concerning my reflections on translated material, including the use of word choices, ways of saying things, repetitions and pauses, were made. This allowed me to stay as close as possible to the experiences of participants by paying attention to how they expressed themselves in their first language, which provided another layer of depth to the analysis process. For example, when a participant described her experience of care in hospital, she specified how care delivery in the Italian healthcare system does not include psychological support. This allowed me to explore further the expectations of participants towards the care they received and the meaning they gave to the healthcare system in their own country. During this initial stage, I made notes in a notebook about some of the most powerful recollections of the interview experience, as well as some of my initial observations regarding the transcripts. Following this, to enter my participants' worlds, I grounded myself in order to actively engage with the data.

Stage 1: Reading and re-reading. This phase involved repeated reading in order to allow a deeper understanding of the general flow or rhythm of the interview. Reading and re-listening was done for both the original transcripts and the translated versions. Re-listening to the recordings allowed me to focus on the use of language as well as any emotions or meanings invoked by specific word choices, tone of voice , choice of syntax and utterances. This allowed me to make a timeline of what was discussed in the interview whilst identifying patterns of shifting from generic explanations to detailed specifics of the participant's experience. Furthermore, reading allowed me to highlight the richer and more detailed sections of the interview. I engaged in reflexive exercise by discussing with my supervisor the epistemological purpose of reading and re-reading the transcripts. I was able think about how my epistemological positioning sustains that this process helps immersing in the data and observing how my thinking process would change providing a base for the analysis. I was then able to make note of this in my reflexive journal.

Stage 2: Exploratory noting. Initial noting includes an examination of the semantic content and language use on an exploratory level. I started this stage by keeping an open mind and began making notes on any interesting parts of the transcripts, such as the way participants talked about, understood and thought about their experiences. This was done by creating a column on the right side of the transcript for where my experiential notes would be written. My aim was to produce a comprehensive set of notes and relevant comments on the data with a clear phenomenological focus by staying close to the explicit meaning of participants' use of language. This was done by making exploratory notes about the specific ways by which participants talked about, understood and thought about an issue.

Stage 3: Constructing experiential statements. This stage involved consolidating my thoughts thus far by creating experiential statements which related directly to the participant's experiences and/or the way they made sense of their experiences. In this stage, I attempted to construct experiential statements by reducing the volume of detail from the transcript and exploratory notes, only articulating the most important features of my exploratory notes. Experiential statements reflect a synergistic process of description and interpretation, whereby they capture and reflect an understanding of what has been done thus far. I did this by creating another column on the left side of the transcript wherein I summarised the meaning of my exploratory notes. This process involved focusing on a local level on discrete 'chunks' of the transcript whilst recalling what I have learned during the process of making exploratory notes. I noticed how initially I was engaging exclusively with descriptive comments, focusing on the content of each transcript and the language used. This was because I was worried about the influence of my biases and state of mind whilst engaging with the data. I felt fearful to make interpretations that were not grounded in the participants' words and that I was moving away from participants' experiences. However, by reflecting on this during supervision and re-reading the analytic steps of IPA, I was able to remind myself and reflect on the importance of the 'I' in the data analysis (Smith & Osborn, 2004). Furthermore, I bore in mind the aim of phenomenology, which is to reach a deep understanding of how participants make sense of their subjective experiences, as well as its focus on hermeneutics, which is related to the process of interpreting such experiences (Smith & Osborn, 2004). Therefore, I was able to engage in reflexive exploratory work by making interpretations whilst trusting myself in making sense of participants' meaning-making (Smith et al., 2022). I include examples of this stage in Appendix K.

Stage 4: Searching for connections among experiential statements. This stage involved the development of a chart on how the statements fit together for each participant separately. The structure that I produced for each participant allowed me to point to all the most interesting and important aspects of my participant's experience. On a separate document on Microsoft Word, I cut out the list of experiential statements and gathered them into clusters based on their similarity. I moved different experiential statements around and tried different clustering until I gradually constructed a pattern of experiential statements that best showed a mapping of their interconnections. For example, statements related to the meaning behind ‘life changing’ were clustered together including both positive and negative aspects of care experiences. This clustering process allowed me to think in depth about the participants’ experiences and it was useful in the process of making connections between participants. Thinking about the ways participants understand their own world and working with a ‘bird’s eye view’ of all the experiential statements allowed me to move them around and examine different possible connections (Smith et al., 2022). During this stage, for clarity I have also coloured-coded the experiential statements for each participant and I then highlighted the transcripts accordingly.

Stage 5: Naming the Personal Experiential Themes (PETs). During this stage I have given a title to each clusters of experiential statements. These clusters are the Personal Experiential Themes (PETs). Each PET was then divided in sub-themes where I wrote the set of experiential statements brought together in developing it. Each experiential statement was identified with the colour code, the page number in the transcript on which it could be found and the related key phrase that prompted it. This supporting information allowed me to locate the exact place of the interview which generated the statement and it allowed me to remember what participants said which stimulated this process.

Stage 6: Moving to other cases. This step involves moving on to the next participant’s transcript and repeating steps 1 to 5. In order to commit to the idiographic lens of IPA, I made sure to treat each transcript individually. However, I was aware that becoming influenced by the previous transcript’s analysis was inevitable and therefore some features of my previous findings may have been repeated in the following transcript. Therefore, I made sure to maintain a rigour in following the same process for each case in order to allow new entities to emerge with each case. Furthermore, I kept a reflexive journal of the main themes that stuck with me and that could have potentially influenced my next case analysis. This allowed me to increase my awareness of my previous interpretations so as to avoid being influenced by them. This enabled me to focus exclusively on the next interview, allowing new entities to emerge.

Stage 7: Developing themes across cases. The next stage involved looking for patterns of similarity and differences across previously generated Personal Experiential Themes (PETs) and creating a set of Group Experiential Themes (GETs). The aim was to highlight and shared the unique features of participants' experiences within a cross-case analysis. In order to do this, I scanned each table of PETs and started to look for similarities and differences broadly in the same way as it was done for each individual case but at a higher level. This was done by writing a list of the PETs on a blank document, identifying resemblances and similarities between participants' PETs. Cluster of PETs were then created and titled. This continued until I had a list of GETs. I then created a table, cross-referencing each theme with participants' transcript extract.

Analysis and Reflexivity

During data collection, I noticed how my interview schedule allowed participants to reflect on the impact that their RTCs had on their mental health. Reflecting on this, I observed how the role of cultural norms and knowledge towards mental health influenced the way participants talked about their experiences. For example, participants who lacked knowledge of psychological support would often mix it up with neurological support. They would often dismiss their emotions by saying that no psychological support was needed as they did not have any brain injury or cognitive damage. I believe that the lack of knowledge around mental health presented a barrier to discussing this topic openly during interviews. However, by keeping a reflexive journal and focusing on the phenomenological nature of this study, I was able to focus on the meaning that participants gave to their experience and to draw my interpretations by reflecting on the language used by participants. For example, when describing the type of support received in hospital, participants would often dismiss their emotional state by saying that they did not need any support, yet they valued the importance of family support for their emotional state by using expressions such as "I couldn't have made it without them". This allowed me to make interpretations on their experiences by reflecting and focusing on the meaning behind their choice of words, syntax and intonations during interviews (Willig, 2012). Furthermore, the analysis involved engaging in a hermeneutic circle between my interpretation of the participant's sense making of their experiences. Since engaging in close interpretation is a subjective process, the themes created during my analysis were inextricably connected to my experience and involvement in road traffic accident injuries. Therefore, as I researcher I engaged in double- hermeneutics and themes emerged from my analysis would likely differ from another researcher's interpretation. Also, Yardley's guidance on transparency in the analysis process was followed (Yardley, 2000). Lastly, when specific terminology could not be accurately translated and was considered of particular importance to the re-counting of the experience I made notes on the transcripts taking them in consideration in the analysis process.

Appraising Quality in Qualitative Research

Yardley's (2000) framework for assessing quality in qualitative research was followed. Therefore, the following criteria was used as a guide: sensitivity to context; commitment and rigour; transparency and coherence; impact and importance.

Sensitivity to context refers to showing awareness of the socio-cultural, linguistic and political contexts that relate individually to the unique narrative of each participant. This was taken in consideration by taking into account participant's tone of voice, non-verbal communication, cultural context and use of words whilst conducting interviews in Italian with them. However, as a new user of IPA, it was challenging to create comments on these aspects whilst attempting to strike a balance between descriptive and interpretative comments. Nonetheless, having had the opportunity to engage with the hermeneutic circle and read transcripts multiple times before and after translation allowed me to develop confidence and engage in more in-depth interpretations. Furthermore, my position as a Trainee CoP allowed me to practice interpretations during the therapeutic work which provided me with a solid base to look at the data.

Commitment and Rigour was followed during recruitment process where I ensured that research was accessible to all participants who asked to take part. All interviews were conducted remotely in order to allow participants with physical disabilities to take part to the research. Even more, rigour was considered when forming the interview questions with my research supervisor and subsequently translated. Lastly, commitment and rigour was evident in my consistency in approaching the data during the analysis process. Following IPA steps 1 to 5 consistently in each interview and keeping a reflective journal allowed me to conduct consistent and reliable work.

Transparency and coherence were evident when discussing my recruitment changes during supervision. This allowed me to reflect on potential methodological amendments and their repercussions. This was evident when looking for literature regarding recruiting outside the UK and when reflecting on the implications of translating my interview transcripts, which had to be coherent with my research aims. Transparency and coherence was also demonstrated by describing how participants were recruited and selected, by providing details of the interview schedule and relevant procedure and thoroughly detailed steps of the analysis used. Transparency was demonstrated in IPA by describing the process and showing examples of the different stages of analysis. Coherence was also respected by checking themes with research supervisor who was experienced in IPA in order to ensure that themes were logical and presented a strong argument.

Lastly, I remained focused on the impact and importance of my research when looking at the large amount of literature on RTCs that was dominated by a positivist paradigm. The studies aimed to demonstrate the connections or cause-effect relationships between RTC injuries, the related psychological consequences and relevant treatment. However, I reflected on how these studies did not capture the individual experiences which are required in order to improve the quality of care delivered to these individuals (Docteur et al., 2004), which is the aim of my study.

Summary

In conclusion, this chapter demonstrates a description of my chosen methodology, recruitment, IPA method, data collection and analysis. A reflection of my epistemological and methodological choices was also provided by taking into account the importance of reflexivity.

Analysis

Chapter Overview

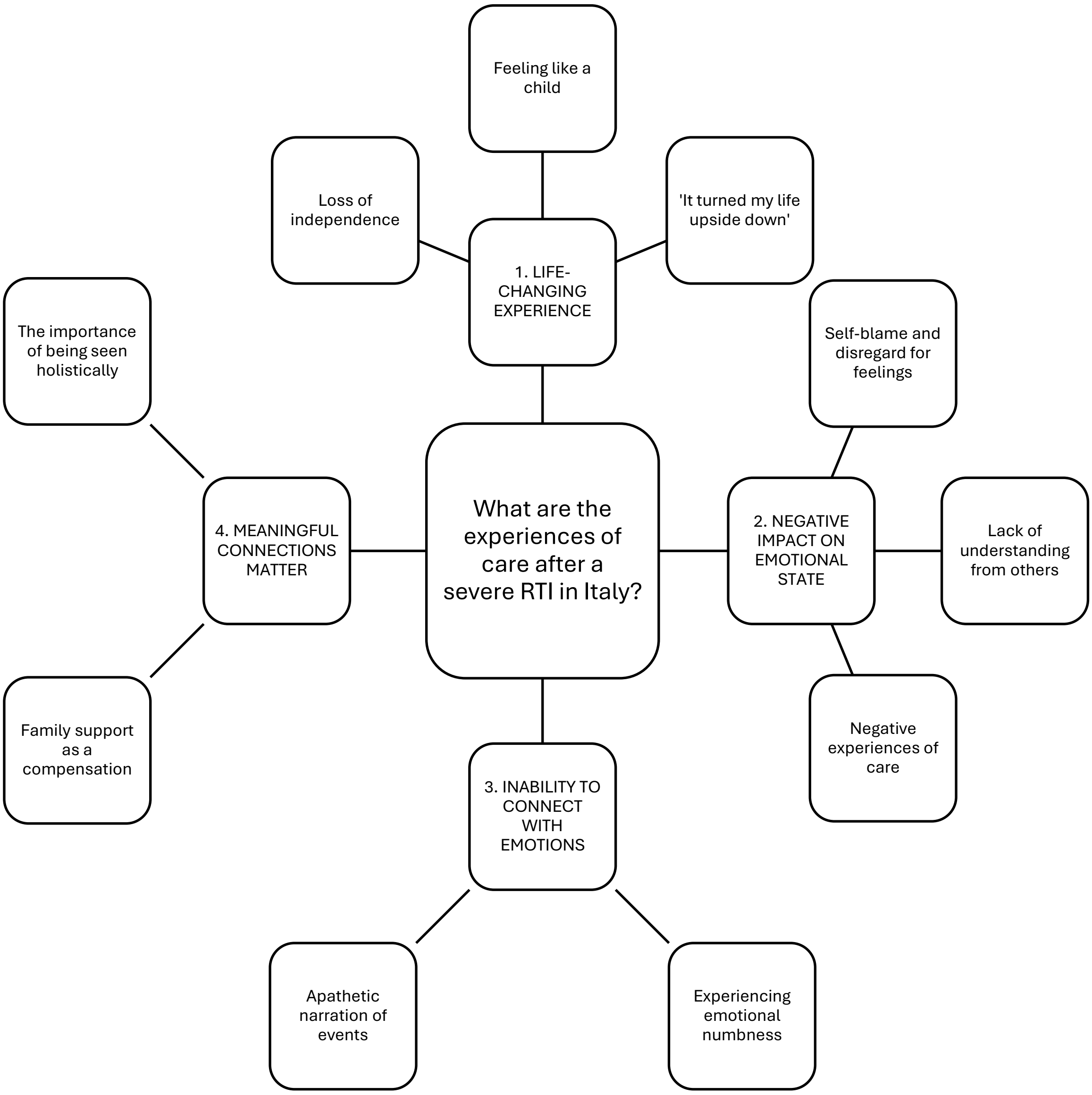
This chapter demonstrates the interpretative phenomenological analysis of the participants' experiences of care after having been severely injured in an RTC. Participants' narratives were analysed and categorised into themes and sub-themes. The results are organised into five Group Experiential Themes (GETs) that attempt to represent and capture the essence of the participants' experiences of care. The themes represent the common and the unique aspects of participants' interpreted narrative. Each GET is composed of two or three sub-themes in order to capture the interpreted meanings.

The Group Experiential Themes are: 1) Life-changing experience, 2) Negative impact on emotional state 3) Inability to connect with emotions, 4) Meaningful connections matter. The GETs and sub-themes have been presented in this specific sequence as each sub-theme is seen to be both distinctive in the emergent narrative and integral to the preceding and subsequent themes that they sit in between. The four GETs and the related sub-themes are presented in the figure below, Figure 1.

I provided a description of each GET, their meanings and the related corresponding sub-themes proving participant's unique idiosyncratic extracts in order to contextualise such themes (See Appendix L for presentation key of Participants and Themes). Extracts are presented following pseudonyms for the participants' names with in indication of the lines number of where in the translated transcript they could be found. Lastly, a key to quote presentation can be found in Appendix M.

Figure 1

Visual Representation of GETS and related sub-themes



GET One: Life-Changing Experience

When discussing the participants' experiences of care after having been severely injured in an RTC, most participants described the whole experience to be life-changing, characterised by painful feelings related to: the sudden unexpected nature of their injuries and the consequent limitations experienced, the way they experienced care, and the impact that such experiences had on their life.

The individual meaning-making will be shown in each sub-theme: 'Loss of independence', 'Feeling like a child', 'It turned my life upside down'. Each sub-theme represents an aspect of how the experience of care after an RTI has been life-changing for the participants. This GET was created on the basis of how the participants described their experience to be, both from a physical and emotional point of view.

Sub-theme One: Loss of Independence

This sub-theme outlines the loss of independence experienced during the hospitalisation as a result of the severe injuries. The meaning behind losing independence for some participants meant experiencing a change in their identity which brought them to reflect on the things they used to do before their RTC and that they no longer can do due to their physical limitations. For example, in his interview Michael discussed the experience of losing independence after his leg was amputated in hospital and how he is no longer able to do the things that he used to enjoy in life:

> This experience has changed me completely, I used to be very energetic and always on the go, I used to drive my motorbike and see my friends whenever I wanted to…now it's different because I have to be careful and I can no longer drive my motorbike (Michael, 374-381).

From Michael's statement, the loss of independence is a limitation that stops him from doing the things that he used to find enjoyable. From his statement "This experience has changed me completely” it seems that his loss of independence can be perceived as a limitation not only on a physical level but emotional too, which has detrimental impacts on the way he saw himself. During this quote Michael showed frustration in his tone of voice which can be interpreted as how lonely his circumstances are, showing how difficult and different his life is now.

For another participant, Rebecca, loss of independence meant experiencing the body as a limitation. In particular, her physical limitations provided a barrier that prevented her from communicating her needs: “Yes, precisely, I couldn't speak, and I remember the feeling that I wanted to communicate things that I had, even my mother came every now and then, but I couldn't speak, I couldn't make myself understood” (Rebecca, 102-107).

From Rebecca’s statement, not being able to communicate and making herself understood shows how limiting and impotent her loss of independence was experienced. Her inability to talk and communicate with her mother who was a great source of support during her hospitalisation, was also a limitation in expressing her needs and feelings in a situation where she was completely dependent on the support of others. It appears that Rebecca’s loss of independence could have been experienced as a limitation not only physical but also psychological, where her inability to communicate prevented her from sharing her physical needs and the related feelings.

Experiencing loss of independence for some participants also meant becoming completely dependent on the help of their family: “My parents had taken the responsibility and gave me everything I needed at the time. I mean, certainly my parents did most of the things for me in the hospital” (Anthony, 208- 213).

For Anthony, losing independence meant losing his sense of responsibility over his life, which was taken over by his parents during his experience of care. Anthony’s description of his parents giving him everything he needed at the time may indicate how the experience of care consisted of being in a state of total dependence and trust on his family who did most of the things for him in hospital. His choice of the word ‘certainly’ indicates that due to his physical injuries he had no choice but to rely on his family support during his care experience.

For other participants, the help from family members became an important aspect of their hospitalisation due to their loss of independence:

> I was a little angry sometimes, if maybe... my mother wasn't there. She was really very good because she used to come there from 8:00 am to 8:00 pm she made her way every day and stayed there, just to make sure that the nurses didn’t have to do all the things for me. And… sometimes if maybe she didn't arrive I... I'm not saying I got angry, but maybe I got annoyed (Rebecca, 184-193).

Rebecca’s constant support from her mother was also a preventative measure from having to be dependent on the nurses’ help. Being dependent on her mother was somehow experienced to be more comforting than being dependent on the nurses' help which could be interpreted as something that was uncomfortable due to the annoyance or anger that Rebecca experienced when her mother wasn’t there. For Rebecca, her mother’s absence would have exposed her to her loss of independence suddenly. Therefore, her mother’s role during her experience of care, may have protected Rebecca from the realisation of having lost her independence which was experienced uncomfortable.

Even more, participants disclosed how the loss of their independence was something that they started noticing and struggling towards the end of her hospitalisation. For example, Rebecca started experiencing embarrassment and self-disgust due to her inability to engage independently in her personal hygiene:

> I realised that it wasn't normal, even because for example I couldn't...I couldn't get up on my own and go pee in the toilet. I wasn't ok with it, I mean, towards the end of the hospital stay it really bothered me especially when I went home for a couple of days as a 'trial' I remembered thinking: 'How did I manage until now, to be dependent on the nurse to bring me a bed pan without feeling embarrassed?' or 'How did I manage to not feel disgusted by myself for needing help to go to the toilet?' (Rebecca, 324-336).

Rebecca's loss of independence seemed to have been more manageable until she was sent home for her discharge 'trial' which is part of the hospital discharge protocol. Her feelings seemed to have intensified afterwards where all of the sudden she realised how much the loss of her independence was bothering her. Rebecca's realisation was somehow triggered by the familiar environment of her home which could have functioned as a reminder of her life before the hospitalisation. This could be interpreted as how emotionally intense her loss of independence could have been for her as her inability to feel anything whilst in hospital may have been a possible disconnection from her feelings which protected her from feeling too overwhelmed. Indeed her inability to conduct her personal hygiene independently was somehow perceived as 'abnormal' with feelings of disgust and embarrassment towards herself. These two feelings show how the lack of independence especially when related to her personal hygiene, may have had a negative impact her mood. Indeed, when reflecting on the reason why this happened, Rebecca explained that going home and experience a degree of independence made her aware of the feelings related to the loss of independence and the sense of vulnerability she may have felt in hospital.

Sub-theme Two: Feeling Like a Child

For some participants, feeling like a child originated from the way they experienced care in hospital such as being woken up, dressed and changed by the hospital staff. For Rebecca, feeling like a child was related to the physical limitations that her injuries caused her to have. Her experience also included not being able to connect with her emotions when feeling like this. In particular, she disclosed feeling as if nothing bothered her whilst being in hospital as she knew that it was her new reality and routine.

> Like…being there at 23 years old in a hospital bed, surrounded by other elderly women in the beds, and... yes, having people who changed you, dressed you like a child.. in the hospital routine, waking you up, basically nothing bothered me, let's say, it didn't upset me, I knew that that was my new reality and routine. When I think about it it does bother me and I don't think is normal feeling like a child… but at the time when I was there in hospital it didn't. I was happy in that bubble (Rebecca, 295-308).

Rebecca's meaning-making of being bed bound, being woken up, changed and dressed by other represented a regression to her childhood's experience. This evidences how the experience of care and lack of independence was characterised by possible feelings of powerlessness and vulnerability. Furthermore, Rebecca's experience seemed to have been addressed by a possible disconnection from her emotions that protected her from the emotional pain related to feeling like a child. Her experience was a state of total dependence, vulnerability that only the hospital staff and her family could witness which may explain the embarrassment that she experienced in relation to her situation. Rebecca's inability to feel bothered or upset about this may also be interpreted as a possible state of numbness that was protecting her from her uncomfortable feelings.

Indeed, when talking about her feelings Rebecca explained how numbness was the main thing that was related to feeling like a child: "I didn't feel... I didn't… I honestly felt nothing. Yes, I was just like a little girl who was taken here and there if that makes sense" (Rebecca, 168-172).

Again, Rebecca's statement "I was just a little girl who was taken here and there" shows how her experience was characterised by a lack of control and power over what was happening to her in hospital which may have brought her to be in a total state of numbness in order to cope with those feelings.

For other participants, feeling like a chid meant having to start from zero with their physical movements. For example, after losing his leg Michael explained how the process of learning to use his fake leg was like learning how to walk again.

> I had to start from zero again because I had to learn how to use my fake leg and how to move around with it. Although people might not really notice that I have a fake leg it is very different from a real one. The fake leg doesn't move as smoothly and you need to take time to learn how to move with it without hurting yourself. Therefore, It was like starting to learn how to walk again (Michael, 203- 213).

In Michael's account, he seems to describe the process of learning how to move his fake leg to be long and time consuming. Although invisible from others, having a prosthetic leg (fake leg) for Michael meant having to be careful and aware of not hurting himself again, indicating a possible increase in his feelings of vulnerability. From his narrative "it was like starting to learn how to walk again" I interpret how his experience was perceived as a regression to his childhood where he had to learn how to walk for the first time.

For Anthony instead, the experience of being involved in a severe RTI as a result of drink-driving meant feeling like dying and being reborn with a new life:

> Well, I felt very close to death. For me it was like dying and being reborn. After this whole experience I realised that first of all I didn't give too much importance to life, for example… drinking and driving the car around... yes I realised that it was a bit ignorant, certainly immature. And then I also realised that life is one so… we have this time available and maybe before this experience I gave a lot of importance to things such as money… now it's not that I don't give any importance to money but from my point of view the most important value it's the time of our lives (Anthony, 267-280).

For Anthony, feeling very close to death brought him to reconsider his values and beliefs in life. Feeling like being reborn for him could have meant realising how life was something that he almost took for granted before the RTC and how his most important value now is the time of his life. Reflecting on his behaviour before the accident could be interpreted as remorse towards drink driving on the night of his accident which he described it as immature. Therefore, injuring himself and having been hospitalised gave him with the opportunity to re-consider the importance of his life and the way he lives, which he experienced it as a rebirth. Anthony's experience of feeling like a child consisted of embracing the chance to rebuild his value system that he would have built in childhood. His wise, experienced eyes are now shaping his identity from scratch in a good and nurturing way.

Sub-theme Three: "It turned my life upside down"

This sub-theme outlines how whilst being cared for, most of participants were reeling with experiences of care that they felt were 'life-changing'. These experiences included the impact of their injuries, their collisions and their recovery.

For Michael, life-changing was going through a leg amputation during his recovery in hospital:

> Everything, everything, everything was difficult. It turned my life upside down, from one moment to the next, changed my life. And you can't do anything about it anymore, it will always be like this for the rest of my life. (Michael, 414-420).

By saying “everything was difficult” Michael was referring to any aspect of care and recovery after his accident. The repetition of the word “everything” three times underlines how much his life has been impacted by his injury. His statement “It turned my life upside down” evidences that the sudden and unexpected nature of his injury (leg amputation) had a detrimental impact on his life. The meaning-making of having his leg amputated in hospital meant going through a life change that was fast and irreversible. Also, his statement “you can’t do anything about it anymore” indicates a sense of powerlessness and lack of control over the consequences of his injury and the medical treatments related to it. From Michael’s statement “It will always be like this for the rest of my life” it’s evident how unforeseen life-changing injuries can leave patients feeling powerless over the irreversible changes of their own bodies.

For Christine the life-changing experience referred to the impact and the memories of her accident. When talking to the perpetrator about her accident, Christine felt emotional during the interview explaining how he attempted to lie to her hoping that she forgot what happened:

> Exactly ((cries)), because these are memories that will never go away, because every time I cross the road on the same roundabout all the memories of the accident come to mind and it makes me angry because he lied to me about something that traumatized me and that I will always carry inside me (Christine, 121-128).

For Christine the memories of the accident may be considered life-changing experiences that will permanently affect her whenever she is reminded of them. The anger experienced towards the perpetrator indicated how impactful the experience has been and how disrespected she felt by the perpetrator for lying to her about something that affected her life so intensely. Christine's meaning-making of her experience may show how irreversible and permanent the experience of being severely injured in an accident can be, suggesting how permanent the memories will be.

For Anthony instead, the life-change involved giving a different meaning to his life wanting to do more things and using the time that he has available to its best:

> From this experience onwards I give much more time to doing things…I do many things, I mean… I want to invest the time I have available as much as I can. Whereas… before all of this I actually lazed around, let's say a little more, even perhaps doing nothing… while nowadays I have to tell the truth, it really rarely happens that I have no desire of doing something or nothing to do during the day (Anthony, 282-291).

From Anthony's statement it was evident how the experience of going through a life-threatening injury and the consequent hospitalisation made him more aware of his values in life, feeling grateful to be alive and having an opportunity to change things. This indicates how his experience of being hospitalised may have allowed him to be more aware of the way he lived his life before the accident. His comparison between his life now and life before the accident may demonstrate how this experience has been life-changing to the meaning he gives to his life. This seems to be a result of going through a life-threatening experience which may have influenced Anthony in perceiving his survival as a 'second chance' for leaving his life more meaningfully. For him, life being turned upside down meant going through an intense and scary experience that made him question the way he lived and the meaning he gave to his life.

For Christine instead, the impact of accident and the sudden nature of it was almost perceived like a betrayal from being careful when crossing the road: "One moment I was completely fine, thinking about my business and making sure I was being careful when crossing the road.. and the next I found myself under a truck, full of blood and completely traumatised" (Christine, 128-133).

The way she described her traumatic memories included overwhelming images of being physically hurt, limited and with no control over what happened to her. This indicates how the meaning-making of her experience may indicate that the impact of the accident was perceived as sudden, unexpected and traumatising from both a physical and emotional point of view. For Christine, life being turned upside down meant being literally turned upside down under a truck and covered in blood. Meaning-making of this experience may include going through a traumatic life-threatening experience of powerlessness and worry. Despite her efforts of being careful, she may have lost control over her body and life.

GET Two: Negative Impact on Emotional State

This GET outlines the negative impact and consequences that all participants experienced on their mental health whilst being cared for in hospital. For some participants, this was experienced through self-blame and disregard for their feelings and needs whereas for others this was experienced through loneliness and lack of understanding from others.

Sub-theme One: Self-blame and Disregard for Feelings

Participants' self-blame and disregard for their feelings was evident when they were asked about their feelings towards their experience of care after the accident. For Anthony, this was evident when he shared the experience of thinking: 'What have I done?' in relation to his accident. This was related to drink-driving and feeling responsible for the accident which was evident in his uncomfortable non-verbal communication and face expressions during the interview:

> I definitely thought about this whole experience every now and then and thought: ‘Damn what have I done? What did I do?’ But on the other hand I also thought: ‘OK, I had support from all sides’ so yes, I didn't even have many reasons to feel too bad about it. Thanks to everyone's external help (Anthony, 323-330).

From this statement Anthony’s disregard for his feelings was evident in his perception of not feeling entitled to feel bad about what happened due to having had support from all sides. Not having many reasons to feel bad about it could also be interpreted as self-blame for his accident as throughout his narration, his way of describing his feelings was solely expressed with the statement ‘What have I done? What did I do?’. This self-blame also may indicate how meaning-making of participants who feel responsible for their accidents results in not feeling entitled to feel a response to their possible trauma. Anthony’s meaning-making of his experience shows how individuals who blame themselves for their injuries may disregard their feelings and therefore avoid asking for further support when needed during their care.

For Michael, his accident was caused by falling asleep whilst driving his motorbike and his self-blame was evident by his feelings of regret of having gone for a ride despite feeling very tired on the night of the accident.

> I'm a completely different person. I regret having gone for a ride on my motorbike that day because I was dead tired, I had worked until late in the evening, I had slept little the night before, and that day I already felt tired during the day. And I am aware that if

> I stayed at home it would have been a good thing, but instead I went away with my friends and I hurt myself (Michael, 395-405).

Self-blame and the disregard for his feelings were evident on the narration of the decisions he made before leading to the accident which lead him to feel like a completely different person. Feeling like a completely different person also links to the first GET ‘Life-changing experience’ where participants expressed how their life changed during their experiences of care. In Michaels’ account, it seems that feeling like a different person as a result of his actions meant becoming aware of what he could have done differently the night of his accident in order to avoid it.

Furthermore, the feelings of loss and shock towards his life-changing injury could have been disregarded by the anger and self-blame towards his decisions: “It really, really annoyed me, it was caused by something so little and stupid like not being able to keep my eyes open and it changed my life and it was bad” (Michael, 408-412).

For Michael, self-blame may have included allowing himself to feel only the anger towards his actions, minimising the cause of the accident by addressing it as little and stupid as something that could and should have been avoided easily. However, no further feelings or thoughts were described in relation to his anger. Therefore, his meaning-making may involve feeling like his life-changing injury could have been avoided easily by his actions. This may indicate that participants’ experiences of self-blame may lead to worsened mood and further disregard for their feelings as a result of not feeling entitled of them.

For Rebecca, the disregard for her feelings was evident when discussing the lack of psychological support in hospital. When reflecting on this, Rebecca hypothesised that maybe she wasn’t in the right department and probably she never asked for it, as if the psychological support should be her responsibility rather than the hospital’s.

> maybe I wasn't in the right department? because I was in neurology...Recovery type department yes physiotherapy and neurological. But no, it wasn’t planned, let's say [**Ok like…it wasn't taken into consideration?**] Well, I probably never asked for it, no, I never asked for it, but they didn’t even ask me once: ‘today you see the psychologist for an hour for the situation you went through’ for example (Rebecca, 237-247)

From Rebecca’s narrative, there is an attempt to justify the reason why no psychological or emotional support was offered to her in hospital. This may be resulting from the lack of knowledge and awareness about holistic care and perhaps the level of responsibility she felt towards her care. In fact, in her statement “I never asked for it” indicates possible self-blame as if the responsibility of receiving psychological support should fall on her. This may also be interpreted as an indication on how she may have not felt entitled to ask for support or how she never thought about the possibility of needing it which indicates a possible disregard of her feelings.

Sub-theme Two: Lack of Understanding from Others

This sub-theme outlines the experience of loneliness that participants felt in their interactions with other people, leaving them experiencing a lack of understanding and empathy from others. For some participants, this was experienced with their interactions with hospital staff, whereas for others it was with family, friends and others.

Michael experienced a lack of understanding from others in his interactions with the doctors where he was told that he will be ok once he received his prosthetic leg:

> Well, after this accident my life changed completely. Everything has changed. Even if doctors told me: 'Well, but later you'll see that you'll recover and be able to do things like before!' Well, in short, I have to do things very slowly, I have to be careful because

> I can fall at any moment. Even though the brace holds me up I have lost sensitivity on my foot and I can lose my balance at any moment if I'm not careful. Also, this experience has changed me completely, I used to be very energetic and always on the go, I used to drive my motorbike and see my friends whenever I wanted to…now it's different because I have to be careful and I can no longer drive my motorbike (Michael, 363-381).

The meaning behind Michael's statement could be interpreted as how doctors did not only lack understanding and empathy towards his situation, but they did not take into consideration the way his experience changed his life. For Michael, doctors saying "you'll be able to do things like before" seemed to have minimised his feelings and raised false hope in Michael who expected his life to go back to how it was before. His comparison with his life before the accident evidenced how this experience has also changed his fearless personality, forcing him to be more careful with what he does. Therefore, Michael's meaning-making of his experience shows how the lack of understanding from doctors affected his expectations towards his recovery and consequently his mood in a negative way.

> Well, I felt annoyed and frustrated. I was annoyed with the people saying that to me and I felt like answering: 'Well, you try it and then tell me...' because it's easy to give advice to people when you are not the one who is suffering…but it's not easy having to rely on the family's help all the time (Michael, 292-299).

For Michael, experiencing this led to frustration towards others and wanting to put them in his shoes in order to understand how much suffering he was going through during his recovery journey. "Well you try and tell me" appears to reveal how lonely and misunderstood he felt when interacting others.

For Rebecca, lack of understanding from others was experienced during her interaction with one of the nurses in hospital:

> I remember, for example, I remember one who at the time almost seemed like I had done her wrong at one point. I called to ask her to give me something because I couldn't move and she answered me,…not badly, but maybe a little abruptly. And these things make you feel a little like…you know you're already feeling bad…You suffer that you can't do things independently and then she answer me like this...it's not nice, and it didn't make me feel good (Rebecca 379-390).

Rebecca's experience indicates the importance of the interaction with the hospital staff. Her meaning making of having a nurse responding abruptly to her resulted in a worsened impact on her emotional state which was already affected by the embarrassment and guilt of her lack of independence. This shows how negative nurse-patient interactions can worsen the mood of patients who are already struggling with the difficulties related to their loss of independence.

For Christine, the experience of talking about the accident with the driver who caused the accident meant experiencing loneliness within her feelings. This was evident in the conversation with the driver who did not take responsibility for causing the accident:

> And the driver told me that it was the pickup truck's fault because it suddenly braked in front of him. I told him: 'No, you cannot say that to me because I felt the hit you gave the truck and we were looking at each other for while to cross... Also, because I remember the hit of the crash. I will never forget it because even now when I have to cross the road I no longer cross unless the cars are stopped and give me the sign to pass. Because the hit was so bad that I will remember it forever, yes (Christine, 107-119).

Christine’s way of defending herself and responding to the driver included providing him a description of the traumatic memories of the accident and the way they affected her. This shows the possible anger that she felt towards him for not taking this into consideration the impact of the accident when lying to her. In her statement “the hit was so bad that I will remember it forever” may show how painful and lonely the experience of being involved in an accident was for her. Therefore, the possible lack of empathy and understanding from the driver may have triggered Christine’s feelings of loneliness in her painful and permanent memories of the accident.

For Michael, loneliness and lack of understanding from others was experienced when being told by others that he was lucky or that there are those who are worse off after his leg amputation:

> Well you know, friends and relatives told me: 'Come on, you're lucky you're still alive..' 'Come on, they saved you..' 'Come on, there are those who are worse off..' Well you know, it's obvious that there are other people who are in worse conditions than me, but everyone deals with his own struggles and I felt like they were minimizing what has happened to me...I know what they were trying to do… they were trying to cheer me up but after this experience my life changed completely and I think I had every right to find it difficult to come to terms with. (Michael, 274-289).

The lack of understanding from others and their attempts to make him feel better may have left him feeling unvalidated by the people close to him whilst going through a life-changing experience. Michael’s meaning-making of this resulted in not feeling understood by others despite their attempts to make him feel better. Furthermore, being told that he was lucky may have minimised the impact and the meaning of his life-changing, leading him to question whether friends and relatives may have judged him for his feelings (“I had every right to find it difficult to come to terms with"). This worsened his mood and the way he felt, leading him to isolate himself and not wanting to talk to anyone because of it:

> Well, it was very painful. It was very difficult not being able to do the things I wanted when I wanted anymore. I felt so demoralized and sad. People would try to come see me and support me. Many friends and relatives came to visit and ask me what happened and how I was… Everything helps, but I felt so demoralized and I didn't really want to talk to anyone (Michael, 262-271).

From his statement it appears that Michael's meaning-making of his experience may have included feeling limited by the change in his life. Also, the lack of understanding from others seems to have worsened his mood as from his statement "Everything helps" may indicate that friends and relatives talking to him should been helpful rather than detrimental. Therefore, from Michaels' statement, it is possible to see how important empathy and understanding from family and friends can be for patients who may experience a decay in their mood if this aspect is missing.

Sub-theme three: Negative experiences of care

This sub-theme outlines how negative experiences of care had a negative impact on the mental health outcomes of patients.

For Michael, negative experiences of care consisted of the lack of empathy and understanding by the doctor whilst Michael was trying to connect and share with him his thoughts about the accident:

> I remember that when I told the doctor that it had gone badly with this accident, he replied that I was lucky to be alive and that they managed to save me. But I was the one

> who had to accept being without a leg, not him. So it's easy to talk when you're not the person who has to pay for the consequences of an accident (Michael, 249-258).

Being told by the doctor that he was lucky to be alive and that they saved him may have resulted with a disregard towards Michaels' feelings and lack of compassion towards his life-changing injury. From Michael's reflection, the frustration and rejection he may have felt towards his doctors' positivity could be seen in his statement "I was the one who had to accept being without a leg, not him". Indeed, Michaels' statement of "It's easy to talk when you're not the person who has to pay for the consequences" it's perceivable a sense of loneliness in his experience of emotional pain. From Michael's statement, doctors' lack of active listening and empathy towards his life-changing injuries left him feeling misunderstood, frustrated and lonely in his experience.

For Christine, the negative experience of care consisted in the lack of sleep that she experienced at night time due to the noises and the presence of other people sharing the same room:

> Yes, because I already had memories of the accident and the past trauma to come to terms with, plus the lack of sleep at night worsened the situation because I was no longer thinking well and the next day I was even worse physically. This made me feel low and snappier with everyone… I felt I wasn't thinking positively as I normally would, and this really bothered me (Christine, 215-223).

The lack of sleep for Christine affected her emotional state by lacking in clear thinking, feeling low and snappier, and lacking positive thinking which were uncharacteristic of her way of being and feeling during the day. From Christine's statement, it could be interpreted how the impact of the accident was having detrimental effects on her sleep quality which, combined with the noises of the hospital environment resulted with a decay in her overall mood.

Another aspect of negative experience of care included being discharged prematurely and having to pay privately in order to complete the recovery process:

> However they discharged me when I was still struggling to walk and I had to go to a private physiotherapist in the end and things got sorted out. But unfortunately, this is how the Italian healthcare system works where... as long as you walk a little and manage to do things, you don’t need to be fully recovered before they discharge you. But yes, for this reason then I proceeded in private (Rebecca, 494-504).

From Rebecca’s statement ‘This is how the healthcare system works here’ it is perceivable a sense of surrender and low expectations towards her care in the healthcare system which did not allow her to recover completely before discharging her. Rebecca’s meaning-making of this experience led to self-care and self-reliance in the search for further support privately in order to meet her own needs. This also shows how Rebecca may have felt let down by the care received in hospital whose premature discharge limited her ability to recover completely. Consequently this led her the unavoidable choice of paying for further support privately in order to complete her recovery.

The negative experiences of care were described by some participants as the parts that stood out the most for them. For example, during an episode of mild delirium triggered by the medication Rebecca was tied up and held by the nurses. Her negative experience here included the inability to move and communicate how she felt at the time:

> They took me out of the medication I had a bit of mild delirium, but due precisely to not understanding where I wanted to take off the collar and I remember this and I know that they had also tied me up and I really remember the feeling that I couldn’t move because there were some nurses that were holding me with their hands. Yes, this

> was quite a strong thing for me, it was very limiting because I wasn't able to move and I couldn't communicate how I felt (Rebecca, 410-421).

The experience of being held down and not being able to move or communicate with the hospital staff resulted in becoming powerless whilst experiencing mild delirium. Rebecca's statement sounded like a terrifying experience of being restrained while feeling out of control through medication. Her expression "quite strong thing" represented a disconnection for me as the adjective "quite" seemed to minimise the intensity of her experience whilst the choice of the word "thing" seemed to indicate a possible inability to connect and name the feeling related to her experience. This shows how the experience of being powerless whilst being unable to communicate her feelings during restrain was detrimental to her freedom and her ability to process her emotions. This links with the third GET *inability to connect with emotions.*

GET Three: Inability to Connect with Emotions

This GET outlines how participants were unable to connect with their emotions during both the experiences of care and during their interviews with me. This was evident in their experience of emotional numbness whilst being in hospital and their apathetic narration of injuries and physical pain experiences.

Sub-theme One: Experiencing Emotional Numbness

This sub-theme represents participant's experiences of emotional numbness during their hospitalisation. In some instances, participants couldn't connect with their emotions even when they expected to, whereas other times numbness was caused by the lack of time to realise what was happening.

For Rebecca, experiencing emotional numbness was a difficult aspect of her experience as the cause was unknown:

> The only thing that I found to be difficult is that I couldn't ... even on a mental level... I don't know if it's due to the drugs, the residues, perhaps from the ICU [**Mhm**] I never really understood, but I was quite… I didn’t feel pain, discomfort or in any case a sense of... embarrassment for example about being treated in hospital when I couldn't even move my legs... I didn't feel... I didn't… I honestly felt nothing (Rebecca, 158-170).

The difficult aspect of this experience for Rebecca was not only the inability to find the cause of her experience, but also the inability to understand how she was feeling in those moments. Her inability to feel any discomfort or embarrassment may be interpreted as the experience of possible numbness as a protection from panful feelings. This is because Rebecca’s experience of being treated in hospital for not being able to move her legs may have been too overwhelming for her to be able to connect with her emotions. Therefore from Rebecca’s account, her experience of distress was not only caused by the inability to feel anything, but also by not being able to understand the reasons of it.

Experiencing emotional numbness for other participants was caused by specific changes on their physical state. For example for Michael, being told about his leg amputation consisted in lacking time to realise what was about to happen:

> They told me that from one day to the next I no longer had a leg. I started thinking: 'I wonder what I'll do now without a leg'. In the end I had to accept it, I had no other choice… I mean.. I didn't have time to make a decision or realize what was about to happen… because it all happened really fast, one moment they try to save you and the other you no longer have a leg…and nobody has asked me if I was ok with it or how I felt about it (Michael, 74-84).

The speed in which the news were delivered to him and the lack of consideration towards his feelings left him feeling like he had no alternative but to accept what was happening. However, the lack of time and space to talk and reflect on his feelings and thoughts may have left him experiencing numbness in response to the possible feeling of loss. This numbness may be perceived in Michaels's way of responding to the experience of being told about his leg amputation, I perceived this by his tone of voice and the way he expressed his thought "I wonder what I'll do now without a leg" and by the speed in which he said 'In the end I had to accept it', showing no emotions related to it. Michael's account might show how the way life-changing news are delivered to patients during their care experiences may affect the way they feel, limiting their opportunity to process what is happening to them. Indeed, on Michael's account, he expressed the need to talk to someone after what happened:

> I think I needed to talk to someone about it because my life was going to change all of a sudden and I didn't even get the time to think about it or reflect on how I was feeling about it. I remember feeling numb and very disappointed with myself for going out that evening despite I was feeling very tired already (Michael 99-107).

Michael's disappointment towards his actions the night of the accident might shows how the painful feelings of loss towards his life-changing news were somehow directed into self-blame and regret towards his actions. Perhaps this was an attempt to avoid the pain and regain control over what was happening to him in a high emotional situation that caused him to feel numb. Indeed, Michaels' expressed need to talk to someone about it shows how the experience of numbness whilst receiving life-changing news, could have been avoided or reduced by allowing him the space and the time to talk about it and to consequently process his feelings.

Sub-theme Two: Apathetic Narration of Events

This sub-theme highlights a phenomenon that frequently emerged during the interviews with the participants. Specifically, after having been asked about their accidents or injuries participants showed a tendency to narrate the facts and events of their experiences in an apathetic way. Apathetic narration in this sub-theme refers to the display of little or no emotion that participants showed when narrating events. This was common when talking about either the dynamics of their accidents or the severity of their injuries which often involved detailed distressing images or memories.

For Christine, the apathetic narration was evident when explaining the way she remembers being stuck under a truck as well as seen the overwhelming amount of blood on her arm with no emotional recollection.

> And yes, when I woke up and opened my eyes I saw the pickup truck above me. And my son was there calling me. Then I raised my arm and saw this sight of blood on my arm and then that was it. I didn't even hear the ambulance arrive because of how much pain I was going through (Christine, 26-32).

Christine’s inability to hear the ambulance arrive and the overwhelming physical pain that she was experiencing may be a result of the emotional numbness that she was experiencing at the time. I interpret this as a possible dissociative response that protected her from the painful feeling and sensations that she was experiencing. Therefore, her apathetic narration during the interview may be a result of her inability to recollect the feelings related to her experience because it was too overwhelming.

For Anthony, the apathetic narration of events included minimising his experience when talking to me:

> The condition I was in was very, very bad and therefore to get to the hospital on time, let's say, they preferred to use the helicopter. So the situation was quite serious, however I already had fractures which were serious. And yes they were very quick, in short. Imagine calling the fire brigade, cutting, pulling out, analysing. I mean now I don't know how to give a timeframe but in my opinion they were more than fast when they came to rescue me (Anthony, 36-46).

The apathetic narration included minimising the seriousness of his experiences by using reductionist adjectives such as “quite” and “let’s say”. This, again, may be interpreted as an attempt to protect himself from the painful and overwhelming feelings of his experiences. Even more, when talking about the severity of his injuries Anthony quickly started talking about the dynamics of his rescuing process rather than expanding his point of view or his feelings about the injuries. Anthony’s attempt to direct the focus of his narrative towards evaluating how efficient and fast the rescue brigade was, could be interpreted as avoidance towards possible painful feelings related to both his injuries and his accident.

Therefore, the apathetic narration of the events of participants may be interpreted as possible avoidance of the overwhelming and painful feelings of their memories. This shows how overwhelming the experience of being injured in an RTC can often be for patients who then are taken to hospital.

GET Four: Meaningful Connections Matter

This GET outlines an aspect that participants described to be important in their experience of care: the importance of emotionally connect with others such as hospital staff and family during their hospital stay. The sub-theme ‘Importance of being seen holistically’ represents the aspects that participants considered to be important when being cared for in a holistic way by the hospital staff, whereas the sub-theme ‘Family support as a compensation’ represent the role played by the support received by their family.

Sub-theme One: The Importance of Being Seen Holistically

This sub-theme outlines how participants expressed the importance of being seen holistically by the hospital staff. This was done by reflecting some of the positive and negative interactions with the hospital staff.

For participants, the importance of being seen holistically was expressed through positive experiences of interactions with the hospital staff which led them to be grateful. For Rebecca, positive experience of interaction consisted in the ability of doctors reassuring her and explaining what has happened to her. For example, for Rebecca, being reassured with kindness by one of the doctors lead to feeling supported:

> I only remember that there was a doctor, a female doctor who when I woke up told me: 'Rebecca don't worry, you're in hospital, you had an accident'. Yes, I remember that there was this very, very kind doctor, who reassured me and told me to calm down because my family members were in intensive care for like an hour a day, that is because they weren’t allowed to stay there any longer. And so when I woke up I was alone and I remember that there was this doctor who helped me. Also because I was the youngest in the ward and also in the intensive care unit, so yes everyone remembered me and even the doctors did, so they had, they had given me enough support (Rebecca, 429-446).

From Rebecca’s statement, doctors taking into account patients’ age and family support is an aspect of care that allows patients to feel positively cared for and supported. From Rebecca’s narrative, waking up alone in hospital and being helped by the doctors seemed to have compensated for the lack of her family’s presence which underlines the importance of patient-doctors interactions. Even more, being remembered and considered by the hospital staff seemed to be an important aspect in the experience of feeling supported and cared for in hospital.

For Anthony, the experience of being seen holistically consisted of feeling really cared for experiencing the hospital environment like a family:

> To tell you the truth, the specialist hospital, where I have been for a long time, gave me a sense of feeling really cared for, in the sense that they treat you really well, from the nurses to the doctors that I dealt with there was this big sense of familiarity and they were kind. Even there in the ward, if you needed anything, you asked the nurses and they were always ready to help you straight away (Anthony, 52-60).

From Anthony’s account, it’s evident how kindness and promptness from the hospital staff is an aspect that lead him feeling really cared for whilst in hospital. Even more, the sense of familiarity perceived by Anthony may have been perceived as a comfortable and caring place that allowed him to develop trust towards the hospital staff. This may underline how, staying in hospital for a long time and being treated well with consistent support by the hospital staff contributes positively to patients’ mood.

Even more, participants experienced a strong sense of connection and gratitude towards the hospital staff who looked after them. For Anthony, the sense of gratitude was experienced towards the intensive care nurses which he considered to be responsible for keeping him alive:

> Once I had recovered a little, like two months later, my mother told me to go and say hello to the intensive care nurses who had practically kept me alive. And I actually remember that I went to say hello to them, and they recognized me straight away, and they said to me: 'Oh, you are number one!!' And I said to them: 'What do you mean

> number one?' And the nurses told me that they remembered my bed number and therefore recognized who I was. So what I mean is that they remembered me even after some time and therefore this gave me the impression that in any case they are fond of the patients. They go even a little beyond their job role and responsibilities, I mean, they put a lot of care and love in what they do (Anthony, 67-84).

Feeling grateful to the hospital staff for saving his life may show the strong sense of connection that Anthony has experienced toward the hospital staff for looking after him and his life-threatening injuries. This shows again how life-changing the impact of severe injuries may have been for Anthony who may have developed a strong connection towards the hospital staff whilst being cared for. Even more, being remembered and recognised by hospital staff and perceiving the staff as caring and passionate individuals who are fond of patients may have led him feeling seen holistically and valued. From Anthony's statement, hospital's staff going beyond their job roles and responsibility means putting love and care in what they do with patients. This could be interpreted as hospital staff's job roles and responsibilities not being enough to make patients feeling cared for whereas love and passion is what makes the difference in their experience of care.

The importance of being seen holistically was also expressed through some negative experiences of care that participants voiced during their interviews. These were described when participants felt seen only through their physical bodies and injuries and when no emotional support was provided in relation to the impact of their injuries. For Michael, this was experienced when he was not informed of what was happening and he was left guessing what was going on by reading the room and paying attention to how quickly the doctors where acting and behaving around his body.

> I was feeling sad and worried for my leg, because I didn’t know if they could save it. I understood that the situation was bad because of how quickly the doctors were trying to help me but no one spoke to me about it. They explained me what was going on only before they tried to do the surgery to save my leg (Michael, 43-50).

Michael’s statement “no one spoke to me about it” shows how in a high emotional situation doctors’ exclusive focus on his physical state may have led him feeling ignored. His attempt to read the room and guessing what was happening may indicate how Michael could have been in a possible state of worry. His emphasis on “no one spoke to me about it” may underline the possibility of Michael feeling ignored whilst needing to receive information about what was happening. This may have left him feeling sad and worried about his physical condition without the possibility to talk to someone about it and without knowing what was happening until the very last minute. From Michael’s account, it is possible to see how the lack of communication from doctors when treating severe injuries may lead patients to focus on doctor’s non-verbal communication in order to manage the feeling of worry towards their physical state. This consequently, can leave patients feeling unaware of what’s happening to them whilst their feelings remain unvalidated.

To follow, Michael explained that he had the opportunity to talk properly to the doctors after the surgery:

> Yes, they took the time to talk to me properly after the operation to let me know that they had to cut my leg and that the surgery didn’t go well. I mean, I wasn't there alone when they spoke to me. I was in a room with other people. Obviously the doctor tried to ask me how I was feeling physically, but they didn't do or tell me much more than that. They didn’t worry about how I could have taken the news or how I could have felt

> about it. They delivered this life-changing news but they didn't worry about how I could have felt about it (Michael, 53-65).

From Michael's account, his feelings of invalidation seemed to not change. This is despite the doctors' attempt to talk to Michael about his leg amputation. Reason for this, could be explained by the way the life-changing news was delivered to him, with no privacy and no consideration for how he could have felt about it. Furthermore, Michaels' repetition of 'they didn't worry' shows of doctors' lack of compassion for him could have been distressing, indicating that he might have needed to talk about his feelings. Therefore, from Michael's account is possible to see how the exclusive focus on the physical state of patients when delivering life-changing news may leave patients feelings unvalidated and ignored.

For some participants, the importance of being seen holistically was expressed when reflecting on the lack of emotional support provided in hospital. For some participants, because this support was not offered, asking for support was not considered as an option as they didn't think about it. For example, for Rebecca, having had the possibility to talk to someone could have allowed her to think about it as an option:

> And from a psychological point of view, I don't remember having being offered any support and this aspect was missing because even just having had the possibility to talk to someone, maybe I could have even thought about it, but I have never had the chance to even think about it as an option. Also, I didn't lack psychological support personally, because at that moment I had all my family members who supported me and helped me, but, to be honest, if I hadn't had them, probably yes, then I would have, I would have needed more emotional and psychological support, I can honestly admit this (Rebecca, 568-583).

Interestingly, when reflecting on the emotional support received by her family members, Rebecca explained how she would have needed more emotional and psychological support in her care experience if she didn't have her family with her in hospital. This shows how family support is an important aspect in the emotional and physical recovery of patients and that without this, participants could be more subjected to increased psychological distress. Furthermore, her last statement 'I can honestly admit this' may be alluding how for Rebecca, admitting that she needed psychological support, is somehow difficult to do and perhaps something to be ashamed of. This is an important aspect to take into consideration as participants not asking for emotional support may be embarrassed, ashamed, or lack of awareness of the option of receiving psychological support in hospital.

Also, participants who did not require psychological support expressed the importance of offering psychological support in hospital: "Because the physical condition of patients can have an impact on the way they feel in hospital and as I said, my experience changed my life completely despite having a lot of external support from family and friends." (Anthony, 371-377).

On Anthony's reflection, the impact of physical injuries is something that should be considered holistically due to the life-changing nature of them. This is an important aspect to consider because similarly to Rebecca, Anthony explained how despite having received support from family and friends his experience changed his life completely. This may underline how the experience of care after a severe RTI is a life-changing experience that needs to take into consideration every aspect of an individual's life that has been affected.

Even more, when reflecting on the importance of emotional support in hospital, Christine expressed the importance of having her family there as opposed to other patients:

> Yes, certainly. I saw that in the hospital there were patients without family and it was clear that they were having a completely different experience. It made me sad to see them alone like that. [**In terms of?**] Loneliness. Because in the hospital there is a lot of loneliness. In the hospital there is a lot of physical support but if there isn't emotional support from your friends and family you are left there alone. Therefore, the emotional support was very important for me. Well, physical support is also fundamental, but emotional support matters just as much, sometimes even more than physical support. So emotional support is a good thing. In fact, very good. Which helps a lot, a lot, a lot. Certain (Christine, 304-321).

From Christine's account, it is possible to see how her experience of having family support during her hospital stay brought her to notice the loneliness that other patients were experiencing. The loneliness that Christine described seemed to indicate possible isolation that patients experience from the connections with the hospital staff despite receiving consistent physical support from them. Furthermore, her statement "physical support is fundamental but emotional support matters just as much" underlines the importance of being cared for holistically, receiving physical and emotional support simultaneously. It seems that during Christine's experience of care, there were zero opportunities to receive emotional support unless you have family and friends who can support you which links to the second sub-theme of this GET, *Support from family and friends as a compensation.*

Sub-theme Two: Family Support as a Compensation

This sub-theme represents the way participants described the support received by family as a compensation from the lack of emotional support offered during their experiences of care. This aspect has evidently influenced the experience of all participant in a positive way.

For example, a common aspect of the family support was that participants wouldn’t know how they would have recovered mentally without it:

> Without all this support from my family, I don't know if I would have managed well mentally, I don’t know if I would have done it in the same way and at the same speed. Surely without them then yes, I would have needed psychological support (Rebecca, 275-280).

From Rebecca’s statement, not knowing how she would have managed well her mental health recovery underlines the negative impact that the experience of care can have on the mental state of patients. Even more, Rebecca’s acknowledgement that without her family she would have definitely needed psychological support shows the importance of offering psychological support to patients whilst they are in hospital.

For Michael, the lack of availability and emotional support of doctors due to their busy shifts prevented him from being able to share and talk to them about his feelings and his mental health. From Michael’s experience, despite experiencing more care from the nurses who took time to talk to him, an important aspect that made the difference for his recovery was the family support.

> The doctors weren’t always available, you know. They were really busy and they would take time to see me only if there was a change on my medication or to double-check how I was feeling after my surgery. The nurses were more caring because they had time to talk to the patients, but it didn’t make much difference, what was really important was my family. I used to have my family there every day, especially my wife is the one who was staying there with me and talking to me to keep me company (Michael, 116-130).

From Michael’s account I interpret that consistent family support allowed him to reduce the feelings of loneliness that he would have experienced otherwise whilst being in hospital. From his statement, it’s evident how the consistent daily support from his wife played an important role that compensated from the lack of support of doctors. This may evidence a possible lack of emotional support for patients who may have needed to talk about the way they were feeling whilst in hospital.

When talking about the importance of family support Christine explained how her experience of care would have been more difficult to face:

> If they hadn't been there, the hospital experience would certainly have been more grey. When I mean grey, I mean worse in everything for sure, more difficult to overcome, in everything… more effort, I would have experienced hospitalization with much more difficulty and I would not have recovered so quickly. If my family hadn't been there to help me emotionally then I would have gone into a crisis and I would have needed more psychological support. But luckily this didn't happen...(Chistine 281-293).

Christine’s meaning-making of her experience is that without her family support, she would have been in distress whilst being in hospital due to the lack of emotional support. From Christine’s account, the lack of emotional support that she would have had to face without her family support would have had detrimental implications for her ability to recover in hospital. This shows how the physical recovery of patients can be strictly connected to their emotional state. Therefore, from Christine’s account, the lack of emotional support in hospital can have detrimental repercussions on the overall recovery of patients especially when no family support is available to them.

Discussion

Chapter overview:

This chapter outlines a summary of my findings including Group Experiential Themes (GETs) and sub-themes. In my discussion I will take into consideration the aim of my research question and the previous literature. Limitations will then be explored together with the implications for CoP and the provision of support for severely injured patients with relevant recommendations for future research. Finally, I will provide a summary of the thesis with relevant limitations and implications. For clarity, I will refer to my research with 'The current study' or 'My study' and to other studies as 'This study'.

Summary of the Research

My analysis reveals the complexity and intricacies of the experiences of individuals with severe RTIs during their hospital stay. Participants identified how the experience of care was perceived to be life-changing, with an impact on their emotional state and affecting their ability to connect with their emotions. Also, participants identified how in their experiences, what made the difference was the importance of meaningful connections with others.

Four themes emerged from the data analysis where the most imminent was 'Life-changing experience' which included the aspects of care that impacted the lives of the individuals including the way they experienced being cared for and how it affected them overall. From this initial theme, participants also explained how their experiences influenced the way they felt, which was outlined in the second and third themes 'Negative impact on emotional state' and 'Inability to connect with emotions' which captured those aspects of the care experiences of participants that negatively impacted their overall emotional state leading them to experience numbness. Lastly, participants also reflected on those aspects that they considered to be important in making a difference in their experiences of care. This was outlined in the fourth theme ‘Meaningful connections matter’ where participants highlighted the importance of creating meaningful connections and receiving consistent emotional support from either family or hospital staff.

Findings and existing literature

Group Experiential Theme One: Life-Changing Experience

Within this GET, the life-changing aspects of participants’ experiences were divided in to sub-themes of: ‘Loss of independence’, ‘Feeling like a child’, and ‘It turned my life upside down’. ‘Loss of independence’ was a well-established finding in the literature where participants reported how their injuries were experienced as a limitation. However, current findings add to the existing literature by outlining how participants felt towards their physical limitations and the reasons why. ‘Feeling like a child’ and ‘It turned my life upside down’ instead, add to the available literature as they offer an in-depth overview of how participants felt during their experiences of care and which aspects were considered to be life-changing.

‘Loss of independence’ for some participants referred to the impact of permanent physical limitations that they encountered as a result of their injuries. This aspect included a change in the identity of participants who no longer could be as independent as they used to be, longing for their lives before the accident. Findings from Sabet et al. (2016a) similarly showed how participants experienced limitations in physical functioning, familial and occupational duties after their injuries. Furthermore, ‘Loss of independence’ also aligns with Yadav and Shrestha (2017)’s findings whose participants experienced various limitations during their return to acceptable physical activity, return of changed roles and returning to work. However, results from these two studies are exclusively referred to the limitations that participants experienced in their familial, occupational and daily routine duties and no further information is provided in relation to how these limitations left them feeling. Finding from my study may add to the existing RTC literature as participants expressed how their loss of independence through physical and emotional limitations caused them to experience changes in their identity where they no longer felt the same person after their loss of independence. This aligns with previous research based on participants' experiences of RTIs which reported that participants experienced limitations in their daily activities which led to loneliness and social isolation (Sabet et al., 2016b). However, findings from Sabet et al. (2016b) were focused on the experiences of RTIs, without specifying whether those limitations were experienced whilst being cared for in hospital. Therefore, the current study provides additional information on how the experiences of care for individuals with severe RTIs often include a loss of independence due to the physical limitations that participants have to encounter. Consequently, this loss has an impact on the perceptions of participants' identities due to the inability of engaging in activities they used to do prior their collisions and to express their emotions related to it.

In their experience of losing independence participants also voiced experiencing their body as a limitation in regards to communicating their needs and feelings. These results are resonant of Sabet et al's (2016a) findings where participants experienced physical limitations when returning to their normal life. However, in the same study, the physical limitations described were discussed in relation to the way participants adapted with their new routines and no details were provided in relation to how participants felt limited. Results from the current study instead, provide an important addition to the existing literature as participants were emotionally and physically limited due to their inability to express and verbalise how they felt to the hospital staff and their families when they needed to. Furthermore, losing independence for participants consisted in the inability to autonomously attend to their personal hygiene causing them to experience self-disgust and embarrassment with potential negative implications on their mood. This was also reported by Franzén et al. (2006) whose participants disclosed experiencing embarrassment after encountering their injuries. However, in Franzén et al. (2006)'s findings, the feelings of embarrassment were related to the accident and the self-blame that participants put on themselves for it. Participants from my study instead, experienced embarrassment when they had to become dependent on the help of others which is one of the most common components of healthcare delivery when patients are hospitalised (WHO, 2022a). Therefore, my results contribute to the current literature evidencing how the loss of independence experienced in hospital can cause patients to experience both physical and emotional limitations with detrimental consequences to their sense of identity and their ability to express their needs and feelings. Even more, participants' experience of losing independence meant having to become dependent on the help of others which often caused them to experience anger, embarrassment and self-disgust during their experiences of care.

In my second sub-theme 'feeling like a child' participants voiced the experience of feeling like a child due to either having to be physically dependent on others, feeling helpless and having to start from zero during recovery and experiencing a loss of control over their bodies. These findings may be resonant of Nutbeam et al's (2022) findings where participants reported experiencing a loss of autonomy when they did not feel listened by emergency workers during their experiences of extrications. However, the loss of autonomy experienced by participants from Nutbeam et al. (2022), was uniquely referred to the lack of communication and active listening by emergency workers. Results from the current study add to this as participants' loss of autonomy consisted of having to become dependent on the help of others and starting from zero with their physical movements during their care experiences in hospital. All these aspects were experienced as a state of regression to their childhood where they became dependent on the help of others again due to their physical limitations. For participants this experience meant feeling powerless and vulnerable.

Furthermore, feeling like a child was also experienced by participants of the current study as dying and being born again as more wise and experienced individuals who had the opportunity to rebuild their value system. These findings echoes the experiences of participants from Franzén et al. (2006) study who explained how they tried to see their accident as a rebirth event that gave them the opportunity to love their lives and be proud of it. Franzén et al's (2006) participants however, did not experience this, rather they attempted to use this positive thinking as an adaptation skill to accept their difficult situation. My participants instead, experienced the accident and the recovery process as their old life ending, proving them with an opportunity to live their lives differently rather than attempting to use it as a coping strategy. This may indicate how participants from the current study may have experienced post-traumatic growth (PTG) which is defined as the experience of positive changes in response to the confrontation with extreme negative experiences (Pat-Horenczyk & Brom, 2007). Indeed, previous research sustained that PTG is a common response on individuals involved in RTCs, who experienced a more positive and efficient adaptation to their situation, with significant improvements to their quality of life (Wu et al., 2016). This shows how impactful the experience of care can be for individuals with severe RTIs, whose experience of feeling very close to death brought them to reconsider their value system and therefore changing their lives by shaping their new identity from scratch. This is in line with Cagnetta and Cicognani (1999) who explained that RTC-injured individuals often find themselves in a real crisis condition that expose them to experience trauma as a positive turning point in their lives. Therefore, the experience of feeling like a child for participants in the current study adds to the current literature by showing how the experience of care had a life-changing impact on participants who experienced care as a stage of regression yet as an opportunity to be born again.

This is also in line with my third sub-theme ‘It turned my life upside down’ which for participants referred to the fast, sudden, unexpected and irreversible change in life that participants had to face during their experiences of care. For participants in Sabet et al. (2016a) returning to their normal lives consisted in having to adapt with the new situation due to the physical limitations of their injuries. However, these findings are limited to the description of the temporary impact that physical limitations had on the lives of participants. My research goes further by explaining how the change in life for participants was resulting from the impact of their life-changing injuries, the impact of the accident and the life-threatening conditions that brought participants to feel powerless and angry during their experiences of care. Even more, for participants feeling like their lives turned upside down meant using the experience of care as a motivator of wanting to live their lives more actively and meaningfully. These findings echoes those from Tan et al. (2008) whose participants reviewed and reflected on their lives realising what was important for motivating them to change and transform many aspects of their lives and planning for their future.

Therefore, GET one outlines how the experiences of participants were considered to be life-changing through different aspects of care that they encountered. These aspects included loss of independence which consisted of physical and emotional limitations that caused participants to experience: a change in their identity, limitations in their ability to communicate, and increased dependency on the help of others. These aspects negatively affected the mood of participants who often felt embarrassed and angry. Life-changing was also the experience of feeling like a child for participants, whose loss of independence was experienced a state of regression and helplessness, yet as an opportunity to be reborn and rebuild their value system. Participants also experienced having their lives turned upside down due to the intense, permanent and irreversible change in life that they had to experience. This change was a result of the impact of their injuries, their accidents and the life-threatening conditions that participants had to face during their care experiences. In response to this change, some participants felt powerless and angry whereas others saw it as a second chance where to adapt and transform their lives in a meaningful way. All these aspects align with the theoretical framework of this thesis based on trauma-informed care, showing how traumatic experiences can have a substantial influence on the lives of patients which, consequently impacted their experiences of care in different ways.

Group Experiential Theme Two: Negative Impact on Emotional state

When discussing the experiences of care participants demonstrated how their emotional state was negatively impacted through different experiences. These will be explained through the following sub-themes: ‘Self-blame and disregard for feelings’, ‘Lack of understanding for others’ and ‘Negative experiences of care’. All these sub-themes were linked to some of the findings withing the existing literature, however, they add new knowledge on the way participants felt and consequently behaved during their experiences of care.

The first sub-theme ‘Self-blame and disregard for feelings’ was evident during interviews when participants showed a tendency to blame themselves and disregard their feelings in relation to their experiences of care. Self-blame was also evident in participants from Franzén et al. (2006) who blamed themselves for the accident and perceived their injury event as embarrassing. However, in the same study, no further information was provided about the way participants reacted towards their self-blame. The current study adds to this as when participants appeared blamed themselves for the accident and their injuries they showed a tendency to disregard their feelings and needs whilst receiving care in hospital. This is in line with previous research from Yadav and Shrestha (2017) who identified that participants used emotional focused strategies such as blame to reduce the intensity of their distressing emotions. Furthermore, in the same study, participants who blamed themselves were found to show more positive emotions and positive thinking. From the current study instead, participants reported feeling like completely different people, showing anger only towards their actions and underlying what could have been done differently to avoid their collisions. This indicated that the only feeling they may have allowed themselves to experience was the anger towards themselves which could have led them to disregard their feelings and needs during their care experiences.

Furthermore, in the current study, participants who blamed themselves for the accident and their injuries felt unworthy of being in distress or sad about it, showing a tendency to disregard their feelings and attributing responsibility to themselves for not receiving more emotional support in hospital. This is an important aspect to take into consideration as when patients may experience emotional distress and/or may need to receive emotional support, it could often be hidden and not voiced during their stay in hospital due to the possible shame that they experienced in their situations. This aligns with the concept of shame that is often experienced by patients within the healthcare setting. Patients' shame often gets exacerbated during interactions with healthcare professionals due to the exposure of aspects of self that may be perceived as shameful, leading patients feeling unworthy and perhaps avoiding seeking medical help when in need. Therefore, hospital staff may be advised to pay careful consideration to the needs of patients even when they seem in no need of any further support. This aspect will be further explored in the Implications and Recommendations section of this chapter.

This complements findings in the second sub-theme 'Lack of understanding from others' where participants experienced a lack empathy or understanding from others towards their situation and their recovery. Lack of understanding from others for some participants was experienced during their interactions with doctors who did not seem to empathise with them or to take into consideration the life-changing impact of their injuries. These findings echoes those from Franzén et al. (2006) where participants who experienced non-active listening and insensitivity towards their needs by the hospital staff resulted to experience increased worry, uncertainty and feeling disrespected. The current study add to these results by showing how the lack of understanding and empathy from doctors, friends and family resulted in minimising what was happening to participants leading them to isolate themselves feeling misunderstood, lonely and judged for their feelings. This adds to the current literature as participants who experience a lack of understanding from others may experience further distress with possible tendency isolated themselves.

These findings link to the third sub-theme ‘Negative experiences of care’ which included participant’s experiences of lacking empathy from doctors, leading to feelings of being misunderstood, frustrated, powerless and lonely in their experiences of care. This is in line with Franzén et al’s (2006) findings where participants experienced a lack of support from caregivers who had no interest in listening and explaining the course of events to patients in a comprehensive way. This resulted in participants feeling anger and despair towards hospital rules and routines that took over their needs with a total lack of compassion from caregivers. Adding to this, participants from my study showed how the lack of empathy from doctors may have led them to experience possible loneliness in their experiences of emotional pain. Even more, participants’ experiences of care included lacking sleep and experiencing unexpected side effects from treatments that led them feeling out of control through their medications. The experience of being restrained whilst not being able to communicate their needs or feelings, led participants feeling powerless and out of control over the care that they were receiving. This aligns with relevant literature based on the experiences of extrication after an RTC which reported that communication failures between emergency workers and patients may limit emergency workers' ability to meet patients' needs and to prevent them from experiencing further distress (Nutbeam et al., 2022).

Additionally, from the current study, participants who have been discharged prematurely from hospital before completing their recovery left them feeling let down, having low expectation in the healthcare system, leaving their needs unmet. This is similar to Franzén et al. (2006) where participants experienced non-active listening and insensitivity from hospital staff towards their needs when being discharged either against their will or without having a conversation or information about it. This left them feeling worried and disrespected. Even more, participants in the same study reported feeling hindered after hospital discharge when they had to manage on their own. However, Franzén et al. (2006) does not provide any additional information about what managing on their own meant for participants. The current study can add to this because the participants who felt let down after hospital discharge experienced possible surrender towards the healthcare system, turning to self-care and self-efficacy in the search for further support privately and their own expenses due to premature discharge. This may shows how when patients' needs are not met during or after their experiences of care, it leaves them with no trust and low expectations towards the support that they can receive, limiting their ability to recover completely.

Therefore, GET two outlines how the negative impact on emotional state consisted in participants experiencing feelings of self-blame which brought them to disregard their feelings and feeling unworthy of being in distress and ask for support. Even more, the negative impact on the emotional state of participants was exacerbated by the lack of understanding from others which left participants experiencing distress during their hospital stay. Lastly, negative experiences of care led participants to possibly feel let down with low trust and expectations towards the care they received in hospital. Consequently, participants would search for further support privately in order to recover completely.

Group Experiential Theme Three: Inability To Connect With Emotions

During their experiences of care participants experienced difficulties in connecting with their emotions as well as a general sense of numbness. This was also evident during their interviews where they were unable to show or describe emotions during the narration of events which appeared to be apathetic. The sub-theme ‘Experiencing emotional numbness’ was reported by existing literature when exploring participant’s reactions on the moment of their collisions. Findings from the current research add to this knowledge because they refer to the experiences of care in particular. ‘Apathetic narration of events’ during interviews instead, add new knowledge to the existing literature, alluding to participant’s potential inability to connect with emotions during their interviews.

‘Experiencing emotional numbness’ outlines the inability of participants to connect with their emotions during their experiences of care. This was particularly evident during moments of discomfort and embarrassment whilst being treated in hospital due to their inability to move. Numbness was also experienced when receiving life-changing news about their injuries which left them unable to process and realise what was happening due to the speed in which the news was being delivered. This is in line with Tan et al. (2008) whose participants felt numb and empty in response to their collisions. However, in Tan et al. (2008)’s results, numbness was described as a response at the time of the accident rather than in relation to their experiences of care. My results add to the current literature as participants experienced an inability to connect with their emotions in response to their experiences of care. Specifically, participants experienced numbness during moments of discomfort, embarrassment, or when receiving life-changing news in relation to their physical health which may have been a coping strategy to deal with the painful feelings related to their experience of care. This shows how overwhelming some aspects of care can be for patients who may be avoiding or may be unable to voice their feelings due to the numbness experienced in hospital and their inability to process their emotions. This aligns with previous research on individuals' experiences of RTCs who identified that emotional numbness was often experienced in order to avoid distressing memories and functioned as a barrier from voicing their feelings and needs (Wilson et al., 2020). However, the focus of the current study was not based on how numbness prevents participants from voicing their needs therefore, future research may benefit exploring the role played by numbness preventing participants from sharing their feelings or needs during their care experiences.

An inability to connect with emotions was evident during the research interviews where participants engaged in an 'apathetic narration of events'. This was perceivable when participants described the course of events of their accident as well as the experience of encountering injuries. Even more, for some participants, the apathetic narration included minimising the severity of their injuries and by using reductionist adjectives to describe them or by avoiding sharing the feelings related to them. This is an important factor to take into consideration because it may be a result of possible avoidance towards remembering the overwhelming and distressing pain or feelings related to their injuries. Perhaps this may indicate a possible limitation in my study where participants may have found the interview experience too overwhelming and therefore they may have needed to protect themselves from it (Temple & Young, 2004). This limitation will be further explored in the 'Participants' engagement' section of this chapter. Lastly, current findings indicate that participants may minimise or disregard their feelings in relation to their injuries during their care experiences. This links with findings from Yadav and Shrestha (2017) where participants used avoidance and denial as coping strategies to reduce the intensity of their emotional distress during the initial phase after trauma. Therefore, future research would benefit from exploring further the avoidance of the feelings related to their experiences and participants' meaning-making in relation to it.

Therefore, GET three outlines participants' inability to connect with their emotions during moments of discomfort, embarrassment and whilst receiving life-changing news and lacking time to process what was happening in their experiences of care. This caused participants to experience emotional numbness as a potential coping strategy from the painful feelings related to their care experiences. Furthermore, participant's apathetic narration of events was evident during interviews where they minimised what has happened and avoided describing their feelings. Therefore, this GET underlines participants' possible tendency to avoid their emotions and minimise their experiences as a coping strategy both during and after their experiences of care.

Group Experiential Theme four: Meaningful Connections Matter

This GET outlines the following sub-themes: 'The importance of being seen holistically' and 'Family support as a compensation'. These sub-themes align with available literature which established the importance of being seen holistically through positive interactions amongst patients and hospital staff. Current findings add to the available knowledge by exploring participants' feelings in response to both positive and negative interactions with hospital staff, and the lack of emotional support offered in hospital. Family support was also an aspect that the literature outlined to be important however, current findings add to this because they show participants' experiences of family support as a compensation from the lack of emotional support in hospital.

‘The importance of being seen holistically’ outlines participants’ needs of having meaningful experiences of care. For participants, this was expressed through both positive and negative experiences in their interactions with the hospital staff. For example, positive interactions were experienced with hospital when they took time to explain and reassure participants of what was happening, which consequently led participants to feel grateful and supported. This aligns with Yadav and Shrestha (2017)’s findings who discovered that having someone close, who patients can trust, during acute phases give them a sense of security. More specifically, in Yadav and Shrestha (2017), patients’ trust was gained with caring qualities such as being friendly, patient, treating them as family members, motivating and explaining procedure as well as always being concerned and asked about the pain that they were experiencing. The current study adds to this as hospital staff taking into consideration participants’ age and family support whilst being prompt and kind towards their needs, allowed participants to feel cared for and supported. Moreover, participants from the current study expressed feeling a sense of connection and gratitude towards the hospital staff for saving and keeping them alive due to the life-threatening nature of their injuries. This showed how the relationship that participants had with hospital staff included establishing a relationship of reliance and trust in a moment where they were totally vulnerable and dependent. Participants also indicated feeling cared for when hospital staff went beyond their job roles and responsibility to care for them, when they were passionate, putting love and care in what they do. All these characteristics led to patients feeling valued, grateful and emotionally connected with them. This aligns with the biopsychosocial model of healthcare, where the psychological component of patients’ health is considered an important part of their recovery that needs to be considered when delivering healthcare to patients.

Some participants instead, expressed the importance of being seen holistically through the narration of some negative interactions with the hospital staff. In particular, participants discussed experiences of feeling seen only through their bodies by hospital staff which led them feeling ignored and unvalidated. This is in line with Franzén et al. (2006)'s findings, whose participants reported feeling neglected and disrespected by hospital staff during hospital rounds when no interest was shown in the individual as a person. Despite Franzén et al. (2006)'s results were similar to the ones of the current study, no more information was provided about the meaning behind the lack of interest on patients as whole persons. The current study instead, shows how participants feeling seen only through their bodies meant experiencing a lack of interest for their emotional state and for their thoughts on the care they were receiving, leaving them feeling excluded and powerless from the decisions related to their care and their physical conditions. Even more, my study adds to Franzén et al. (2006)'s results as when participants were not treated holistically they felt ignored and unvalidated in their experiences of care.

When reflecting on the importance of being seen holistically, all participants voiced the importance of providing emotional support in hospital, due to both the life-changing impact of their care experiences and the loneliness that participants are subjected to experience. This aligns with findings on from (Nutbeam et al., 2022), which sustained that providing information and emotional support to patients allows them develop a sense of safety whilst preventing negative health outcomes. Moreover, from the current study it was also evident how participants not asking for emotional support during their care experiences may be resulting from their feelings of embarrassment and shame towards mental health, or lacking awareness of the option of receiving further support during their stay in hospital. This is another aspect to take into consideration as individuals may not always be aware of the option of receiving psychological support during their stay in hospital, or they may be embarrassed and therefore, they might not ask for emotional support even when in need. This echoes findings by Wilson et al. (2020) which reported that participants saw the act of emotional numbness as a demonstration of inner strength because it was used as a deliberate strategy for preventing family and friends from noticing their emotional pain. However, Wilson et al. (2020) focused on the experiences of RTCs rather than the care experiences of individuals and no further information was provided as to why participants felt the need to hide their emotional pain. Therefore, future research may benefit from exploring this aspect further to identify the barriers preventing RTC-injured patients from asking for emotional support during their care experiences.

‘Family support as a compensation’ outlines how participants expressed the importance of consistent family support which facilitated their recovery and prevented them from falling apart and from needing emotional support during their care experiences. This adds to Tan et al’s (2008) results which, when exploring the way participants survived the impact of the accidents through coping strategies, participants highlighted how the support from family and friends provided a great source of comfort for them. However, no further information was provided in relation to the reasons why the support from family and friends was a coping strategy, nor it was specified which aspects of their collision participants survived. When reflecting on these aspects in my study, participants doubted their ability to recover mentally without family support due to the loneliness that they may have experienced in hospital otherwise, indicating a possible lack of emotional support offered during their experiences of care. Therefore, family support as a compensation from the lack of emotional support in hospital shows how detrimental and lonely the experience of care could be for the mental health of participants who voiced the need of receiving consistent emotional support during their stay in hospital in order to recover. Participants attributing their ability to recover to the consistent emotional support received by their families, echoes findings from previous research supporting that psychological comorbidity predicts prolonged recovery periods in hospital (Alharbi et al., 2019; Marasini et al., 2022). This also complements previous studies that found that the presence of relatives during hospital stays contributes to patient's feelings of trust and security who also attribute their recovery in part to presence of family (Franzén et al; 2006). This aspect has also been seen by Wilson et al's (2020) findings on the experiences of RTCs where participants reported that family support played a major role in their recovery due to the constant assistance with daily chores and activities and constant visits during their hospitalisations. Therefore, findings from the current study add to the present literature showing how family support functioned as a preventative measure for participants from needing emotional support during their care experiences, indicating that the care experiences after a severe RTI could often predispose individuals to experience loneliness due to the lack of emotional support offered in hospital.

Therefore, findings from GET four show the importance that patients give to meaningful connections during their care experiences. Specifically, participants voiced the importance of being seen holistically by hospital staff who should take time to explain what's happening to patients and offering emotional support when caring for them. Even more, participants voiced the importance of family support as a compensation from the lack of emotional support offered during their experiences of care. Specifically, participants underlined how without this kind of support, the experiences of care would otherwise cause loneliness and distress causing a possible delay in their ability to recover.

In conclusion, in line with the theoretical frameworks of this thesis, the discussed findings underlined: the importance of taking into consideration subjective experiences of patients in relation to the healthcare they received, the role that stigma and shame plays on this, and the importance of considering how trauma has an impact on such experiences within the healthcare setting. More specifically, GET one showed the experiences of care can have an intense, permanent and irreversible life-changing impact on participants who, despite their ability to adapt and grow, they can also be subjected to detrimental consequences on their self-esteem, sense of identity and sense of control in their lives. GET two, outlines participants' tendency to blame themselves and disregard their feelings which consequently impacted their ability to acknowledge their needs and ask for support during their care experiences. Even more, patients' emotional state was negatively impacted by the lack of understanding from others and the negative experiences of care which led to participants feeling lonely, powerless and let down during their experiences of care. GET three showed how during their care experiences participants experienced numbness during potential overwhelming and distressing situations in hospital. Furthermore, participants appeared apathic and dismissive of their needs and feelings when narrating events during interviews, indicating a general inability to connect with their emotions during and after their experiences of care. Lastly, GET four outlines the importance of meaningful connections with doctors and family during participants' experiences of care. This included the importance being seen holistically by hospital staff whose passionate and caring attitudes, and going beyond their job roles to meet patients' needs led participants feeling cared for and supported. Furthermore, participants voiced the need of receiving consistent emotional support due to life-changing impact of their care experiences and the potential emotional detriment that they could have experienced otherwise.

Limitations

I chose to use IPA to explore the experiences of care amongst severely injured individuals in RTCs. In this section, I will discuss the limitations of my study and discuss implications and recommendations for future research.

The Role of Language

One of the first limitations of the current study is that my interviews were conducted in Italian, and subsequently translated in English. My position as a researcher and translator aimed to capture the meaning conveyed by participants in a way that stayed as close as possible to their Italian accounts. However, this process aimed to capture my understanding of the participant's accounts so it is important to consider to what extent the translated quotes retain the voices of my participants. Considering that interviews were firstly conducted in Italian and then translated to English, the transparency of transcripts can only be evaluated by an Italian speaking native. However, the choice of having a dual role of researcher and translator in the research was reflected on and supported by previous research that indicated that the dual-role gives an opportunity to the researcher to experience difficulty in meaning equivalence that an outsider may not be aware of (Temple & Young, 2004). This is because a researcher who is fluent in the language of communities they are working with can use the translation experience as an opportunity to discuss points in the text where they have to stop and think about meaning. Furthermore, my dual role allowed me to analyse data without having to include the influence of the translator and therefore avoiding an addition to the interpretation. I was then able to make notes and observations in my interpretations which allowed me to retain the Italian tone of my participants. This also allowed me to ensure that the translated material conveyed my understanding of the meaning-making of my participants (Temple, 2005).

Participants' Engagement with Interviews and use of mental health screening

Although PHQ-9 and GAD-7 questionnaires were used as screening tools were used to screen participants' emotional distress, not using a PTSD or trauma scale is a limitation from an ethical perspective. This is because interviews may have triggered traumatic memories related to the accidents and injuries for participants. Even more, during interviews, participants' engagement with the data could have been clouded by potential shame, embarrassment or distress when talking about their experiences of care and the feelings related to it. This was particularly evident in the sub-theme 'Apathetic narration of events' during interviews where participants may have found the interview experience to be too overwhelming and therefore it could have influenced the depth of experience they shared with me. In order to mitigate this, I attempted to set out a safe space by providing participants with sufficient information about the research and reminding them their right to withdraw or modify their consent to participate anytime. Moreover, the use of active listening, an empathic tone of voice and offering participants the opportunity to pause allowed me to facilitate participants' engagement during interviews whilst minimising distress. I also took into account the power dynamics between me and my participants. I realised how my position as a trainee counselling psychologist researcher could have been perceived as a position of power from participants who were sharing their experiences of care as hospital patients (Hutchinson & Wilson, 1992). Therefore, I ensured to avoid the use of clinical terminology when communicating with them in order to avoid potential confusion about the topic whilst enhancing a sense of rapport and mutual trust in the research interview (Karnieli-Miller et al., 2009). I also allowed participants to ask any questions both before and after the interviews in order to clarify any doubts in relation to what has been discussed (Anyan, 2013).

Sample size

Lastly, the sample size of four participants may raise issues with transferability. Despite the various guidance suggesting some opaque direction on sample sizes between three to six or four to ten participants, in the available literature there is a lack of clear direction on sample size, suggesting that this should be tailored to the research questions (Giorgi, 2009; Smith et al., 2009; Wertz, 2005). Furthermore, Bartholomew et al. (2021) warns researchers against going above the recommended sample size as a negative relationship between sample size and study quality was found in their study. Instead, they recommended researchers to be certain of their ability to answer the research question with the data they have. This is because, phenomenological research adopts an attitude that places emphasis on imaginative variation the expressions of few individuals (Smith et al., 2009). These emphases influence sampling in phenomenology where “too many voices could foster discord, or a cacophony, when depicting results whereas a focused sample may encourage a more harmonious expression of participants’ interpreted lived experiences in which individual voices are honoured and can contribute to a coherent whole” (Bartholomew et al., 2021).

Reflexivity

Central to good quality in qualitative research should be reflexivity. From early stages of forming the research question through to the writing of the thesis I have become increasingly aware of how my views and assumptions have influenced the research process. For this reason, I made sure to engage in reflexive journaling throughout the whole process of this research with the aim of reflecting on how my previous experiences and motivations may influence the decisions made throughout the research. As an Italian individual who has experienced severe injuries from a road traffic accident in Italy, I can be described as an ‘insider’ in this research (Yardley, 2000). On one hand, this allowed me to evoke more information in the interview process due to the awareness and attention of cultural nuances. However, being an insider may have raised some issues as my perception might be clouded by my personal experience with potential difficulty separating it from that of the participants. Moreover, I engaged in detailed reflection on the research process to build awareness towards my own personal biases and perspectives with the aim to reduce potential concerns associated with the insider position (Olmos-Vega et al., 2023). According to Dwyer and Buckle (2009) the core ingredient of being a researcher is not the insider or outsider position but rather, the researcher’s ability to be open, authentic and interested in accurately and adequately represent the experience of participants.

Implications and Recommendations

Practice in Counselling Psychology

The discussed findings indicate that the experiences of care after being severely injured in an RTC have been life-changing for participants. Specifically, participants reported how the loss of their independence and the experience of feeling like a child had detrimental implications on their mood impacting their sense of identity. Despite the ability of some participants to adapt and transform their lives in a meaningful way, the third sub-theme 'It turned my life upside down' suggests how sudden and unexpected the life-change was for participants. Therefore, therapy practice with individuals with severe RTIs may benefit from exploring the meaning behind going through a sudden and unexpected change allowing them to learn ways to manage the feelings related to it. It may also be helpful for practitioners to explore the impact on the identity of participants and the meaning behind the relationship between identity and loss of independence. Therapy practice may introduce psychological interventions such as resilience enhancement and modifying cognitive processes into more adaptive patterns of thought can promote cognitive flexibility and active coping (Kalisch, 2015).

Additionally, findings suggested that participants experienced an overall negative impact on their emotional state. Specifically participants who experienced self-blame demonstrated a tendency to disregard their feelings whilst feeling unworthy of experiencing any emotional distress or receive support for it. Therefore, therapy practice may allow participants to explore the relation between self-blame, shame and stigma by introducing mindfulness-based interventions whose target is the context, function and way of relating to clients' self-blaming thoughts and the degree to which such thoughts are held with psychological flexibility (Hayes et al., 2011).

Participants also demonstrated an inability to connect with their emotions when they experienced numbness during their care experiences and apathy during their narration of events in interviews. Practitioners may explore the role of both these aspects in order to understand participants' potential coping strategies in regards to painful feelings as well as their ability the process emotions in the therapy room. Even more, therapy practice may allow clients learning helpful coping strategies such as emotional regulation, grounding strategies and mindfulness in order to allow clients to adapt more efficiently to stress and to increase their cognitive flexibility by learning to accept negative situations and emotions (Grossman, 2004).

Lastly, the forth GET 'Meaningful connections matter' showed the importance of meaningful connections including the importance of being seen holistically, the need for more emotional support and the importance of family support. These aspects underline how participants expressed the need of consistent emotional support due to the impact of their care experiences, their injuries and their accidents as well. As suggested by previous research (Bergbom & Askwall, 2000; Muscatelli et al., 2017) it may be useful to implement specific support services for individuals during their hospitalisation experience with the aim to prevent exacerbation of further emotional distress. Even more, increasing psychoeducation and awareness of these aspects via training for hospital staff may improve individuals' psychological outcomes during and after their experiences of care (Søvold et al., 2021).

Future Research

Different types of research and epistemological underpinnings may contribute to the knowledge and understanding of the experiences of care and a severe RTI and the provision of further support.

Future research may focus on aspects related to the experience of losing independence in hospital and the identity of patients after an RTI. This would allow research to explore the meaning behind losing independence and the implications on the emotional state of patients who may experience changes in their identity. This may predict potential emotional distress that patients may experience during hospital care allowing clinicians to anticipate the psychological sequalae related to the loss of independence of their patients.

Research from social constructionist perspectives can explore discourses such as the role of language and culture in their perception of psychological support. Considering these topics in the context of the Italian culture may allow the identification of any barriers to seek or access psychological support including stigma, stereotypes, shame, mental health awareness and traffic safety. Even more, social constructionist research may explore the level of guilt that participants have for their accidents and how this changes the way they talk about their experiences or their emotional distress. This would provide knowledge on the aspects to take into consideration when relating to patients during their experiences of care or when conducting mental health assessments.

Taking into account GET two ‘Negative impact on emotional state’, future qualitative research may focus on the experiences of caregivers in meeting the needs of patients who are unable to communicate their needs in hospital. These may then be used to inform which aspects of care provision could be improved in order to help caregivers responding to patient’s needs.

Additionally, taking into account the inability of patients to connect with their emotions, future research may want to focus on patients’ needs in hospital. A quantitative methodology may help to identify the percentage of patients who experience numbness during their hospital stay allowing caregivers to pay attention to historical backgrounds, triggers and possible early warning signs. On the other hand, qualitative longitudinal research with the use of diary entries may allow participants to share their experiences of care and identify the role played by numbness and avoidance of feelings during their experiences of care and after hospital discharge.

Lastly, the sub-theme ‘Family support as a compensation’ shows how the support of family prevented participants from experiencing further emotional distress. Quantitative research may investigate whether there are any correlations between the psychological outcomes of participants with this kind of support and participants without. This would allow to identify key aspects of care and support that are helpful or not helpful in predicting negative psychological outcomes after an RTI.

Conclusions

The current study explored the experience of care after a severe RTI in Italy. IPA, with its appropriateness to my phenomenological attitude and value in meaning-making, was used to analyse four interviews with Italian participants who have received hospital care for a severe injury as a result of an RTC. Findings reported that participants experienced care to be life-changing due to their experiences of losing independence, feeling like a child, and feeling like their life turned upside down. Consequently, findings indicated that participants experienced a negative impact on their emotional state where they showed a tendency to self-blame and disregard their feelings. Participants’ emotional state was also affected by the lack of understanding from others and the negative experiences of care. Furthermore, participants demonstrated an inability to connect with their emotions. This was evident from their experience of emotional numbness in hospital and on their apathetic narration of events during the interviews. Lastly, participants highlighted the importance of meaningful connections during their experiences of care which included being seen holistically by hospital staff, and the support from family and friends as a compensation from the lack of emotional support provided in hospital.

The findings presented above offer insights regarding the meanings participants made of their experiences of care and the aspect that they considered to be more helpful or less helpful in their recovery. After carefully considering the limitations of my study, recommendations and implications for future practice in CoP and research were provided. This aimed to contribute to the body of knowledge in CoP in this topic and to refine future practice in the provision of support for RTC-injured individuals.

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Appendix A: Ethical Approval

University of East London

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:	Please type your full name **Deborah Lee**
Supervisor:	Please type supervisor's full name **Vanessa Contreras-Negretti**
Student:	Please type student's full nameOr **Elisa Piotto**
Course:	Please type course name **Prof Doc Counselling in Psychology**
Title of proposed study:	**Experiences of Care following a Road Traffic Collision: A Phenomenological Study of Injured Individuals**

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	☐	☐	☐
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	☐	☐	☐
Clear and detailed outline of data collection	☐	☐	☐
Data collection appropriate for target sample	☐	☐	☐
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	☐	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
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

Please clearly detail the amendments the student is required to make

Major amendments

Please clearly detail the amendments the student is required to make

Assessment of risk to researcher

Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **<u>adequate risk assessment.</u>**	

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

HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
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):	**The researcher has addressed the risks in the application.**

Reviewer's signature

Reviewer: (Typed name to act as signature)	**DA Lee**
Date:	**25823**

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

RESEARCHER PLEASE NOTE

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

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

Confirmation of minor amendments

(Student to complete)

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

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

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

University of East London

School of Psychology Ethics Committee

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for a proposed title change to an ethics application that has been approved by the School of Psychology

By applying for a change of title request, you confirm that in doing so, the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed, then you are required to complete an 'Ethics Application Amendment Form'.

How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).

3	Using your UEL email address, email the completed request form along with associated documents to Dr Jérémy Lemoine (School Research Ethics Committee Member): j.lemoine@uel.ac.uk
4	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.

Required documents

A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	**Elisa Piotto**
Programme of study:	**Professional Doctorate in Counselling Psychology**
Title of research:	Experiences of Care following a Road Traffic Collision: A Phenomenological Study of Injured Individuals in Italy
Name of supervisor:	**Dr. Lydia Tan**

Proposed title change

Briefly outline the nature of your proposed title change in the boxes below

Old title:	Experiences of Care following a Road Traffic Collision: A Phenomenological Study of Injured Individuals
New title:	Experiences of Care following a Road Traffic Collision: A Phenomenological Study of Injured Individuals in Italy
Rationale:	Experiences of Care following a Road Traffic Collision: A Phenomenological Study of Injured Individuals in Italy

Confirmation

Is your supervisor aware of your proposed change of title and in agreement with it?	**YES** ☒	**NO** ☐
Does your change of title impact the process of how you collected your data/conducted your research?	**YES** ☐	**NO** ☒

Student's signature	
Student: (Typed name to act as signature)	**Elisa Piotto**
Date:	**09/03/2024**

Reviewer's decision		
Title change approved:	**YES** ☒	**NO** ☐
Comments:	**The new title reflects better the location of the research study and will not impact the process of how the data are collected or how the research is conducted.**	
Reviewer: (Typed name to act as signature)	**Dr Jérémy Lemoine**	
Date:	**11/03/2024**	

University of East London

School of Psychology Ethics Committee

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology

Note that approval must be given for significant change to research procedure that impact on ethical protocol. If you are not sure as to whether your proposed amendment warrants approval, consult your supervisor or contact Dr Trishna Patel (Chair of School Ethics Committee).

How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	When submitting this request form, ensure that all necessary documents are attached (see below).
4	Using your UEL email address, email the completed request form along with associated documents to Dr Trishna Patel: t.patel@uel.ac.uk
5	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.
6	Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

Required documents	
A copy of your previously approved ethics application with proposed amendment(s) added with track changes.	**YES** ☒
Copies of updated documents that may relate to your proposed amendment(s). For example, an updated recruitment notice, updated participant information sheet, updated consent form, etc.	**YES** ☒
A copy of the approval of your initial ethics application.	**YES** ☒

Details	
Name of applicant:	**Elisa Piotto**
Programme of study:	**Professional Doctorate Counselling Psychology**
Title of research:	Experiences of Care following a Road Traffic Collision: A Phenomenological Study of Injured Individuals
Name of supervisor:	**Dr. Lydia Tan**

Proposed amendment(s)

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
3.2 Summary Background and aims: To conduct phenomenological study of injured individuals in Italy and relevance in the UK	Research that focused on RTC s highlighted that RTC injuries are considered subjective experiences involving both physical and psychological consequences whose impact can influence individuals in unique ways (Franzen et al. 2006). For this reason, previous research highlighted the need to increase the awareness of healthcare professionals in relation to the physical and psychological recovery of RTC individuals (Mayou et al., 2002; McGarry et al., 2013). The recovery of severely injured RTC individuals often starts from the hospital admission which involves the delivery of care from healthcare professionals (Charmaz, 1995; Morse O'Brien, 1995). This recovery experience is often linked to an increased feeling of fragility, disorientation and vulnerability in individuals who are subjected to worsened mental health and quality of life in the future (Holbrook and Hoyt, 2004; Butcher and Ruston, 2008). This is because the physical and psychological recovery of individuals after an RTC was found to be

	interdependent, predicting future psychological comorbidities including PTSD, anxiety and Depression resulting from the injury severity, the impact of the RTC and the recovery experience in hospital (Marasini et al., 2022).However, research evidenced that there is a lack of qualitative resources available worldwide to understand the recovery experiences of RTC injured patients who receive care in hospitals which highlights the need to increase our understanding on such area (Peden, 2005). Most of the available literature aimed to measure the comorbidity of psychological distress as a result of either physical injuries, RTCs or both aspects together (Alharbi et al., 2019; Marasini et al., 2022; Craig et al., 2016). There is lack of understanding of the recovery aspects which limits the healthcare professionals' understanding of the aspects affecting the emotional wellbeing of such individuals who are likely to access therapy in the future (Sabet et al., 2016). Therefore, the aim of this research is to understand the recovery of individuals focusing on their care experiences in hospital after an RTC. Statistics in 2022 in Italy registered 165,889 road accidents with 223,475 injured individuals whereas the UK reported 135,480 casualties with 29,742 injured individuals (Istat, 2023). This means that there is a larger number of individuals in Italy that have been subjected to long hospital stay and recovery process (Istat, 2023). By conducting research on a topic that is prevalent across multiple countries, notably reported more in Italy rather than UK (Istat, 2023), practitioners will be more equipped to work with many RTC individuals whose experiences of care are known to be key aspects of both their physical and mental health wellbeing for the future. As the aim of the research is to shed light on the recovery aspects related to the emotional wellbeing of Italian individuals following an RTC injury, an in-depth understanding of their care experiences during their recovery will be transferrable for future research and practice in the UK as well. This research will be transferrable and useful in understanding the subjective experiences of recovery and care, known to have an influence on the physical and mental wellbeing of participants (Craig et al., 2016). Such contribute will be useful in the UK as physical and mental health wellbeing of individuals are expected to emerge in Counselling Psychologists' future work (Papadakaki, 2017). Furthermore, research conducted in Italy contributes to Counselling psychologist's knowledge

	of social and cultural explanations of distress which is needed to deliver psychological interventions more broadly and to raise the issue of inequality and discrimination in the society (Kagan et al., 2010).
3.5 Participants (Italian participants aged between 20 and 84 years old who speak English)	Purposive sampling with maximum variation in gender will include participants who have been involved in a road traffic collision with consequent severe injury in Italy. The sample size used in phenomenological research can range between four and ten participants which, following Smith et al., (2022) guidelines, five participants should provide an adequate range of data. Creswell (2012) suggested that the selection of participants in phenomenological research should reflect and represent the homogeneity of the participant's sample. This is to get a better estimate of the overall perceptions of participants in order to best help the researcher to understand the main phenomenon (Creswell, 2012). Therefore, I aim to recruit a minimum of 5 participants if possible. Participants will be given the right to withdraw from the research if they need to. Inclusion criteria will involve participants aged between 20 and 84 years old because in line with what research shows, out of all casualties in Italy, this is the age group that is most likely to be involved in a RTC in Italy (Istat 2022). Additionally, recruitment will involve participants who were involved in any type of RTCs. This is because previous literature found that the recurrence of psychological distress among RTC individuals was present regardless of the type of accident that they were involved in (Marasini et al., 2022). Participants will be required to understand the English language. This is needed in order to complete the relevant Injury Severity Score Questionnaires, Patient Health Questionnaire (PHQ-9) and Generalised Anxiety Disorders scale (GAD-7) whose original language is English (Baker et al., 1974; Kroenke et al., 2001; Spitzer et al., 2006). Participants must have been hospitalised for at least 2 days and the RTC must have happened at least three months and at most two years from the moment they are interviewed as

	autobiographical memory could vary. Autobiographical memory is a form of declarative or explicit memory that informs the storage of memories events that a person has, and the most reported events are recalled more accurately from the last few years of when the events have happened (Gunasekara et al., 2020; Roediger et al., 2017). Even more, only participants with severe physical injuries will be included in the study. This is because individuals presenting with these types of injuries resulted to be subjected to longer hospital length of stay and therefore with a wider range of care experiences (Lee et al., 2016). Injury severity will be screened through the global Abbreviated Injury Scale (AIS) before taking part in the study and the highest scores will be then summed to calculate the Injury Severity Score (ISS) (Gennarelli, 2008). This will be kept in its original language as Italian participants will be required to have knowledge of the English language in order to take part to the study. Furthermore, participants who encountered Traumatic Brain Injury (TBI) will not be included in the study. This is because participants' awareness will need to be as less affected as possible for the purpose of my study. However, TBI involves transient diminished consciousness resulting from an insult to the brain (Sbordone & Liter, 1995). Even more, research established that in order to protect the brain against PTSD, TBI can involve possible impaired consciousness limiting the awareness of the traumatic nature of the injury (Gil et al., 2005). Finally, participants with current mental health diagnosis will not be included in the study. This is because they have a higher tendency to be triggered by traumatic memories and flashbacks when discussing possible distressing events during interviews (Labott et al., 2013). Therefore, mental health screening will be conducted in English through the Patient Health Questionnaire (PHQ-9) and the Generalised Anxiety Disorder scale (GAD-7) and participants scoring 10 or higher will be excluded from the study (Kroenke et al., 2001; Spitzer et al., 2006).
3.6 Recruitment Strategy: Italian participants	I aim to recruit Italian participants through snowball sampling via word of mouth as the researcher was already approached by two Italian participants who are interested in taking part. Although this can

	provide potential benefits in reaching eligible participants, I am aware of the potential difficulty in recruiting participants in this setting. Therefore, a poster will be used to explain recruitment criteria and purpose of the study and only UEL accounts will be used to advertise the study and to communicate with participants.
3.8 Data collection and 3.11 Data Analysis (Semi-structured interviews will be conducted in Italian and immediately translated to English following the transcription + Translated Information Sheet, Consent Form and Debrief form)	This is because Italian is the language spoken in Italy and therefore the language in which participants express and capture their experiences (Willig, 2012). Considering reflexivity and my position as a researcher in IPA, my familiarity with Italian culture and the Italian language provides me with an opportunity to explore Italian participants' experiences whilst entering their world in the way they experience it (Willig, 2012). Phenomenological research is mainly interested in the content of the data and how the participant's account explains the phenomenon of interest (Willig, 2012). Yet, IPA does not seek to separate the subjectivity of an individual from the experience that they are reporting. Therefore, the role of language is expressive as a way of transmitting information from the participants to the researchers who are able to use language as a medium to understand how participants construct meaning (Willig, 2012; Heidegger, 1993). Furthermore, IPA pays attention to the choice of words, syntax, intonations and the meanings behind them, as well as emotional and psychological states that can be interpreted from these (Willig, 2012). As a phenomenological researcher, I focus on language in terms of the meanings communicated in Italian, and translation choices to interpret participants' accounts. Therefore, not only would I be at an advantage of knowing how to communicate in my participants' first language, but I would be better able to interpret participants' narratives (Temple & Koterba, 2009). However, I am aware that the impact of translating transcripts from Italian to English might present obstacles such as the loss of meaning in translation (Palanganas et al., 2017; Squires, 2009; Van Nes et al., 2010). I aim to tackle this challenge by engaging in reflexivity before and during the translation process whereby, instead of translating word by word using dictionary translation, I will retain foreign features and make notes of the meaning of those (Hammersley, 2010). This will allow me to remain closer to the meaning of words used by participants and avoid loss of meaning during translation (Pietkiewicz & Smith, 2014).

4.7 Long Term retention for the data. (Anonymised research data will be securely stored on the researcher's UEL's password-protected OneDrive account until qualification, after which point, it will be stored by the research supervisor on their UEL OneDrive.)	As recommended in the ethics amendments feedback
5.1 and Appendix D Risk Assessment (Please ensure that the risk ratings have been accurately calculated (for example, LxS); b) in terms of psychological distress to the researcher, please also include the use of research supervision; c) please include that contact information for supporting agencies in Italy will be provided to participants; d) please ensure that these supporting organisations have positive reviews by those who have used them.)	As recommended ethics amendments feedback
Participant Information Sheet, some font in a different style, introduce use of acronyms (e.g., RTC). PIS, GAD is for anxiety, so please include this alongside the explanation of measuring mood. PIS, section on confidentiality, is currently very long and repetitive in places, please reduce in length and ensure consistency in information.	As recommended ethics amendments feedback
Consent form, it is mentioned that short anonymised quotes might be used, but this is not explained in the PIS, please include. Debrief form, please include supporting organisations in Italy.	As recommended ethics amendments feedback

Confirmation

Is your supervisor aware of your proposed amendment(s) and have they agreed to these changes?	**YES** ☒	**NO** ☐

Student's signature

Student: (Typed name to act as signature)	**Elisa Piotto**
Date:	**03/12/2023**

Reviewer’s decision

Amendment(s) approved:	**YES** ☒	**NO** ☐
Comments:	These comments are for discussion with your research supervisor, you do not need to submit another form for review: - The ratings in the Risk Assessment Form still require adjusting (e.g., physical pain, 2 x 2 = 4). - PIS, how will information be kept secure and confidential section, please remove reference to storage on password protected laptops, as you already state data will be stored securely on UEL OneDrive. Also, please ensure you state the data will be stored by you on your UEL OneDrive until qualification, after which point it will be stored by the research supervisor on their UEL OneDrive – consistency in information across documents and the application form is important.	
Reviewer: (Typed name to act as signature)	**Trishna Patel**	
Date:	**06/12/2023**	

Appendix B: Information Sheet in English

PARTICIPANT INFORMATION SHEET

Experiences of Care following a Road Traffic Collision: A Phenomenological Study of Injured Individuals

Contact person: Elisa Piotto

Email: u2158996@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 Elisa Piotto. I am a doctorate student in the School of Psychology at the University of East London (UEL) and am studying for a Counselling Psychology degree. 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?

I am conducting research into Road Traffic Collisions (RTCs) Injuries and the experiences of care received by participants. The research aims to contribute to the understanding of RTC injured individuals, and their experiences of quality of care received in hospital. This is in line with the

Division of Counselling Psychology guidelines (2020) which focuses on the primacy of both physical and mental wellbeing of individuals. The unique contribution of the study would provide an insight into the aspects of the treatment provided to individuals who are likely to experience both physical and psychological consequences from RTCs.

Why have I been invited to take part?

To address the study aims, I am inviting adults aged between 18 and 49 years to take part in my research. If you have had a severe injury from a RTC at least 3 months and at most 2 years ago, and you have been hospitalised for at least 2 days in hospital, you are eligible to take part in the study. Please note that exclusion criteria will be applied for participants who encountered a Traumatic Brain Injury as a result of the RTC.

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 take part, you will be asked to take part to an online interview that will last 35 to 40 minutes.

- First you will be asked to fill in a consent form, to follow, you will be required to fill some questionnaires.
- The first questionnaire will be the Injury Severity Score (ISS) which is used to understand the severity of injuries that you encountered.
- To follow, you will be asked to complete Patient Health Questionnaire (PHQ-9) and Generalised Anxiety Disorder scale (GAD-7) which will determine your mood and anxiety scores.
- Participation will be approximately 50 minutes long.
- Interviews will take place online via videocall online on MS Teams.
- Interviews will consist in an informal chat where you will be asked to answer questions about your care experiences in hospital after having been involved in a Road Traffic Collision.
- Interviews will be audio-recorded on a password protected external device from which they will be immediately stored in password protected UEL One Drive account and deleted from the device.

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 asking to stop the interview and for the recording to be deleted. 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?

You might experience some distress during the interview when talking about a past experience, however the interview will involve general questions about the experience of hospitalization, and you don't need to answer all the questions if you don't want to. The formulation of the questions will take into consideration any possible triggers that you might experience and therefore try and minimise the likelihood of emotional distress. You have the right to withdraw from the interview at any time during the meeting and at that point the interview will be interrupted.

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:

- Croce Rossa Italiana (1520) Support Service available from Monday to Saturday from 8am to 8pm. Website: https://cri.it/supporto-psicologico/#:~:text=Per%20iniziare%20il%20percorso%20di,sabato%20dalle%208%20alle%2020
- Un ascolto sempre in linea: **800.274.274**. mobile **02.29007166**. email: linea.ascolto@progettoitaca.org. Website: https://www.progettoitacaparma.org/cosa-facciamo/linea-dascolto-numero-verde/
- Telefono Amico Italia, **022 327 2327**, Whatsapp **324 011 7252**, Email: mail@micaTAI.

- InOltre service **800 334 343, available 24/7** for emotional and psychological support.
- Pronto Soccorso Psicologico Centro Alfredo Rampi: **800.68.50.25** (Mon to Friday 8am-10pm)

- Pronto Soccorso Medico-Psicologico di Mediterranea Saving Humans, Francesco **392 895 9198** (from 10.30 to 19.30) Diego: **338 324 5092** (from 10.30 to 19.30)

- Ania Cares, psychological emergency service for Road Traffic accident victims: **800 893 510**. Website: https://aniacares.it/

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

All information and data collected about you will be kept securely and only the researchers named in this information sheet will have access to it. All the information will be anonymous.

- Your personal details will remain confidential on any material resulting from the data collected, or in any write-up of the research.
- You will not be asked to provide your name or other identifying details when completing the initial surveys. You will be given a participant ID which will allow you to withdraw the data from the study if you wish to do so. You ID will enable the researcher to identify your data and delete it easily.
- Research data including transcripts will be securely stored in password protected laptops and only the researcher will have access to those.
- Only researchers named in this research will have access to the recorded data and data will be transferred via secure UEL emails.
- The output of the project will be an assessed report. You will never be named or personally identified in any output from this research.
- Anonymised quotes from the interview data may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and these will not personally identify you
- Anonymised research data will be securely stored on the researcher's UEL's password-protected OneDrive account for a maximum of 3 years, following which all data will be deleted. Only supervisors and examiners will have access to the anonymised data.

- If I believe you are in risk towards yourself or someone else, I will have to contact emergency services and share the information, therefore confidentiality will be broken.

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

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 you will not be asked to provide your name or other identifying details when completing the initial surveys.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided. Anonymised research data will be securely stored by the researcher for a maximum of 3 years, following which all data will be deleted.

Who has reviewed the research?

My research has been approved by the School of Psychology 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.

Elisa Piotto u2158996@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr. Lydia Tan School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: L.Tan@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

Appendix: Participant Information Sheet in Italian

SCHEDA IFORMATIVA PER IL PARTECIPANTE

Esperienze ospedaliere a seguito di un incidente stradale: uno studio fenomenologico sugli individui feriti

Contatto responsabile: Elisa Piotto

Email: u2158996@uel.ac.uk

Sei stato invitato a partecipare a uno studio di ricerca. Prima di decidere se partecipare o meno, leggi attentamente le seguenti informazioni che delineano cosa comporterebbe la tua partecipazione. Sentiti libero di parlare con altri dello studio (ad esempio amici, familiari, ecc.) prima di prendere una decisione. Se qualcosa non è chiaro o hai domande, non esitare a contattarmi all'e-mail sopra.

Chi sono?

Mi chiamo Elisa Piotto. Sono una studentessa di dottorato presso la Scuola di Psicologia dell'Università di East London (UEL) e sto studiando per una laurea in Psicologia del Counselling. Come parte del mio percorso di studi, sto conducendo la ricerca a cui sei invitato a partecipare.

Qual' è lo scopo della ricerca?

Sto conducendo una ricerca sulle lesioni da incidenti stradali e sulle esperienze di cura ricevute dai partecipanti in ospedale. Ciò è in linea con le linee guida della Divisione di Counseling Psychology (2020) che si concentra sul benessere sia fisico che mentale degli individui. Il contributo di questa ricerca fornirebbe una visione approfondita degli aspetti del trattamento fornito agli individui che potrebbero subire conseguenze sia fisiche che psicologiche causate da incidenti stradali.

Perché sono stato invitato a partecipare?

Per raggiungere gli obiettivi della ricerca, invito adulti di età compresa tra 18 e 49 anni a prendere parte alla mia ricerca. Se hai avuto un grave infortunio derivante da un incidente stradale almeno 3 mesi e al massimo 2 anni fa e sei stato ricoverato in ospedale per almeno 2 giorni, sei idoneo a partecipare allo studio. Si prega di notare che verranno applicati criteri di esclusione per i partecipanti che hanno subito una lesione cerebrale traumatica a seguito di un incidente stradale. Inoltre, dipende interamente da te se partecipare o meno, la partecipazione è volontaria.

Cosa mi verrà chiesto di fare se accetto di partecipare?

Se accetti di partecipare, ti verrà chiesto di prendere parte a un colloquio online che durerà dai 35 ai 40 minuti.

- Innanzitutto ti verrà chiesto di compilare un modulo di consenso, a seguire ti verrà richiesto di compilare alcuni questionari.
- Il primo questionario sarà l'Injury Severity Score (ISS) che viene utilizzato per comprendere la gravità degli infortuni che hai riscontrato.
- Successivamente, ti verrà chiesto di completare i questionari Patient Health Questionnaire (PHQ-9) e Generalised Anxiety Disorder scale (GAD-7) che determineranno i tuoi livelli sull'umore generale e ansia.
- La partecipazione durerà circa 50 minuti.
- I colloqui si svolgeranno online tramite videochiamata online su MS Teams.
- I colloqui consisteranno in una chat informale in cui ti verrà chiesto di rispondere a domande sulla tua esperienza di assistenza in ospedale dopo essere stato coinvolto in un incidente stradale.
- Le interviste verranno registrate audio su un dispositivo esterno protetto da password dal quale verranno immediatamente archiviate nell'account universitario One Drive protetto da password e cancellate dal dispositivo subito dopo.

Posso cambiare idea?

Sì, puoi cambiare idea in qualsiasi momento e recedere senza spiegazioni, svantaggi o conseguenze. Se desideri ritirarti dal colloquio, puoi farlo chiedendo di interrompere il colloquio e di cancellare la registrazione. Se ti ritiri, i tuoi dati non verranno utilizzati nell'ambito della ricerca.
Separatamente, puoi anche richiedere di revocare l'utilizzo dei tuoi dati anche dopo aver preso parte allo studio, a condizione che tale richiesta venga effettuata entro 3 settimane dalla raccolta dei dati (dopodiché inizierà l'analisi dei dati e la revoca verrà non essere possibile).

Ci sono degli svantaggi nel partecipare?

Potresti avere qualche difficolta’ durante il colloquio quando parli di un'esperienza passata, tuttavia il colloquio comprenderà domande generali sull'esperienza del ricovero e non sarà necessario rispondere a tutte le domande se non lo desideri. La formulazione delle domande prenderà in considerazione tutti i possibili fattori scatenanti che potresti sperimentare e quindi cercherà di ridurre al minimo la probabilità di disagio emotivo. Hai il diritto di recedere dal colloquio in qualsiasi momento durante l'incontro e a quel punto il colloquio verrà interrotto.
In caso di bisogno, potresti trovare utili le seguenti risorse/servizi per ottenere informazioni e supporto:

- Il supporto psicologico gratuito della Croce Rossa Italiana offre sostegno e ascolto a chiunque stia affrontando un momento di difficoltà. Chiamare il numero di pubblica utilità **1520**. Il servizio è attivo dal lunedì al sabato dalle 8 alle 20. Sito: https://cri.it/supporto-psicologico/#:~:text=Per%20iniziare%20il%20percorso%20di,sabato%20dalle%208%20alle%2020
- Un ascolto sempre in linea: **800.274.274**. per chiamate da cellulare **02.29007166**. email: linea.ascolto@progettoitaca.org Sito: https://www.progettoitacaparma.org/cosa-facciamo/linea-dascolto-numero-verde/
- Telefono Amico Italia, servizio gratuito **022 327 2327**, Whatsapp **324 011 7252**, Email: mail@micaTAI.

- Il numero verde **800 334 343** del servizio "inOltre" della Regione Veneto è operativo 24 ore al giorno, 7 giorni su 7, per aiutare i cittadini a gestire situazioni di ansia, stress, abbattimento, tristezza e solitudine.

- Servizio nazionale: Pronto Soccorso Psicologico Centro Alfredo Rampi: **800.68.50.25** (lun-ven dalle 10 alle 18)

- Servizio nazionale: Pronto Soccorso Medico-Psicologico di Mediterranea Saving Humans, Approdi, Laboratorio Salute Popolare: Francesco: **392 895 9198** (dalle 10.30 alle 19.30), Diego: **338 324 5092** (dalle 10.30 alle 19.30)

- Ania Cares, il pronto soccorso psicologico per le vittime della strada, numero gratuito: **800 893 510**. https://aniacares.it/

Come verranno mantenute sicure e riservate le informazioni che fornisco?
Tutte le informazioni e i dati raccolti su di te saranno conservati in modo sicuro e solo i ricercatori nominati in questa scheda informativa avranno accesso ad essi. Tutte le informazioni saranno anonime.

- I tuoi dati personali rimarranno confidenziali su qualsiasi materiale risultante dai dati raccolti o in qualsiasi articolo della ricerca.
- Non ti verrà chiesto di fornire il tuo nome o altri dettagli identificativi durante il completamento dei sondaggi iniziali. Ti verrà fornito un ID partecipante che ti consentirà di ritirare i dati dallo studio se lo desideri. Il tuo ID consentirà al ricercatore di identificare i tuoi dati e cancellarli facilmente.
- I dati della ricerca, comprese le trascrizioni, verranno archiviati in modo sicuro su laptop protetti da password e solo il ricercatore avrà accesso a tali dati.
- Solo i ricercatori nominati in questa ricerca avranno accesso ai dati registrati e i dati verranno trasferiti tramite e-mail UEL secure system.
- Tutte le informazioni saranno anonime. Il risultato del progetto sarà una relazione valutata. Non sarai mai nominato o identificato personalmente in nessun risultato di questa ricerca.
- Le citazioni anonimizzate dei dati dell'intervista possono essere utilizzate in materiale come presentazioni di conferenze, rapporti, articoli in riviste accademiche risultanti dallo studio e questi non ti identificheranno personalmente

- I dati di ricerca anonimizzati verranno archiviati in modo sicuro sull'account OneDrive protetto da password dell'UEL del ricercatore per un massimo di 3 anni, dopodiché tutti i dati verranno cancellati. Solo i supervisori e gli esaminatori avranno accesso ai dati anonimizzati.
- Se ritengo che tu sia in pericolo per te stesso o per qualcun altro, dovrò contattare i servizi di emergenza e condividere le informazioni, pertanto la riservatezza verrà infranta.

Ai fini della protezione dei dati, l'Università di East London è il titolare del trattamento dei dati personali trattati nell'ambito di questo progetto di ricerca. L'Università tratta queste informazioni nella condizione di "incarico pubblico" contenuta nel Regolamento generale sulla protezione dei dati (GDPR). Laddove l'Ateneo tratti dati particolarmente sensibili (c.d. "dati di categorie particolari" nel GDPR), lo fa perché il trattamento è necessario per fini di archiviazione nel pubblico interesse, o di ricerca scientifica e storica o a fini statistici. L'Università garantirà che i dati personali trattati siano conservati in modo sicuro e trattati in conformità con il GDPR e il Data Protection Act 2018. Per ulteriori informazioni su come l'Università tratta i dati personali, consultare www.uel.ac.uk/about/about -uel/governance/sicurezza-informazione/protezione-dati

Cosa accadrà ai risultati della ricerca?

La ricerca verrà redatta come tesi e sottoposta ad una valutazione. La tesi sarà pubblicamente disponibile sul Repository online della UEL. I risultati saranno inoltre diffusi a una vasta gamma di pubblicazioni (ad esempio accademici, medici, pubblico, ecc.) attraverso articoli di riviste, presentazioni a conferenze, conferenze, articoli di riviste, blog. In tutto il materiale prodotto la tua identità rimarrà anonima, nel senso che non sarà possibile identificarti personalmente in quanto non ti verrà chiesto di fornire il tuo nome o altri dati identificativi al momento della compilazione dei sondaggi iniziali.

Una volta completato lo studio, ti verrà data la possibilità di ricevere un riepilogo dei risultati della ricerca per il quale dovranno essere forniti i dettagli di contatto pertinenti.

I dati di ricerca anonimizzati verranno archiviati in modo sicuro dal ricercatore per un massimo di 3 anni, dopodiché tutti i dati verranno cancellati.

Chi ha revisionato la ricerca?

La mia ricerca è stata approvata dal Comitato Etico della Scuola di Psicologia. Ciò significa che la valutazione da parte del Comitato di questa applicazione etica è stata guidata dagli standard di etica della ricerca stabiliti dalla British Psychological Society.

Chi posso contattare se ho domande/dubbi?

Se desideri ulteriori informazioni sulla mia ricerca o hai domande o dubbi, non esitare a contattarmi.

Elisa Piotto u2158996@uel.ac.uk
In caso di domande o dubbi su come è stata condotta la ricerca, contattare il mio supervisore della ricerca Dr. Lydia Tan School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: L.Tan@uel.ac.uk

oppure

Presidente del comitato etico della scuola: Dott.ssa Trishna Patel, Scuola di Psicologia, Università di East London, Water Lane, Londra E15 4LZ.
(Email: t.patel@uel.ac.uk)

Grazie per aver dedicato del tempo alla lettura di questa scheda informativa

Appendix C: Consent Form in English

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Experiences of Care following a Road Traffic Collision: A Phenomenological Study of Injured Individuals

Contact person: Elisa Piotto
Email: u2158996@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated …/…/… (version X) 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 three weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be recorded using a password protected recording device.	
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

……

Consent Form in Italian

University of East London

CONSENSO A PARTECIPARE ALLA RICERCA

Esperienze ospedaliere a seguito di un incidente stradale: uno studio fenomenologico sugli individui feriti

Persona Responsabile: Elisa Piotto

Email: u2158996@uel.ac.uk

	Initiali nome
Confermo di aver letto la scheda informativa del partecipante datata .../.../... per la ricerca e di averne ricevuta una copia da conservare.	
Ho avuto l'opportunità di considerare le informazioni, porre domande e aver ricevuto risposte in modo soddisfacente.	
Comprendo che la mia partecipazione allo studio è volontaria e che posso ritirarmi in qualsiasi momento, senza spiegazioni o svantaggi.	
Comprendo che se mi ritiro durante lo studio, i miei dati non verranno utilizzati.	
Capisco che ho tre settimane dalla data del colloquio per ritirare i miei dati dallo studio.	
Sono consapevole che l'intervista verrà registrata utilizzando un dispositivo di registrazione protetto da password.	
Comprendo che le mie informazioni e i miei dati personali, comprese le registrazioni audio della ricerca, saranno archiviati in modo sicuro e rimarranno riservati. Solo il gruppo di ricerca avrà accesso a queste informazioni, a cui do il mio consenso.	
Mi è stato spiegato cosa accadrà ai dati una volta terminata la ricerca.	

Comprendo che citazioni brevi e anonime tratte dai dati delle mie interviste potrebbero essere utilizzate in materiali quali presentazioni di conferenze, rapporti, articoli su riviste accademiche risultanti dallo studio e che questi non mi identificheranno personalmente.	
Desidero ricevere un riepilogo dei risultati della ricerca una volta completato lo studio e sono disposto a fornire i dettagli di contatto a cui inviarlo.	
Accetto di prendere parte allo studo spiegato qui sopra.	

Nome del partecipante

……

Firma del partecipante

……

Nome dello studente

……

Firma dello studente

……

Data

……

Appendix D: Injury Severity Score

Please rate only the most severe injury from each body system. Head or neck (including cervical spine), Face (including the facial skeleton, nose, mouth, eyes and ears), Chest (thoracic spine and diaphragm), Abdomen or pelvic contents (abdominal organs and lumbar spine), Extremities or pelvic girdle – pelvic skeleton.

Head and neck worst injury? (Including cervical spine)	No injury	
	Minor	
	Moderate	
	Serious	
	Severe	
	Critical	
	Unsurvivable	
Face worst injury? (Including facial skeleton, nose, mouth, eyes and ears)	No injury	
	Minor	
	Moderate	
	Serious	
	Severe	
	Critical	
	Unsurvivable	
Chest Worst injury? (Including thoracic spine and diaphragm)	No injury	
	Minor	
	Moderate	
	Serious	
	Severe	
	Critical	
	Unsurvivable	
Abdomen pelvic contents worst injury? Including abdominal organs and lumbar spine	No injury	
	Minor	
	Moderate	
	Serious	
	Severe	
	Critical	
	Unsurvivable	
Extremities or pelvic girdle worst injury? Including pelvic skeleton	No injury	
	Minor	
	Moderate	
	Serious	
	Severe	
	Critical	
	Unsurvivable	
External worst injury?	No injury	
	Minor	
	Moderate	
	Serious	
	Severe	
	Critical	
	Unsurvivable	

Appendix E: PHQ-9 and GAD-7

PHQ – 9 and GAD – 7

PHQ- 9

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
		PHQ-9 total score-			☐

GAD-7

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
		GAD-7 total score-			☐

Appendix F: Initial Recruitment Poster in English

University of East London

What was your experience of care after your Road traffic Collision?

My name is Elisa and I am a Counselling Psychologist Trainee at the University of East London. I am currently recruiting participants for my research and I would be grateful if you could share your experience with me.

What is the aim of my research?

This research aims to contribute to the understanding of Road Traffic Collision Injuries and the quality of care experienced in hospital by participants.

What will the research involve?

You will be asked to complete two initial questionnaires and to attend to a 35-40 minutes interview that will take place online via videocall on Microsoft Teams

You can help us if:

-You are aged between 18 and 49 years old

-You have been involved in a Road Traffic Collision at least three months and at most two years from now

-You have encountered a severe injury resulting from the Road Traffic Collision

-You have been hospitalised as a result of your injury for at least 2 days

If you are interested in taking part
Please Email:

Elisa Piotto: u2158996@uel.ac.uk

Thank you

Appendix G: Amended Recruitment Poster in Italian

Esperienze Ospedaliere dopo un incidente stradale

Ciao, mi chiamo Elisa e sono una laureanda in psicologia all'universita' di East London in Inghilterra . Come parte del mio dottorato, sto conducendo una ricerca focalizzata sulle esperienze di cura ricevute in ospedale, a seguito di un incidente stradale. Ti sarei davvero grata se potessi condividere la tua esperienza.

In cosa consiste la tua partecipazione?

La tua partecipazione consistera' in un colloquio di 40 minuti dove parleremo della tua esperienza di ricovero e supporto ricevuto in ospedale.

Inoltre prima del colloquio ti chiedero' di completare due questionari veloci riguardanti il tuo stato fisico ed emozionale.

Quali sono i criteri di partecipazione?

- Eta' compresa tra I 20 e 84 anni
- Essere stato coinvolto in un incidente stradale minimo 2 mesi fa e massimo 2 anni fa
- Aver avuto dei traumi fisici seri con conseguente ospedalizzazione di almeno 2 giorni

Se sei interessato/a a condividere la tua esperienza contattami via email:
u2158996@uel.ac.uk

Appendix H: Interview Questions

1. Tell me about your accident, do you remember what happened?, Was anyone there to help you?
2. Tell me about your injury, did you experience any physical pain? When did you receive help?
3. Tell me about your hospitalization? (how long were you hospitalized for?)
4. Can you describe your initial thoughts when you were hospitalized? Did you do something about it?
5. Can you remember how did you feel whilst you were hospitalized? Why do you think that was?
6. What was your experience of hospital care?
7. Where there any experiences that stand out to you? Can you describe it? Why do you think that was?
8. What was your experience with the staff? How did the hospital staff help? Were there any other people that were more or less helpful? Why do you think that was?
9. Do you remember how you felt after the experience of hospitalization?
10. Do you have any additional thoughts/reflections regarding your experience of care after the RTC?
11. If you were asked to give a feedback to the hospital in relation to your experience, what would you say?
12. How did you see yourself after this experience?
13. Did you receive to get any additional help after the experience of hospitalization?

Appendix G: Interview Questions-Italian version

1. Mi puoi parlare del tuo incidente (Ti ricordi cos' è successo? C'era qualcuno che ti ha aiutato?)
2. Parlami del tuo infortunio, hai provato dolore fisico? Quanto tempo hai aspettato prima di ricevere aiuto?
3. Mi parli del tuo ricovero? (per quanto tempo sei stato ricoverato?)
4. Puoi descrivere i tuoi pensieri iniziali quando sei stato ricoverato in ospedale? Hai fatto qualcosa al riguardo?
5. Ti ricordi come ti sentivi mentre eri ricoverato in ospedale? Perché pensi che sia stato?
6. Com'e' stata la tua esperienza di cura in ospedale?
7. Ti ricordi qualche momento/episodio particolare che ha avuto un impatto sulla tua esperienza di cura? Puoi descriverlo? Perché?
8. Com'e' stata la tua esperienxa con il personale ospedaliero? Com'e' stato l'aiuto che hai ricevuto? C'erano anche altre persone che erano consapevoli o disponibili? Perché?
9. Hai ricevuto qualche ulteriore aiuto dopo l'esperienza di ricovero?
10. Hai ulteriori pensieri/riflessioni riguardo la tua esperienza di cura dopo il tuo incidente?
11. Se devi dare una valutazione alla tua esperienza ospedaliera, cosa diresti?
12. Come ti sei visto/sentito dopo la tua esperienzadi ricovero?
13. Hai ricevuto qualche ulteriore aiuto/support dopo la dimissione ospedaliera?

Appendix J: Participant Debrief Sheet

University of East London

PARTICIPANT DEBRIEF SHEET

Experiences of Care following a Road Traffic Collision: A Phenomenological Study of Injured Individuals

Thank you for participating in my research study on the experiences of care among Road traffic collisions injured individuals. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

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

What will happen to the results of the research?

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

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

Anonymised research data will be securely stored by researcher 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:

- Croce Rossa Italiana (1520) Support Service available from Monday to Saturday from 8am to 8pm. Website: https://cri.it/supporto-psicologico/#:~:text=Per%20iniziare%20il%20percorso%20di,sabato%20dalle%208%20alle%2020
- Un ascolto sempre in linea: **800.274.274**. mobile **02.29007166**. email: linea.ascolto@progettoitaca.org. Website: https://www.progettoitacaparma.org/cosa-facciamo/linea-dascolto-numero-verde/
- Telefono Amico Italia, **022 327 2327**, Whatsapp **324 011 7252**, Email: mail@micaTAI.

- InOltre service **800 334 343, available 24/7** for emotional and psychological support.
- Pronto Soccorso Psicologico Centro Alfredo Rampi: **800.68.50.25** (Mon to Friday 8am-10pm)

- Pronto Soccorso Medico-Psicologico di Mediterranea Saving Humans, Francesco **392 895 9198** (from 10.30 to 19.30) Diego: **338 324 5092** (from 10.30 to 19.30)

- Ania Cares, psychological emergency service for Road Traffic accident victims: **800 893 510**. Website: https://aniacares.it/

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.

Elisa Piotto u2158996@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr. Lydia tan. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: L.Tan@uel.ac.uk

or

Chair of School 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

Participant Debrief Sheet- Italian Version

LETTERA PER IL PARTECIPANTE

Esperienze ospedaliere a seguito di un incidente stradale: uno studio fenomenologico sugli individui feriti

Grazie per aver partecipato alla mia ricerca sulle esperienze di assistenza dei feriti da incidenti stradali. Questo documento offre informazioni che potrebbero essere rilevanti alla luce della tua partecipazione.

Come verranno gestiti i miei dati?

L'Università di East London è il titolare del trattamento dei dati personali trattati nell'ambito di questo progetto di ricerca. L'Università garantirà che i dati personali trattati siano conservati in modo sicuro e trattati in conformità con il GDPR e il Data Protection Act 2018. Informazioni più dettagliate sono disponibili nel foglio informativo del partecipante, che hai ricevuto quando hai accettato di prendere parte alla ricerca .

Cosa accadrà ai risultati della ricerca?

La ricerca verrà redatta come tesi e sottoposta a valutazione. La tesi sarà pubblicamente disponibile sul Repository online della UEL. I risultati saranno inoltre diffusi a una vasta gamma di pubblicazioni (ad esempio accademici, medici, pubblico, ecc.) attraverso articoli di riviste, presentazioni a conferenze, conferenze, articoli di riviste, blog. In tutto il materiale prodotto la tua identità rimarrà anonima, nel senso che non sarà possibile identificarti personalmente.

Una volta completato lo studio, ti verrà data la possibilità di ricevere un riepilogo dei risultati della ricerca per il quale dovranno essere forniti i dettagli di contatto pertinenti.

I dati di ricerca anonimizzati verranno archiviati in modo sicuro dal ricercatore per un massimo di 3 anni, dopodiché tutti i dati verranno cancellati.

Cosa succede se ho subito conseguenze negative dalla partecipazione?

Non è previsto che subirai effetti negativi prendendo parte alla ricerca dato che sono state adottate tutte le misure ragionevoli per ridurre al minimo il disagio o il danno di qualsiasi tipo. Tuttavia, è possibile che la tua partecipazione possa essere stata in qualche modo impegnativa, angosciante o difficile. In caso di bisogno, potresti trovare utili le seguenti risorse/servizi per ottenere informazioni e supporto:

- Il supporto psicologico gratuito della Croce Rossa Italiana offre sostegno e ascolto a chiunque stia affrontando un momento di difficoltà. Il servizio è completamente gratuito e accessibile a tutti (+18 anni). Per iniziare il percorso di supporto psicologico basta chiamare il numero di pubblica utilità **1520**. Il servizio è attivo dal lunedì al sabato dalle 8 alle 20. https://cri.it/supporto-psicologico/#:~:text=Per%20iniziare%20il%20percorso%20di,sabato%20dalle%208%20alle%2020
- Un ascolto sempre in linea: **800.274.274**. per chiamate da cellulare **02.29007166**. email: linea.ascolto@progettoitaca.org. https://www.progettoitacaparma.org/cosa-facciamo/linea-dascolto-numero-verde/
- Telefono Amico Italia, servizio gratuito **022 327 2327**, Whatsapp **324 011 7252**, mail@micaTAI..

- Il numero verde **800 334 343** del servizio “inOltre” della Regione Veneto è operativo 24 ore al giorno, 7 giorni su 7, per aiutare i cittadini a gestire situazioni di ansia, stress, abbattimento, tristezza e solitudine.
- Servizio nazionale: Pronto Soccorso Psicologico Centro Alfredo Rampi: **800.68.50.25** (lun-ven dalle 10 alle 18)
- Servizio nazionale: Pronto Soccorso Medico-Psicologico di Mediterranea Saving Humans, Approdi, Laboratorio Salute Popolare: Francesco: **392 895 9198** (dalle 10.30 alle 19.30), Diego: **338 324 5092** (dalle 10.30 alle 19.30)
- Ania Cares, il pronto soccorso psicologico per le vittime della strada, numero gratuito: **800 893 510**. https://aniacares.it/

Chi posso contattare se ho domande/dubbi?

Se desideri ulteriori informazioni sulla mia ricerca o hai domande o dubbi, non esitare a contattarmi.

Elisa Piotto u2158996@uel.ac.uk

Se avete domande o dubbi su come è stata condotta la ricerca, contattate il mio supervisore della ricerca, la dottoressa Lydia Tan. Scuola di Psicologia, Università di East London, Water Lane, Londra E15 4LZ,

Email: L.Tan@uel.ac.uk

oppure

Presidente del comitato etico della scuola: Dott.ssa Trishna Patel, Scuola di Psicologia, Università di East London, Water Lane, Londra E15 4LZ.

(E-mail: t.patel@uel.ac.uk)

Grazie per aver preso parte al mio studio

Appendix K: Example Analysis Process

Experiential Statements	**Transcript**	**Exploratory Notes**
	Researcher Of course, and do you remember what thoughts you had during your hospitalisation?	
Avoiding loss and worry by rationalising medical decisions Downplaying his physical condition despite being told of having a permanent disability Rationalising the reasons and the impact of medical decisions for his future in order to cope with his feelings of worry Internalising doctors' emotional state	**Participant** Well, with the accident I lost the hearing in my right ear anyway, and during the operation they actually blocked my ear to avoid the possible entry of viruses etc. So anyway they told me: 'you're not using it' so they plugged it. Let's say that the only con was that by plugging it, it prevented the vibrations from the right side from reaching the left ear, so in this case I struggled a little to hear the sounds coming from the right side... but wasn't plugged, just a little plugged. And at the time I thought about it a bit and said: 'hell, but now that they've operated on me, they'll then plug it, and I'll hear even less on the right side'. But this was still an initial thought that I had... then I reflected on it and I thought: " Well, if the surgeon says it's better for me because I have less risk of getting Hepatitis C.... if the surgeon says it's for the best, it means it's for the best". So...in short I thought it's not as if hearing fewer sounds or noises will bring me these enormous problems. Sometimes when I don't hear something I have to ask to repeat....but yes, I remember that in hospital I was thinking and helping myself by asking myself: 'what impact would x have had?'	Loss over hearing Negative consequences over care decisions Rationalizing medical decisions Feelings of worry over losing hearing Downplaying his permanent disability by using terminology like 'a little plugged'. Rationalizing as a coping mechanism from the loss and worry Downplaying the feelings related to a physical disability
	Researcher Hmm.. did that help you think through this?	
Coping mechanism of relying on the opinion of hospital staff and putting his faith on it	**Participant** Well yes, but the answer I always gave myself was: 'OK, they saved my life so, if they say it's better this way, it means that they know these things and therefore I trust what they tell me'. But if they were more doubtful or if they didn't look so confident maybe I would have had more doubts, but they were always calm, so I was calm.	Rationalizing the loss by trusting the doctors Trusting doctors for saving his life Trusting doctors when they look confident
	Researcher So having so much trust in the surgeon and the staff led you to feel more relaxed?	Feeling calm when the doctors are calm
	Participant Yes exactly.	
	Researcher Okay, and what kind of support did you receive during your hospitalisation?	
Downplaying and disregarding his emotional and psychological needs by relying on the support offered in hospital instead of describing his opinion on it Describing the lack of psychological support and follow-up by underlying the importance of the psychiatrist's opinion rather than his own	**Participant** So.. after the accident they gave me eight sessions with the psychiatrist who asked me questions and analysed my cognitive abilities. And then at the fourth session he told me that there were four sessions left but he told me that he had analysed the situation and filled out the forms that he had to do and said: 'From my point of view there is no need' like...he explained to me that I had no cognitive damage. So he told me: 'but you know that you still have four other sessions available, so whenever you want/need... text me or call me, you know where I am' he told me. So, even in that moment I trusted him and I thought: 'if he says that I don't need any more support... then I trust him'.	Psychiatric support available anytime Downplaying and disregarding his psychological needs by relying on what the psychiatrist said instead of saying what he thought No psychological support offered as part of the healthcare system Receiving psychiatric sessions as a result of the head injury Avoidance in describing his thoughts

Appendix L: Presentation Key of Participants and Themes

GETs	Sub-themes	Michael	Christine	Rebecca	Anthony
		Participants			
Life-changing experience	Loss of independence	✓	✓	✓	✓
	Feeling like a child	✓		✓	✓
	It turned my life upside down	✓	✓		✓
Negative Impact on emotional state	Self-blame and disregard for feelings	✓		✓	✓
	Lack of understanding from others	✓	✓	✓	
	Negative experiences of care	✓	✓	✓	✓
Inability to connect with emotions	Experiencing emotional numbness	✓	✓	✓	✓
	Apathetic narration of events	✓	✓	✓	✓
Meaningful connections matter	The importance of being seen holistically	✓	✓	✓	✓
	Family support as a compensation	✓	✓	✓	✓

Appendix M: Key to quote presentation

In-text Example	Description
[**text**]	Researcher's speech during participants' speech extract
…	Short pause
..	Very short pause
(text)	Name of city or Hospital omitted
((text))	Non-verbal communication or audible aspects of speech such as crying or laughing
'text'	Narrating/imitating someone or themselves talking/thinking