Article

Patients' perceptions of a multidisciplinary pain management programme in relation to trauma-informed practice principles: a narrative-based qualitative service evaluation

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Clair Jacobs[1,2*], Madeleine Anderson[1], Panayiota Chrysostomou[1], Kezia Kadri[1], Camille Leteurtre[1], Patrycja Jakubiec[1], Whitney Scott[1,3]

[1]INPUT Pain Management Unit, Guy's and St Thomas' Hospital NHS Foundation Trust, London, United Kingdom. [2]Department of Health Sciences, Brunel University London, United Kingdom. [3]Health Psychology Section, Institute of Psychology, Psychiatry, and Neuroscience, King's College London, London, United Kingdom

**Correspondence to: Clair Jacobs, INPUT Pain Management Unit, Guy's and St Thomas' Hospital NHS Foundation Trust, London, United Kingdom. Ground Floor, Gassiot House, St Thomas' Hospital, Westminster Bridge Road, SE1 7EP. Phone: +44 2071883255, clair.jacobs1@nhs.net*

Abstract

Background: There is growing recognition of the importance of trauma-informed practice in pain care. However, the extent to which current delivery of a multidisciplinary pain management programme (PMP) based on acceptance and commitment therapy (ACT) aligns with principles of trauma-informed practice has not been evaluated. Therefore, the aims of this service evaluation were to gain an in-depth understanding of patients' experiences of a routinely delivered ACT-based PMP in relation to principles of trauma-informed practice and use these findings to direct improvements for our service.

Methods: This service evaluation used a qualitative methodology with individual patient interviews (*n*=10). All patients were completing an intensive ACT-based PMP in the service. Reflexive thematic analysis was combined with a narrative analysis approach to make sense of the data.

Results: A superordinate theme was generated from the data, reflecting that trauma-informed practice is an evolving and continuous process over time. This superordinate theme was woven through the three other main themes: 1) Forming, expanding, and dissolving the "bubble"; 2) Balancing risks of distress with opportunities to engage, learn, and transform; and 3) Transformative self-narratives: hindrance to agency.

Discussion: This service evaluation highlights areas of good practice with respect to trauma-informed principles within the delivery of a multidisciplinary PMP. The service evaluation findings have shaped further developments in training and clinical practice within our service. Ongoing reflexivity and meaningful engagement with diverse patient partners have been essential to continue to optimize the delivery of trauma-informed pain care.

Contribution of the Paper

- Many people with persistent pain have experienced trauma. It is therefore important for clinicians to implement principles of trauma-informed practice when delivering multidisciplinary pain management programmes (PMP) based on acceptance and commitment therapy (ACT).
- This service evaluation identified that trauma-informed practice within an ACT-based PMP is an evolving, continuous process over time, which involves fostering a safe treatment environment and balancing distress and opportunities for growth to enable transformative self-narratives.
- Ongoing clinician reflexivity and engagement with diverse patient partners is crucial to ensure trauma-informed practice principles are followed across all parts of patients' journeys within pain services.

Keywords
Trauma-informed practice; chronic pain; acceptance and commitment therapy

Introduction

Post-traumatic stress disorder (PTSD) is common among people living with persistent pain. A meta-analysis reported a point prevalence of 9.7 percent (range 0-57%) for PTSD among people with persistent pain.[1] In contrast, the lifetime prevalence of PTSD in the general population is approximately 6.8%.[2] Importantly, people living with pain and trauma-related distress may experience barriers to accessing pain care.[3, 4]

In the wider health field and within physiotherapy and interdisciplinary teams, there has been increasing focus on trauma-informed practice.[5,6] Trauma-informed practice recognizes that anyone may be impacted by trauma which can affect their ability to feel safe or develop trusting relationships with services.[7, 8] The purpose of trauma-informed practice is not to treat trauma directly, although trauma-specific interventions may be part of a wider trauma-informed approach.[7] Instead, trauma-informed practice addresses the barriers that people affected by trauma can experience when accessing services.[7]

Trauma-informed practice uses a strength-based approach to optimize engagement in services.[6] The working definition of trauma-informed practice provided by the UK government highlights the need to recognize the widespread biopsychosocial impacts of trauma on individuals and communities and to prevent re-traumatization.[9] Six key principles of trauma-informed practice have been proposed: *safety* (physical, psychological); *trustworthiness* (transparency in policies and procedures); c*hoice* (shared decision-making), *collaboration* (working with and actively involving patients)*, empowerment* (sharing power)*;* and*, cultural considerations* (responsive to needs and strengths of diverse individuals and communities).[9] However, there is a lack of consensus about how to optimally implement these principles, including in pain care. Greater understanding of the extent to which pain services adhere to trauma-informed principles is imperative to minimize the risk of exacerbating trauma-related distress in patients, and to reduce burnout in clinicians.[10]

Within the UK, evidence-based multidisciplinary pain management programmes (PMPs) based on cognitive-behavioural principles have been widely implemented.[11, 12] PMPs are increasingly based on acceptance and commitment therapy (ACT).[13] ACT aims to enhance functioning and quality of life in the

presence of pain.[13] This is done through targeting psychological flexibility—the capacity to persist with or change behaviour while remaining in conscious and open contact with difficult pain-related experiences, in a manner that aligns with personally-relevant values.[14] There is growing evidence from randomized controlled trials[15] and observational studies[16-18] supporting ACT for persistent pain. ACT has also been used to support people experiencing the effects of trauma.[19] However, the extent to which delivery of ACT-based PMPs in routine clinical practice is consistent with the principles of trauma-informed practice is unclear.

Many PMPs, including those based on ACT, are group-based[20] which presents opportunities and challenges for trauma-informed practice. Shared experiences may foster feelings of safety and trust within the group. However, PMP group members may have different experiences and impacts of trauma, which could adversely affect feelings of safety. Emerging research suggests that trauma exposure and PTSD symptom severity do not predict outcomes following a group-based cognitive-behavioural PMP.[21] However, quantitative data alone do not capture the nuances of how trauma-related experiences can shape engagement with group-based PMPs. Therefore, in-depth understanding of patients' experiences of pain management programmes is needed in this regard.

This service evaluation had two main aims. Firstly, to gain an in-depth understanding of patients' experiences of the current delivery of an ACT-based PMP in relation to principles of trauma-informed practice, identifying areas of good practice and areas for service improvement. The second aim of this service evaluation was to use these findings to guide trauma-informed developments in our pain management service.

Methods

The Consolidated Criteria for Reporting Qualitative Research (COREQ) reporting guidelines[22] have been followed in describing this service evaluation. However, given that a reflexive thematic process was used, a coding trail rather than a coding tree has been reported (Appendix).

Ethical Considerations

This was a service evaluation based on the Health Research Authority's decision tool, as it was designed to judge current care and inform future improvements in service delivery.[23] Therefore, the evaluation did not require research ethics approval. The service evaluation was registered with the Trust's audit database (no. 15282) prior to data collection. We adhered to ethical principles in the conduct of this service evaluation. In the informed consent process, individuals were made aware that their participation was voluntary and would not affect their care, and that their data would be securely stored and anonymized. Each participant provided written informed consent prior to their interview, including for the use of their anonymized

quotations. To manage any potential distress, it was communicated during the interview that participants were free to choose to continue or to stop. Additionally, the interviewers monitored participants' well-being during the interviews and supported them to manage any distress, including signposting to their clinical team in the service.

Design

A qualitative methodology with individual interviews was used. This enabled in-depth exploration of experiences of trauma-informed practice within the service. A critical realist position underpinned the evaluation. This assumes that whilst reality exists outside of one's perceptions and construction (ontological realism), understanding of reality is inevitably constructed from one's own subjective and sociocultural standpoint (epistemological constructivism and relativism).[24] This position allowed for consideration of how individuals gave meaning to their experiences, whilst recognising the basis of these experiences in a shared reality.[24] A narrative medicine approach was used to gain a deeper understanding of patients' stories, ensuring the individuality of their voices.[25] This approach has been used for people who have experienced trauma, allowing them to tell their story and have the listener acknowledge their suffering.[25]

Treatment

Treatment was delivered within a speciality pain service that provides a three-week, residential, multidisciplinary ACT-based PMP. The programme aims to improve quality of life with pain by targeting psychological flexibility.[26] It does not focus on strategies to control pain. The programme consists of approximately 84 treatment hours (9:00am to 5:00pm, 4 days/week) and involves group-delivered psychology, physiotherapy, occupational therapy, and nursing sessions. The focus is on increasing present-moment awareness; openness towards difficult thoughts, feelings, and bodily sensations; and engagement with meaningful activities. This is facilitated through reflective discussions involving metaphors, opportunities to practice mindful movements, experiential exercises, creative activities, and values-based goal setting.

Treatment groups consist of approximately 10 patients, comprising a range of ages, genders, ethnicities, pain presentations, and trauma experiences. The programme does not specifically focus on processing traumatic experiences, although clinicians within the service recognize that many people who complete the programme have experiences of trauma. This has led to an increasing focus on and reflection about trauma-informed practice within the clinical team.

Participants

Ten patients were recruited from five PMPs. This sample size was chosen for practical reasons, because as a service evaluation there were limited resources to expand recruitment. This sample size was similar to a previous qualitative study of experiences within an ACT-based PMP.[27] We aimed to include a sample with diverse perspectives in terms of demographics, post-traumatic symptom severity, and treatment experiences. This was monitored during recruitment, and the decision to stop recruitment after 10 interviews was made based on having captured this range of perspectives. Based on recommendations for reflexive thematic analysis,[28] data saturation was not used to determine sample size.

All patients were assessed for eligibility for the programme by a psychologist/occupational therapist and a physiotherapist. They had to be over 18 and living with pain for more than six months, associated with significant distress and/or disability. Participants also had to be likely to benefit from the treatment, as indicated by a willingness and ability to engage in an English-language group programme focused on improving quality of life with pain. Those with severe and poorly managed mental health problems (e.g. active psychosis, suicidal intent), alcohol/substance misuse, moderate to severe cognitive impairment, or inability to mobilize independently, were excluded.

The inclusion/exclusion criteria for the residential PMP and the service evaluation were the same. There were no additional inclusion/exclusion criteria for the service evaluation. Everyone engaging in the residential programme during the time of the service evaluation was invited to participate. Importantly, we aimed to recruit those with and without trauma experiences because the focus was not on experiences of trauma, but on all patients' experiences of trauma-informed practice within the programme.

During the first week of the programme, groups were informed by a member of the service evaluation team verbally and with written information about the objectives and process of the evaluation (Appendix A) and given an information sheet and consent form. It was highlighted that this was a service evaluation related to trauma-informed practice focusing on individuals'

experiences within the PMP. Participants were informed that no questions would be asked specifically about individuals' trauma experiences. Interested participants informed their group clinical lead. After the first five participants were recruited through convenience sampling, purposive criterion sampling[29] was used to identify the remaining five to intentionally capture diversity in terms of age, gender, ethnicity, trauma exposure, and PTSD symptom severity scores. Across the five PMPs invited to participate, 26 patients declined.

Data Collection

Ten individual semi-structured interviews were conducted face-to-face by four team members (CJ, CL, PC (qualified physiotherapists) and PJ (qualified psychologist)). To increase the likelihood that patients felt able to speak openly about their treatment experiences, the interviewer was a clinician who was outside their direct treatment team. No prior relationship was established between the interviewer and the participant. Nine interviews were conducted during the final week of treatment, and one took place at the end of week two for practical reasons.

Participants were encouraged to share their perceptions of the care they received within the PMP and to reflect on their experiences, negative and positive. The interview schedule consisted of open-ended questions and prompts exploring programme experiences based on the trauma-informed principles. The interviewers were clinicians. The lead author CJ received specialised training through a 10-week online course in Narrative Medicine at Columbia University. This curriculum covered qualitative enquiry, structured observation, and ethnographically informed semi-structured interviewing. CJ shared foundational reading material with the service evaluation team. The interview questions were initially informed by the narrative principles on the course, for example, by focusing on specific moments within the PMP to elicit stories about patients' journeys. The questions were developed as a team and discussed as to how the interviewers could implement the guide drawing on existing clinical interviewing skills. No formal training for the other interviewers was undertaken. We had regular team meetings to reflect on the extent to which the interviews captured data relevant to the evaluation aims and to ensure consistency across interviewers. A member of the wider service evaluation team who did not conduct any interviews (WS) has experience conducting qualitative interviews for research purposes. WS supported the team's reflections on the implementation of the interviews for the service evaluation.

After the first two interviews, iterations to the schedule were made based on feedback from participants and the treatment team. Questions and prompts were revised to be less direct about the trauma-informed principles and phrased to focus more broadly on the participant experience. This enabled the team to explore how trauma-informed principles were discussed in relation to patients' narratives (Appendix B). Interviews took place between September and December 2023, each lasting between 35-50 minutes. They were audio recorded, transcribed verbatim, anonymised, and securely stored.

As part of the standard baseline assessment, patients answered demographic questions. They also indicated whether they had experienced a traumatic event, and if so, completed the PTSD Symptom Checklist (PCL-5)[30] for descriptive purposes. Participants provided consent for baseline questionnaire data to be used to provide context for the evaluation.

Data Analysis

A reflexive thematic analysis (RTA) framework[31] was used to analyse the data. Alongside the RTA, a narrative analysis approach was also used to direct the analysis towards patient narratives, enabling deeper insight into the individuality and complexity of experiences.[32] The team viewed themselves as active in interpreting and constructing meaning from the data and, therefore, recognize that the findings are shaped by their values and perspectives. The team met regularly to reflect on how their different clinical perspectives shaped data collection and analysis. Given the critical realist and reflexive approach, the analyses focused on producing shared and clinically useful patterns of meaning from the data, rather than on identifying a singular 'truth'.

Data analysis was guided by RTA principles.[31] The first step involved familiarisation with the data through several readings of the transcripts and summarising to the team. In the second step, team members applied deductive codes based on trauma-informed care principles and generated inductive codes where the deductive codes did not adequately capture the data.[31] Deductive coding was carried out using the principles of safety, trustworthiness, choice, collaboration, empowerment, and cultural considerations[9] focusing on which principles were mentioned, and their impact on the

patient narrative. Inductive coding was carried out alongside deductive coding using a narrative analysis approach, looking through the lenses of language (pronouns, pauses, repetition), context, and moments (salient, summative, evocative, essence capturing, words/phrases).[33] Inductive codes were brought together with the deductive codes to allow more nuanced narratives to be identified within the data, such as tracing experiences of the trauma-informed principles over time. See Appendix C for a coding trail.

Three team members manually coded the transcripts using Microsoft Word, with CJ and PC both coding the first two interviews in parallel. After coding the first two interviews, the initial application of the deductive and inductive codes was discussed and agreed amongst the group, and the codes were entered into an Excel file. These codes were applied to subsequent interviews with new codes added as needed. The remaining interviews were coded individually (between CJ, PC, and KK). In the third step, six team members regularly met to combine codes into themes based on similar patterns of meaning. This process was iterative and evolved through discussion. The team discussions acted as a 'reflection space' moving between the coding sets and allowing deeper themes to be developed. After initial coding, the analysis process was visual and used spatial thematic mapping.[34] By physically laying out the deductive and inductive codes, the team assembled patterns of meaning reflecting how trauma-informed principles were intertwined with patient narratives across the dataset. At this stage, initial themes were actively and collectively formed. Themes were reviewed in relation to the service evaluation aims. They were then presented to the wider clinical team for feedback and subsequently refined to ensure cohesive, distinct, and clinically meaningful themes. This feedback process contributed to the evaluation team further emphasizing competing needs and identities within the treatment group. Finally, themes were grouped into superordinate and subordinate themes.

During the introductory discussion when recruiting (Appendix B) the team's reasons for doing the service evaluation (shared interest in creating a more trauma-informed programme) were shared with the participants. The evaluation team consisted of female clinicians (qualified psychologists and physiotherapists), a trainee, and clinical academics from psychology and physiotherapy backgrounds. This composition creates an interdisciplinary lens that favoured biopsychosocial interpretations of patient experiences. All held values about the importance of interdisciplinary, patient-centred, and trauma-informed pain care as defined by the six principles. All team members worked within the service and valued continual service improvements to optimize patients' experience and outcomes. Therefore, the team was committed to actively looking for evidence within the data to highlight instances of poorer adherence to the trauma-informed principles. Nonetheless, we all have an identity as working within a service that is internationally recognized and value demonstrating the impact of the service. This may have shaped our focus on positive instances of trauma-informed care. The time-limited nature of the service is something we are very conscious of as a team. This may have shaped the interpretation of data and themes in terms of time.

Results

The sample was comprised of mostly women (7/10, 70%) and had a mean age of 53.7 years (SD = 16.1, range 19 – 80). Two (20%) patients identified as Asian, one as Black (10%), one as mixed (10%), and six as White (60%). Seven patients indicated that they had experienced a traumatic event, with PCL scores ranging from 6 to 70; four of these scored above the threshold of 31 for 'probable' PTSD (range 31-70). One superordinate theme and three connected themes were generated from the data (Figure 1).

Superordinate theme: Trauma-informed care is an evolving, continuous process over time

The importance of time and timing was prominent throughout the data and is woven through each of the three themes. Treatment participants reflected on important time periods and processes before, during, and after the programme. In this way, experiences of trauma-informed care depended on the context and individual needs at various points in time. Time was a factor that shaped participant experiences of the programme, from the unfolding process within "the bubble", to the programme being a moment in time within the longer transformational journey of living with pain in the future.

A key time-related concern was the importance of attending the programme at the right time, particularly considering the need to complete other psychological therapy in preparation.

"before when I used to think back and talk about stuff like that - I used to become very overwhelmed and struggle quite badly (…) now I feel I'm a lot better – I

can talk…if I feel myself getting overwhelmed I can focus and calming myself down (…) "If I hadn't had a lot of therapy before coming here, I think it would have been a struggle." –P10

Alongside this, participants discussed the impact of having to wait a substantial length of time to access treatment.

"I've been in pain for 15 years. And I waited on and off, to argue to get on to this with doctors and la la, la, la, la and I'm finally here." –P4

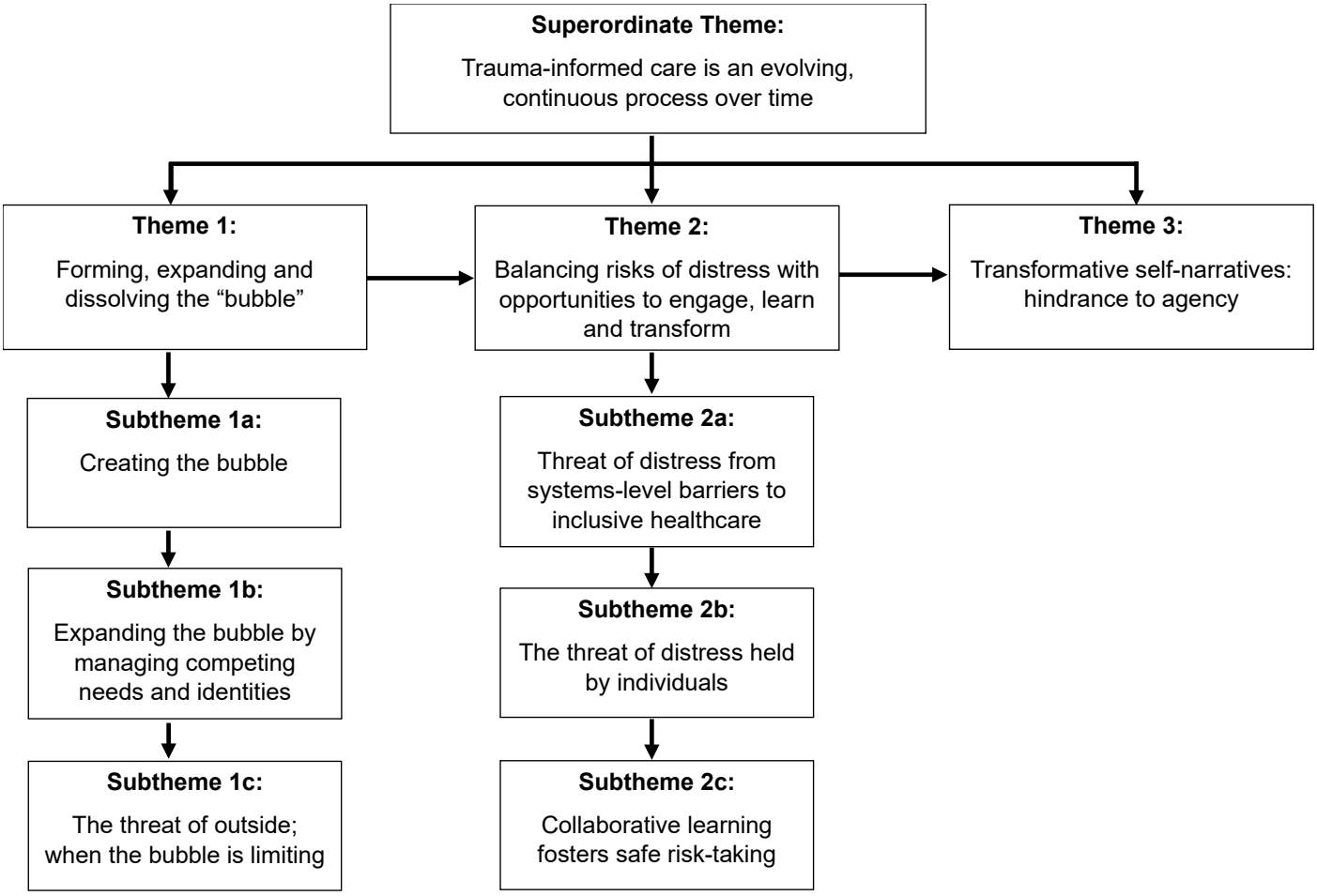

Figure 1. Thematic map showing the superordinate theme of time woven through three connected themes.

Time was also discussed as a pressure in the context of a time-limited programme, with the end feeling very sudden despite being discussed throughout the programme.

"I could have sat there for the whole 3 weeks and we still wouldn't have had enough time."
–P1

In contrast, time was also a therapeutic factor as participants noticed and reflected on how time positively impacted their changing experiences over time.

"But the first weekend I went back, I was really unsettled…when I went back the second weekend, I felt better mentally than the first weekend." –P3

"it is at a slow pace. It's not a, you know, a ram, like ram it down your throat pace, it's relaxed. There's time to talk about it. Time to digest it, and you can ask questions if you don't understand" -P6

"so, then I just started to trust the process and actually, was looking forward to coming back for the third week, but like I've just said, it's just gone and it's virtually gone. So, I think the third week it all gels. A lot of week one, especially in week two, you're thinking where is this going, I don't really understand it, but the more

time goes on. As it goes on. It seems to like today everything's gone Click, click, click, click, click, click, click and it seems to all falling into place." –P2

Theme 1 – Forming, expanding, and dissolving the "bubble"

This theme captures patients' experience of treatment as a safe, protected environment that separates them from their external life, and the challenges that this presents during and after treatment.

Subtheme 1a – Creating the "bubble"

Alongside initial feelings of uncertainty, patients expressed how the treatment team made them feel safe and welcome on arrival to the programme. They described how the clinical environment was characterised by a lack of judgement and an emphasis on choice and collaboration, which promoted a sense of belonging.

"being here, the environment was very warm, welcoming. So I felt like I had a space here. Like I belonged." –P8

During the PMP, the evolving patient group identity strengthened the protection offered by the "bubble". Within the "bubble" of the group, patients felt they could be uniquely understood by those who shared their experiences with pain. This context enabled them to reach a point of allowing vulnerability to be present and seen.

"I thought it was safe here because everybody in the room was going through the same thing, trying new stuff. I wasn't being watched […] we all understood each other." –P3

"At first, I was a bit shy to, you know, be myself around everyone and I was a bit closed off and reserved, and I think I felt the need to protect myself but […] everyone was showing me that it's OK to be myself and I not need to hide away basically." –P8

Patients came to view this space as an escape from the "real world", such that the "bubble" offered a retreat from the weight of responsibility and judgement from others they felt in "normal" life.

"*Nothing's wrong here, and that's what's great because nothing you do is wrong. I think here it might be a bit of a bubble. And easy to not be in the real world" –P6*

Subtheme 1b – Expanding the "bubble" by managing competing needs and identities

For many, the protective "bubble" afforded by the cohesive group context was central to their journey through treatment despite initial reservations about group work. Patients frequently found safety and connection within the group. At the same time, they reflected conflicting views regarding the boundaries of sharing and listening in sessions and differences in the relative contributions of group members. At times, patients felt some particularly distressing experiences were not appropriate to share within the "bubble" and threatened the foundation of safety.

"Some people have a voice, some have a bigger voice. I have a medium voice, but…I think I do know when to share and when to let somebody else share […] the first couple of days there was quite a lot of talk about not being able to cope anymore, as if like suicidal thoughts. And I honestly thought you've got a girl here. She's got, you know, this removed and that removed and this removed. Is that appropriate to be sharing that?" –P5

Whereas for other patients, the opportunity to share freely and openly was important to establishing their feelings of safety in the group, unaware that this may have the opposite impact on their peers. To maintain balance, there is a clear need for the treatment team to remain in-touch with group dynamics and expectations to ensure safety of sharing distressing content for all group members.

"How can we be helped if we're not allowed to talk? And this is what we were allowed to do here, openly…It was a nice surprise, we were allowed to open up and say anything. And I think that's a big part of the holistic therapy" –P3

Despite a general sense of a safety within the group, several patients expressed instances of their individual needs not being met. In particular, a patient with a hearing impairment and another from a racially minoritized group questioned if more could be done to take their needs into consideration and how this might have altered their engagement with treatment.

"I was looking at all the practitioners that are here and the staff members. None of them are people of colour, unless I've seen wrong […] I feel like if there was more diversity, then it would feel more like comfortable being in the space because there's you know, you can relate to… to someone who is similar to you" –P8

"I've got hearing aids. And it means that in sort of social groups where a number of people are speaking, it can be quite difficult to follow and that slows one down, you know. I didn't join in as much of the discussion as ideally I would have liked to because you know I'm not quite sure of everything that had been said and just whether it was the appropriate moment to make my contribution." –P9

Subtheme 1c – The threat of outside; when the "bubble" is limiting

The safety and comfort of the bubble generated fear about returning to "life outside" after the programme. The programme was seen as an escape, and patients felt uneasy about how they would cope when returning to their "reality".

"And I'm panicking because I think, "Oh my God we've got to go home and there's gonna be the dogs and my daughter, and doing the housework and all them things are gonna start churning in."" –P4

Despite their apprehension, patients also recognised the need to burst the "bubble" and implement what they've learned to meaningfully engage with life beyond the programme.

"I don't want it to end. None of us do so, whether it's a bubble that we're in, where we know we're happy, safe, secure and we're allowed to be. I think that is what it is. What will it be like when you go out in the big real world…I don't know how you could improve it, make it longer, but then that's just keeping us in the bubble." –P6

Theme 2 – Balancing risks of distress with opportunities to engage, learn, and transform

This theme recognises the risks of distress that can surface when experimenting with the boundaries of safety and comfort zones within treatment and how these are mitigated across service, individual, and staff levels. It captures the significance of safely allowing space for distress as a therapeutic mechanism of change.

Subtheme 2a – Threat of distress from systems-level barriers to inclusive healthcare

On a wider level, patients reflected on the challenges of accessing healthcare, particularly for individuals from ethnically minoritized groups. They recounted the distress associated with their own journey to get onto the programme and acknowledged that many people still face obstacles which impede their access to pain management.

"The majority of people who have chronic illnesses in the South are black women, but they're not getting the treatment that they need…I think not enough people of colour get the opportunity to do programmes like this." –P8

This created a risk that distress experienced during the programme may be compounded by distress associated with patients' journeys through the healthcare system, alongside feelings of guilt and sadness held for others still unable to access treatment.

Subtheme 2b – The threat of distress held by individuals

Patients expressed concerns regarding the risk of experiencing emotional distress on the programme. Those who recalled traumatic experiences felt worried about the possible repercussions of confronting these thoughts and memories about the past.

"I thought, ooh is this the right place where I should be going because there was a big can of worms over there that I thought I'd shut. I'd had therapy for it and I'd shut and all of a sudden it went bang and hit me right in the face." –P4

Not only did it feel challenging to manage their own emotional responses, but some patients also struggled with sharing this emotional weight and hearing others' distress.

"I take in everyone's emotions and feelings…don't know how I'm going to be able to handle everyone's emotions and everyone's feelings and experiences...I did go back to my room in tears, and I just felt like I needed a break because it's hard listening to other people's problems." –P8

However, there was also a recognition of the value of self-disclosure, and this being supported by group members.

"It took a lot of mental force to be able to sit there and listen, but I think there was a lot of sharing as well within the group, sharing of experiences and sharing of emotions… It was good for me as well physically and mentally to be able to do that." –P7

"I was surprised and pleased that that people would quite often refer to some point that I'd made…I had that

sort of support and willingness, you know, to value the contributions that that you're making." –P9

Subtheme 2c – Collaborative learning fosters safe risk-taking

The context of patients and clinicians working together as one team fostered a trusting environment that allowed for safe risk-taking. There was a recognition that although this risk-taking might generate physical or emotional discomfort, the treatment team was able to support patients through this.

"Just the trust that she's there, if I get stuck or something, she's there, not to hold me, she wouldn't. She'd give me the chair to support. Just to trust that that you know I'm in the right place…It just gave me the confidence to stretch myself, we did it a few times and today this morning I managed to get on the floor without the chair, but I needed the chair to get up. So I've learned how to twist my knee and how to do it safely, So that's a big thing." –P3

"It wasn't that the professionals were just going according to their plan, there was enough flexibility for them to be able to go according to our plan, with whatever that may be." –P7

Patients also felt they benefitted from the treatment team's encouragement to be autonomous in making their own choices about how to experiment with and engage in treatment-related activities.

"The choice is ours. How much we take part, how much we open up, how much we tell people, it really is. And I think in turn that actually helps us more." –P6

Theme 3 – Transformative self-narratives: hindrance to agency

In recognising changes within themselves, patients reflected a point of transformation. This process of change had multiple catalysts, including empowerment through freedom of choice, a collaborative relationship with the treatment team, and acknowledgement of the active role patients hold in their own transformation.

"I recoiled from being put in a position to have a voice…but now I have found a voice from somewhere." –P2

Patients saw their experience as a journey that will continue to evolve over time, in contrast to the initial view of the programme as a "bubble" that ends with a harsh return to reality. Instead of ruminating on feelings of finality, they recognised that returning home was important to continue to put skills and knowledge into practice.

"The point of this is, the last you know, last resort and she said 'no, think of it as the first, think of it as the beginning'. And then I understood what she meant, because there's so many lessons to take from these three weeks." –P3

"I've learned on the course that you don't have to do it, straight from there, straight to there, it can be a journey rather than A to B" –P2

There was acknowledgement of the challenges they will continue to face in adjusting to their condition, but there was a move toward openly acknowledging these difficult feelings and creating space for them.

"from an outside point of view, you'd be like quite happy and content with that how far you have come with certain thing…but you can still be frustrated that you can't put everything back together how it was." –P10

Discussion

This service evaluation explored patients' perspectives of how a multidisciplinary PMP aligns with principles of trauma-informed practice. We identified a superordinate theme describing trauma-informed care as an evolving, continuous process over time. This superordinate theme was woven through three other themes related to patients' experience of the protective treatment "bubble"; balancing distress with growth; and, transformative self-narratives. This evaluation aligns with a growing movement towards implementing trauma-informed healthcare practices.[5] The findings from this service evaluation have shaped further developments in training and clinical practice within our service. While the current evaluation and subsequent changes in practice are specific to our treatment context, the results may enable reflection about trauma-informed practices in other services.

The service evaluation indicated that the therapeutic relationship was central to establishing a protective treatment "bubble" that enabled safe risk-taking, growth, and self-transformation. This aligns with research showing that a strong therapeutic alliance, characterized by a positive bond between patient and

clinician and a shared sense of treatment goals and tasks, is one of the biggest predictors of psychological treatment outcomes.[35] These features of an effective therapeutic alliance map onto the trauma-informed principles of safety, collaboration, and trustworthiness,[9] which participants described in the current interviews. Therefore, across different treatment modalities, formats and contexts, clinicians' capacity to establish these qualities in their relationships with patients may be key to trauma-informed pain care.

The relationship among treatment participants was also an important part of the protective "bubble". Although PMPs are commonly group-based, relatively limited research has investigated group processes that facilitate optimal outcomes. Within the pain field, work has focused on the effects of PMP group composition in terms of demographic, pain, and psychosocial characteristics.[36, 37] A recent review of qualitative studies exploring patients' perspective of attending group-based PMPs identified the group experience as a core treatment component.[20] Social psychology research highlights the benefits of shared social identity and cohesion among treatment group members.[38-40] Taking the current evaluation and previous research together, establishing and maintaining effective group relationships, characterized by shared understanding and belonging, appears foundational to trauma-informed PMPs. While this may be particularly relevant within an intensive residential programme, similar group relationships are likely to be important in outpatient programmes.

Themes two and three highlighted the importance of balancing the risk of distress with safe risk-taking and opportunities to grow and expand life beyond pain and trauma. This reflects key aspects of *workability* within ACT.[41] However, the balance of safety and growth is particularly important in the current context given that patients have different experiences of trauma within the group. Therefore, specific attention to how ACT strategies are applied in a trauma-informed way is needed. In some cases, there may be relatively limited information provided prior to delivering ACT-based exercises as the focus is on experiential learning.[42] As a result of this service evaluation, clinicians now endeavour, where possible, to more explicitly communicate the purpose of these exercises to safely contain uncertainty in a manner that still provides opportunities for growth. This includes naming the function of experiencing uncertainty in the moment as an opportunity to learn different, and possibly more helpful, responses. To keep the space safe for individuals and the wider group, it may be important to set boundaries for discussing experiences of trauma that can emerge following ACT exercises. This includes an agreement to focus on the impact of these experiences in the present-moment versus discussing the traumatic experiences in detail. This has followed on from the service evaluation, and the team continues to reflect on how to best support the implementation of these boundaries.

There is emerging evidence that even low intensity ACT can reduce distress among people who have experienced trauma, even if it does not focus on processing traumatic events.[43] However, where post-traumatic stress symptoms are severe or poorly managed, other trauma-focused psychological approaches[44-47] may be needed prior to or alongside a PMP. Research is needed to understand how best to integrate pain management approaches with trauma-focused treatments where needed.

The evaluation resulted in further developments within our service. The process of discussing the evaluation with the wider team identified training needs to increase knowledge of trauma-informed care. This led to the organization of a 1.5-day service-wide training led by Traumascapes,[48] a survivor-led charity that works to improve understanding of trauma through art and science. Following presentation of the service evaluation findings to the clinical team, the team came together to develop explicit service values, rooted in trauma-informed principles. The service has a longstanding patient involvement group and the importance of engaging with this group was reflected in the service values that were developed. Indeed, patient involvement has great potential to support continual service developments with respect to trauma-informed practice[49] and pain care,[50, 51] and the focus on sharing power and collaboration is consistent with trauma-informed principles.[9] The evaluation results reinforced our commitment to actively support the involvement of diverse patient partners in this process[49, 52] and the group is comprised of people from a range of ethnic backgrounds, genders, and ages. A draft of the service values was discussed with this patient involvement group and refined following feedback (Appendix D). Clinicians have since shared these values with treatment groups to further support the development of the group agreement to foster effective relationships. Where other services are committed to providing trauma-informed care, they may similarly benefit from developing explicit trauma-

informed values that are specific to their treatment context.

The service evaluation highlighted challenges in ensuring effective relationships among treatment group participants and that the group is safe for everyone. At the start of the PMPs, clinicians ask group members to reflect on how they will work together effectively as part of co-producing the group agreement. The refinement of a key statement to guide this discussion, "We will feel safer in this space if…" evolved from our understanding of safety from the service evaluation. Following from the evaluation, there has been more explicit discussion of diversity within the treatment group alongside this. For example, during the discussion of safety, there is now more prompting to think about this specifically in relation to individual's life experiences, culture, identity, and/or learning needs. Group and individual safety are monitored throughout the programme and clinicians can return to the trauma-informed values when challenges arise, which can help manage distressing group dynamics and competing needs. Relatedly, the clinical team recognizes that some people may feel marginalized within the group[53] and may not feel able to raise specific needs in this format. Therefore, one-to-one discussions with patients alongside the programme are also used to enable treatment teams to review individuals' feelings of safety with respect to various aspects of trauma and social identity. As a result of the service evaluation, the team has committed to more routinely discussing equity, diversity, and inclusion across meetings, case formulations, and in supervision. The aim of these discussions is to support clinician reflexivity, cultural humility, and anti-racism to ensure assumptions are not made about individuals' needs based on aspects of their social identities.[54-56] Optimal management of conflicting needs within the group is an ongoing challenge that we continue to reflect on as a team.

The clinical team continues to think about how best to implement our trauma-informed service values moving forward to increase transparency, accountability, and continual reflection. Ideas that are being developed to this end include having trauma-informed values outlined in pre-assessment/programme information and in material displayed throughout the department. Based on the current evaluation, trauma-informed practices need to be considered for all interactions with the service over time, from referral and assessment, to treatment and the point of discharge. Therefore, it is important to ensure that wider experiences within the services, including administrative procedures, align with trauma-informed principles as much as possible.

The process of conducting the service evaluation has also led us to think more about the relevance of trauma-informed principles for supporting the treatment team's well-being. Clinicians who are frequently exposed to disclosures of traumatic events may experience vicarious trauma.[57] They may also experience moral injury[58] when they repeatedly encounter systems-level factors that contribute to patients' distress for which they may have little influence (e.g., long wait times, disjointed services). As a result, we continue to think about how to optimize appropriate support, such as through regular supervision and wider meetings, to maintain the well-being of the team.

Several limitations of this evaluation must be considered. It was conducted in the context of an intensive group-based, multidisciplinary ACT-based PMP. Although there is learning relevant to other treatment contexts, the findings were shaped by this specific context. Interviews were conducted while patients were in the second or third week of treatment. While this captures their real-time perspectives of treatment, this evaluation is not able to speak to patients' longer-term experiences. Interviews with people at follow-up would improve understanding of the service's alignment with trauma-informed principles over time.

It is important to consider the impact of having clinicians within the service conduct the interviews. To mitigate social desirability bias, we ensured that no interviewer was part of the participant's direct clinical team and the interview introduction encouraged participants to provide honest responses. Nevertheless, it is plausible that participants provided more positive responses as they were aware that the interviewers were part of the wider service team. Participants may have felt less comfortable providing negative feedback given the interviewers' roles as clinicians.

The interviewed patients were diverse with respect to gender, ethnicity, trauma history, and the severity of post-traumatic stress. However, the views of people who did not participate are not captured and their perspectives could have altered the findings. Relatedly, we did not capture the experiences of people who were not offered this treatment. This is particularly important given a previous audit found that approximately one third of patients assessed for a programme

within our service are discharged following assessment.[4] The presence of severe and poorly managed 'psychosocial distress', including trauma-related distress, was a common reason for exclusion from our service. Therefore, we must acknowledge the extent to which the service does not currently meet the needs of this group. The fragmentation of pain and community mental health services presents additional threats to trauma-informed practices that truly appreciate individuals' holistic care needs. Improved integration of pain and mental health services may reduce the exacerbation of trauma-related distress when people are excluded by design.[59]

To conclude, this service evaluation highlights areas of good practice with respect to trauma-informed care within the delivery of an intensive multidisciplinary PMP. The findings also provided directions for further service developments that have enabled us to continue to advance adherence to trauma-informed principles. Ongoing reflexivity and meaningful engagement with diverse patient partners have been essential to continue to optimize the delivery of trauma-informed pain services.

Conflicting interests:
CJ has received a conference presentation award from The Chartered Society of Physiotherapy for the In Sickness and In Health conference and World Congress of Physiotherapy. CJ has received conference support costs from the Special Interest Group on Pain and Trauma of the International Association for the Study of Pain. WS was previously partly funded through the National Institute for Health and Care Research (NIHR) Biomedical Research Centre at the South London and Maudsley NHS Foundation Trust and King's College London. The views expressed are those of the authors and not necessarily those of the NHS, the NIHR, or the Department of Health and Social Care. WS has also received funding from a Medical Research Council and Versus Arthritis consortium grant as part of the Advanced Pain Discovery Platform (MR/W002388/1). WS has received travel support to attend scientific meetings of the British Pain Society and the Neuropathic Pain Special Interest Group of the International Association for the Study of Pain. These sources of funding are unrelated to the current work. The authors report no further conflicts of interest.

Funding:
No funding was received for this service evaluation.

Ethical Approval:
This was a service evaluation based on the Health Research Authority's decision tool, as it was designed to judge current care and to inform future improvements in service delivery. Therefore, the evaluation did not require research ethics approval. The service evaluation was registered with the Trust's audit database (no. 15282) prior to data collection.

Informed consent:
Written informed consent was obtained from all patients for their participation in this service evaluation. Written informed consent was obtained from all patients for their anonymised quotations to be used.

Data Availability:
Participants did not consent to the sharing of their full interview transcripts beyond the team involved in the service evaluation and, therefore, transcripts cannot be shared.

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Author Contributions:
CJ, MA, PC, CL, and WS contributed to the conception and design of the service evaluation. All authors contributed to the collection and/or analysis of the data, the interpretation of the results, drafting/editing the manuscript, and approval of the final version. Artificial intelligence tools were not used in the preparation of this manuscript.

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Appendix A: Initial information provided to potential service evaluation participants

We aim to deliver this 3-week programme in a specific way. In a way that although challenging and exploratory also feels both collaborative and safe. A manner that is trustworthy, offers choice and empowerment and considers each person's cultural/diverse needs. As such we are hoping to deliver pain management care in a trauma-informed way, one that adheres to these key principles.

We know that many of you and people living with and suffering with chronic pain, may have had very difficult life experience. These may have contributed to, or impacted on the challenges you continue to face. This service evaluation is not about delving into these experiences.

We are looking to hear your voice, your experiences, your stories about some of these aspects whilst being here on this programme. We hope this might show us how we are doing as a service in providing trauma-informed care (from your perspective), show us any gaps that are missing and changes that we can make in the future.

Would you be willing to share with us?

If you are willing, we would ask that you read and sign a consent form, or I can read this out to you if you prefer. This would be to consent for a 45 min interview with myself, that is noted, and audio recorded. The audio would be deleted immediately after being transcribed and any quotes from the interview used only with your consent.

If at any time you wish to stop the interview or feel uncomfortable that is of course totally your choice.

Appendix B: Interview Protocol (Iteration 6)

Welcome to interview:

- Introduce self and project
- Ensure confidentiality and privacy
- Tell interviewee that their views are important and why
- Ask permission for recording and writing notes
- Informal question to establish rapport i.e have you travelled far to the programme?

We are hoping to deliver pain management care in a trauma-informed manner. What we mean is adhering to the principles of trauma-informed care: safety, trustworthiness, choice, collaboration, empowerment, and cultural considerations.

We are seeking to consider emotional, psychological and social factors that impact you and other clients and hope to learn about the circumstances that affect the care you receive here, by listening to your stories.

This service evaluation is not about delving into difficult past experiences. If at any time you feel uncomfortable and wish to stop the interview that is of course totally your choice.

Q1: How was it for you to come into this treatment space – the whole area, room, accommodations, environment, group?

Prompt: How did you feel you could relax, talk to people, be yourself, feel included?

Q2: I'm curious about your experiences on the programme. What was it like to be challenged to do something different/new? Can you give an example?
Prompt: What did this feel like? What happened? Did you feel you had choice? What surprised you, if anything?

Q3: How do you feel you have been supported in making choices on the programme?
Prompt: Was there a time you felt you didn't have a choice? Can you tell me about this? What was that like?

Q4: There is often a tension between 'staying safe' with where you are at and not triggering (i.e pain, emotions) versus a willingness to face challenges and do things differently - how do you navigate new things, do things differently?
Prompt: What was that like? What helped, or helps you?

Q5: Learning new pain management skills can be really challenging. What are your ways to manage/cope?
Prompt: Were there things you didn't want to do that you were encouraged to do that felt beneficial? What was that like?

Q6: Can you tell me about a time on the programme that was emotionally difficult for you?
Prompt: How did it feel? How was it handled? What did you do? (How did you manage or navigate this?) What was your perception of how you were supported? Were there any longer-term consequences i.e not electing to share/participate?
Q7: What happens to you when you talk about/or hear others talk about distressing experiences in the PMP group?
Prompt: How did you feel listened to, valued, that your opinion mattered? Was there an effect/impact on you? (of either speaking or hearing distress?)

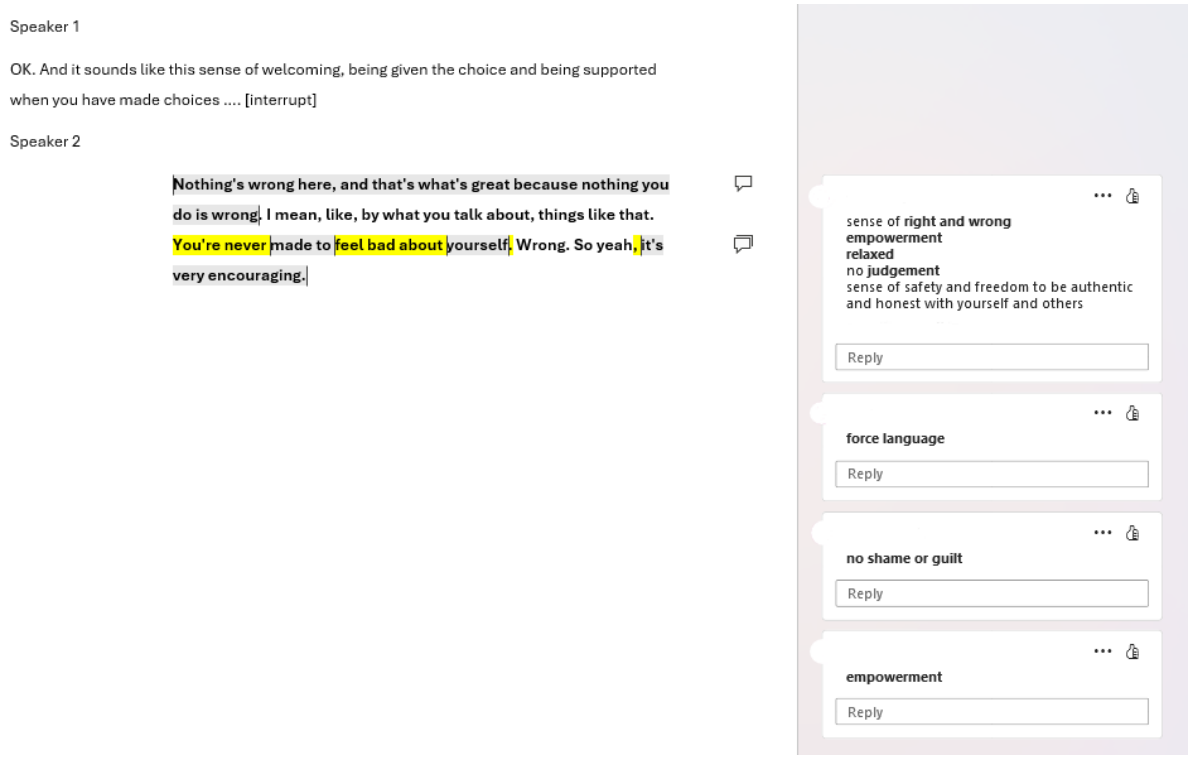
Q8: I'm curious to know - when there's the choice to share or not to share in sessions, what was that like for you?
Prompt: Sometimes there can be pressure to share or to stay silent, how was that for you?

Q9: We try to deliver programme to diverse groups, diverse cultures, ethnicities, genders, people with diverse needs including language, how do you feel the programme considered *your* needs?
Prompt; With this in mind, how was your experience as an individual - with your identity, your background? - Was there anything missing for you?

Exit / end questions: Is there anything else you feel we need to know? Is there anything important/significant that I didn't ask about or that you would like to share with me?
Are you ok? Are there any concerns? Are there any sections you would like removed from recording? Are you happy to leave it there?

Appendix C: Coding Trail

Coded Extract

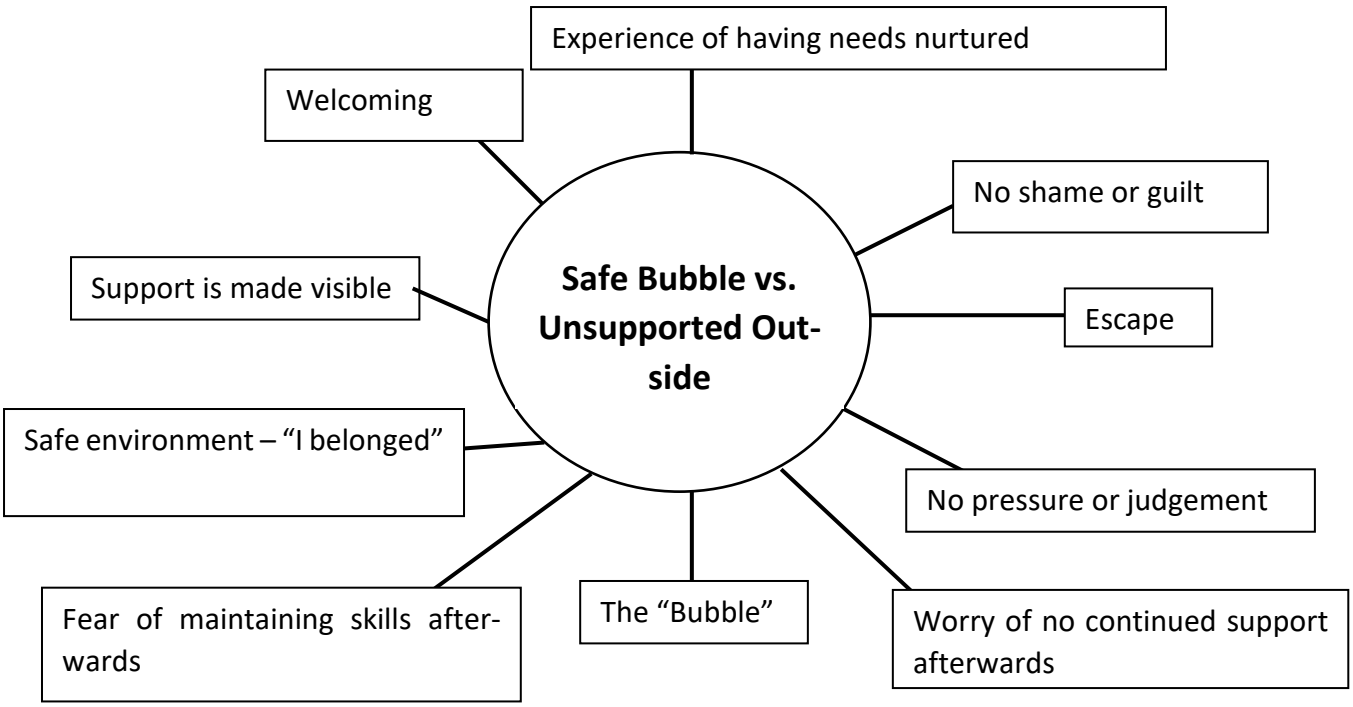


Excerpt from Interpretive Memo

"Nothing's wrong here, and that's what's great because nothing you do is wrong. I mean, like, by what you talk about, things like that. You're never made to feel bad about yourself. Wrong. So yeah, it's very encouraging. "

- A safe space where they don't feel forced – sense of being in a bubble
- Is this beneficial or harmful if it is too safe/not like the real world?
- No judgement encourages trying new things and vulnerability
- Safety

Preliminary Theme - Safe Bubble vs. Unsupported Outside



Final Theme

Theme 1 **- Forming, expanding, and dissolving the "bubble"**

Subtheme 1a– Creating the "bubble"

"Nothing's wrong here, and that's what's great because nothing you do is wrong." -P6

"being here, the environment was very warm, welcoming. So I felt like I had a space here. Like I belonged." –P8

Subtheme 1b – Expanding the "bubble" by managing competing needs and identities

"Some people have a voice, some have a bigger voice" – P5

"I've got hearing aids. And it means that in sort of social groups where a number of people are speaking, it can be quite difficult to follow and that slows one down, you know. I didn't join in as much of the discussion as ideally I would have liked to because you know I'm not quite sure of everything that had been said and just whether it was the appropriate moment to make my contribution." –P9

Subtheme 1c – The threat of outside; when the "bubble" is limiting

"And I'm panicking because I think, "Oh my God we've got to go home and there's gonna be the dogs and my daughter, and doing the housework and all them things are gonna start churning in." –P4

Appendix D: Current draft of service values developed following the service evaluation

The values that guide our work with you

SAFETY

- We aim to create a space where everyone feels listened to, and where you feel safe enough to face challenges and explore making changes.
- People have different needs for "safety", and we encourage you to share yours with us.

CHOICE

- We acknowledge that you may have experienced a lack of safety or control over the course of your pain journey.
- Everything is an invitation. It's okay to say no.
- We will invite you to explore your choices with curiosity.

TRUSTWORTHINESS

- We believe your experience is real. Pain is a complex mind-body experience, and we do not have all the answers.
- As much as possible, we will explain what we are doing and why.

COLLABORATION

- You are an active participant in your treatment. The team is working alongside you, and we can learn from each other.
- We approach difficulties within the group with kindness and as an opportunity to learn.
- We are continually working with former programme participants to improve our service. Your feedback is important.

EMPOWERMENT

- We believe that you are the expert in your experience of pain.
- We prioritize supporting you to make decisions that benefit your health and wellbeing in the long-term.
- We want to build on the strengths you already have.

DIVERSITY, EQUITY, INCLUSION

- We recognize that injustice exists. People experience different burdens on top of pain, including systemic oppression and discrimination.
- People have different values and beliefs. We aim to navigate group work with sensitivity and curiosity, whilst also maintaining safety.
- We educate, advocate, and participate in research to change systems and improve pain care for all people with pain.