Counselling after Workplace Bullying among Malaysian House Officers: A Conceptual Framework Integrating Person-Centred Theory and the Transtheoretical Model

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ABSTRACT

Workplace bullying is an occupational and educational concern for Malaysian house officers, whose clinical responsibilities coexist with dependence on senior staff for supervision, evaluation, and progression. Existing research documents exposure and associated distress, yet offers less explanation of how affected doctors recognise a need for support, decide whether counselling is safe, engage therapeutically, and maintain gains when workplace threats persist. This theory-synthesis article integrates Person-Centred Theory (PCT) and the Transtheoretical Model (TTM), situated within organisational and sociocultural conditions of Malaysian housemanship. PCT specifies the relational conditions through which psychological exploration may become possible; TTM is used heuristically to distinguish readiness to seek counselling from readiness to engage in change, and to understand recursive movement between them. The proposed contribution is a reciprocal process account: perceived relational safety may reshape readiness through reduced defensiveness and enhanced agency, whereas changes in readiness may alter disclosure and use of the therapeutic relationship. Five probabilistic propositions address professional identity and distress, contextual barriers, therapeutic engagement, recursive change, and organisational sustainability. The article identifies candidate measures, methodological safeguards, and a phased programme of empirical testing. Recent Malaysian multicentre evidence reinforces the organisational relevance of the framework. Counselling is presented as a potentially helpful, but not sufficient, response: credible recovery support also requires confidentiality, service independence, and action on bullying at its source.

Keywords: workplace bullying, house officers, person-centred counselling, Transtheoretical Model, help-seeking

INTRODUCTION

Workplace bullying is now recognised as a serious occupational hazard in healthcare and medical education. It is distinguished from isolated conflict or legitimate performance management by its repeated and persistent character, its harmful interpersonal consequences, and a power imbalance that makes resistance difficult (Einarsen et al., 2020; Leymann, 1996). In medicine, these features intersect with a training system in which junior doctors depend on senior clinicians for supervision, assessment, progression, and professional validation. The hierarchy that underpins clinical governance can therefore also create conditions in which humiliation, intimidation, exclusion, and professional undermining are difficult to name, let alone challenge (Leisy & Ahmad, 2016; Paice & Smith, 2009; Samsudin et al., 2018).

House officers occupy a particularly exposed position as newly qualified doctors who are simultaneously learners and service providers. Internationally, a meta-analysis estimated that nearly three in five trainees had experienced at least one form of harassment or discrimination during medical training (Fnais et al., 2014). In Malaysia, a study of 1,025 house officers in 12 government hospitals reported a 13.3% six-month prevalence using combined behavioural and self-labelling criteria (Samsudin, Isahak, Rampal, et al., 2021). More recently, a multicentre study across 13 Malaysian public hospitals reported bullying among 23.4% of respondents and identified associations with psychosocial safety climate and conflict-management styles (Mohd Rahim et al., 2026). These percentages should not be interpreted as a trend because designs, samples, and operational

definitions may differ. Following concern over house-officer welfare in 2022, the Healthcare Work Culture Improvement Task Force (HWCITF) drew public attention to bullying and workplace culture. Malaysian studies also describe psychological distress among house officers (Yeoh et al., 2019).

Despite this evidence, research has concentrated on prevalence, risk factors, and outcomes. Far less is known about how affected doctors recognise distress, decide whether to seek help, engage with counselling, and recover while remaining inside the same hierarchy. Counselling is routinely recommended for healthcare professionals, and Malaysian reporting and support channels were expanded after the HWCITF report. Yet the availability of a service does not explain whether a distressed house officer will feel safe enough to disclose, experience the therapeutic relationship as trustworthy, or be ready to act on new understanding. Reports that the Malaysian Ministry of Health's new complaint channel required complainants to identify themselves, alongside staff fears of reprisal, illustrate how confidentiality concerns can shape engagement before any therapeutic contact occurs.

This paper develops a pre-empirical conceptual framework integrating Person-Centred Theory (PCT; Rogers, 1951, 1957) and the Transtheoretical Model (TTM; Prochaska & DiClemente, 1982) within Malaysian housemanship. It proposes that counselling-related adaptation depends on the dynamic interplay of (i) the workplace context and perceived consequences of disclosure, (ii) readiness to access support and to engage in psychological change, and (iii) relational conditions that permit disclosure, reappraisal, and agency. It deliberately distinguishes seeking counselling from changing one's responses to mistreatment: these are related, but not identical, change targets. The framework does not assume a universal sequence or that counselling necessarily leads to improved outcomes.

The article makes four contributions. First, it identifies a previously under-specified feedback mechanism between relational safety and readiness: feeling understood without evaluation may enable deeper disclosure and reconsideration of options, while evolving readiness may increase or constrain participation in counselling. Second, it differentiates help-seeking readiness from readiness for within-counselling change, avoiding an overly literal transfer of TTM stages from other behavioural domains. Third, it places these interactions within organisational conditions, including credible confidentiality, service independence, workload, and the possibility of continued exposure. Fourth, it advances five falsifiable propositions and a phased research agenda, including operational definitions and methodological cautions. The paper is conceptual, not an account of collected empirical data.

Conceptual Approach

The article follows a theory-synthesis approach to conceptual scholarship (Jaakkola, 2020). The focal phenomenon is counselling after workplace bullying among Malaysian house officers. Literature was selected purposively across four interconnected bodies: Malaysian and international evidence on bullying in medical training; person-centred psychotherapy and therapeutic relationship research; readiness, help-seeking, and change processes; and workplace culture, organisational safety, and barriers to support. Seminal theoretical works were read alongside relevant clinical and occupational studies, including recent Malaysian multicentre evidence (Mohd Rahim et al., 2026). Sources were selected for conceptual relevance and their capacity to support, challenge, or delimit particular links in the proposed model. This is neither a systematic review nor a reproducible evidence synthesis; no claim of exhaustive retrieval or quantitative evidence weighting is made.

Five theory-selection criteria were specified before integration: (a) explanation of relational harm and the potential for relational repair; (b) relevance to processes occurring inside counselling; (c) capacity to conceptualise ambivalence, changing readiness, and return to earlier concerns; (d) an established and critically discussed research base; and (e) implications for practice in hierarchical settings. PCT offers the principal account of therapeutic conditions, whereas TTM provides a provisional vocabulary for variation over time. Neither adequately explains institutional risk alone; occupational and organisational perspectives therefore operate as contextual rather than decorative additions. The integration is evaluated by explanatory complementarity, clarity of change targets, and the availability of propositions that could be contradicted by evidence.

Workplace Bullying In Medical Training

Defining the Problem in the Malaysian Context

Workplace bullying refers to repeated negative acts directed toward an individual who has difficulty defending themselves because of an actual or perceived power imbalance (Einarsen et al., 2020). Acts may be overt, such as shouting or public humiliation, or subtle, such as exclusion, withholding information, and persistent devaluation. Rigorous supervision is often necessary in medicine; bullying differs because its pattern is demeaning or professionally undermining rather than proportionate and improvement-focused. Medical training blurs this distinction because authority gradients are embedded in everyday work and harshness may be normalised as professional socialisation. Reviews consistently identify hierarchical culture, workload, performance pressure, and organisational tolerance as contributing factors (Leisy & Ahmad, 2016; Samsudin et al., 2018), and organisational structures can enable or legitimise mistreatment through failures to act (Hutchinson & Jackson, 2015; Salin, 2003).

Malaysian evidence adds specificity. The Negative Acts Questionnaire-Revised (NAQ-R) has been examined psychometrically among Malaysian junior doctors (Samsudin, Isahak, & Rampal, 2021). Earlier multicentre findings identified bullying in the context of medical hierarchy (Samsudin, Isahak, Rampal, et al., 2021), while the 2026 multicentre study linked bullying with the psychosocial safety climate and approaches to managing conflict (Mohd Rahim et al., 2026). These associations support attention to hospital-level conditions, without establishing causal direction. Public reporting on the HWCITF and the MyHelp complaint channel also raises questions about whether affected doctors regard institutional processes as independent and confidential (CodeBlue, 2022, 2023). Crucially, lodging a workplace complaint and accessing therapeutic counselling have different purposes, information flows, and risks. A house officer may recognise mistreatment yet be unwilling to initiate either process, or may accept confidential counselling without wishing to complain.

Psychological and Professional Consequences

Meta-analytic and longitudinal research links bullying with anxiety, depressive symptoms, sleep disturbance, and the erosion of job and personal resources (Tuckey & Neall, 2014; Verkuil et al., 2015), and a meta-analysis found a moderate association between bullying and post-traumatic stress symptoms (Nielsen et al., 2015). For trainees, consequences may extend to diminished professional confidence and compromised clinical functioning, which is why bullying of trainee doctors has been framed as a patient-safety issue (Paice & Smith, 2009). Distress is also professionally loaded. In a culture that values competence and emotional control, a house officer may read anxiety or shame as evidence of professional inadequacy, so that seeking counselling requires reinterpreting what help-seeking means for professional identity. Stigma is a well-documented barrier to help-seeking, particularly where disclosure is perceived to carry career risk (Clement et al., 2015).

Theoretical Foundations

Person-Centred Theory as the Relational Foundation

Rogers (1951) positioned the client as an active meaning-maker whose capacity for growth is facilitated within a relationship of empathic understanding, genuineness, and non-possessive acceptance, and later specified empathy, congruence, and unconditional positive regard as core conditions for therapeutic change (Rogers, 1957). Contemporary evidence supports these relational elements: therapist empathy is robustly associated with outcome (Elliott et al., 2018), and the alliance predicts outcome across modalities (Flückiger et al., 2018; Norcross & Lambert, 2018). Client-perspective research shows that what clients find helpful cannot be reduced to technique; being understood and the fit between intervention and need are central (Elliott, 2008, 2010). Among young people who had been bullied, counselling was valued chiefly for the relationship with the counsellor and the opportunity to talk openly (Verasammy & Cooper, 2021).

PCT is especially apt for workplace bullying. Bullying communicates that the target is incompetent, weak, or undeserving of respect, and these messages are amplified when delivered by people with authority over evaluation and progression. A relationship organised around non-judgemental understanding offers a contrasting

experience in which the client is not being graded, corrected, or subordinated. PCT also names the discrepancy between the resilience a house officer feels compelled to display and the fear or exhaustion privately experienced, a state Rogers termed incongruence. Person-centred counselling may support greater congruence by allowing denied experiences to be acknowledged within a relationship in which acceptance does not depend on performance.

The Transtheoretical Model as a Process Lens

Help-seeking in hierarchical settings may involve uncertainty about whether mistreatment is 'normal training', concern about career consequences, informal coping, and delayed use of formal support (Carter et al., 2013; Clement et al., 2015). TTM describes precontemplation, contemplation, preparation, action, and maintenance (Prochaska & DiClemente, 1982; Prochaska & Velicer, 1997); associations between pretreatment readiness and psychotherapy outcomes have been reported (Krebs et al., 2018). For the present application, two change targets must be separated. Help-seeking readiness concerns identifying a need, exploring options, and making initial contact; therapeutic-change readiness concerns exploring painful meanings, revising self-blame, trying coping responses, or making informed choices after counselling begins. A house officer could be ready to attend a session yet not ready to disclose details or alter workplace behaviour, and the reverse is also possible. Accordingly, stages here are non-exclusive analytic prompts, not diagnoses or intervention mandates.

TTM has been criticised for uncertain stage boundaries and overly sequential depictions of change (West, 2005). Its application to bullying-related counselling is particularly tentative because the target behaviour may not be singular, observable, or fully under the client's control. Movement away from disclosure or confrontation may reflect rational appraisal of workplace danger rather than therapeutic failure. The model is therefore employed as a heuristic to generate testable questions about shifting readiness, not as a claim that all house officers traverse a predetermined series of stages. Empirical work must test whether stage-derived categories are meaningful to participants before quantitative stage assignment or adapted inventories are used.

Alternative and Complementary Perspectives

Several other perspectives could plausibly frame counselling after workplace bullying. Table 1 compares the most relevant against the selection criteria and states how each is incorporated.

Trauma-informed care organises services around safety, trustworthiness and transparency, peer support, collaboration, empowerment, and attention to cultural and historical issues (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Given evidence of trauma-related symptoms after bullying (Nielsen et al., 2015), these principles are directly relevant to service design. However, trauma-informed care is an organisational approach to delivering services rather than a theory of how change occurs within counselling, and not every bullied house officer will experience the harm as traumatic. Its principles are therefore adopted as service-level conditions surrounding the framework.

Resilience theory explains positive adaptation in the face of adversity (Fletcher & Sarkar, 2013). It usefully frames recovery as more than symptom reduction, but when applied to workplace mistreatment it risks locating the problem in the individual's capacity to withstand harm rather than in the conditions producing it. The framework retains resilience as a possible outcome, expressed as restored confidence and agency, while deliberately avoiding resilience as an explanation of who recovers.

Occupational stress models explain why bullying is harmful and why its effects persist. The transactional model of stress emphasises appraisal and coping (Lazarus & Folkman, 1984), the job demands-resources model explains strain as an imbalance between demands and resources (Bakker & Demerouti, 2007), and conservation of resources theory proposes that resource loss is more salient than gain and that losses spiral (Hobfoll, 1989). These models illuminate the initiating context and help explain Proposition 5, since continued exposure may deplete resources faster than counselling can restore them. They do not, however, describe the counselling relationship or the process of help-seeking.

Organisational psychology contributes the construct of psychological safety, the shared belief that a team is safe for interpersonal risk-taking (Edmondson, 1999), along with evidence that leadership and organisational strategy shape physician well-being (Shanafelt & Noseworthy, 2017). These perspectives are incorporated as moderators of help-seeking and of the sustainability of change. Finally, behavioural models of help-seeking such as the theory of planned behaviour (Ajzen, 1991) predict intention from attitudes, subjective norms, and perceived control. They are well suited to explaining the decision to seek counselling but say little about what happens once counselling begins.

Table 1 Comparison of PCT and TTM With Alternative and Complementary Perspectives

Perspective	**Main contribution to this problem**	**Limitation as the primary lens**	**Role in the present framework**
Person-Centred Theory (Rogers, 1957)	Explains how empathy, congruence, and unconditional positive regard can repair relationally inflicted harm.	Gives limited attention to readiness, timing, and organisational context.	Primary relational lens for the counselling process.
Transtheoretical Model (Prochaska & DiClemente, 1982)	Describes variation in readiness from recognition through help-seeking to maintenance and relapse.	Stage boundaries contested; says little about how change is relationally facilitated.	Primary process lens, used heuristically.
Trauma-informed care (SAMHSA, 2014)	Principles of safety, trust, choice, and empowerment for service delivery; fits evidence of trauma symptoms after bullying.	An organisational approach rather than a theory of change within counselling; not all bullying is experienced as trauma.	Service-level conditions surrounding counselling (moderating context).
Resilience theory (Fletcher & Sarkar, 2013)	Frames recovery as positive adaptation, not only symptom reduction.	Risks locating the problem in the individual's capacity to withstand mistreatment.	Informs outcome conceptualisation (confidence, agency) only.
Occupational stress models (Bakker & Demerouti, 2007; Hobfoll, 1989; Lazarus & Folkman, 1984)	Explain why bullying depletes resources and why continued exposure erodes recovery.	Do not describe help-seeking or the counselling relationship.	Inform the initiating context and Proposition 5.
Organisational psychology (Edmondson, 1999; Shanafelt & Noseworthy, 2017)	Psychological safety and leadership shape disclosure and well-being.	Does not address individual therapeutic change.	Moderators of help-seeking and sustainability (Propositions 2 and 5).
Theory of planned behaviour (Ajzen, 1991)	Predicts help-seeking intention from attitudes, norms, and perceived control.	Ends at the decision to seek help; silent on counselling process.	Informs measurement of help-seeking attitudes (Proposition 2).

PCT = Person-Centred Theory; TTM = Transtheoretical Model; SAMHSA = Substance Abuse and Mental Health Services Administration. Appraisal reflects the selection criteria stated in the Conceptual Approach section.

PCT and TTM were selected for explanatory complementarity, not because the other frameworks are unimportant or empirically inferior. PCT addresses what a trustworthy therapeutic relationship may enable; TTM directs attention to changing engagement with specific goals over time. Trauma-informed care contributes service principles, occupational models explain ongoing demands and resource loss, and organisational psychology explains institutional conditions in which disclosure can be safe or hazardous. Together these perspectives delimit a central claim: changes within counselling should not be mistaken for proof that an unchanged workplace has become safe.

The Integrated Framework

Integrating PCT and TTM

PCT and TTM become theoretically integrated when readiness and relational safety are treated as mutually influential rather than as two separate, sequential phases. First, a doctor may weigh anticipated benefits of counselling against fears of surveillance, stigma, or negative assessment. Second, an initial interaction characterised by empathic understanding, congruence, unconditional positive regard, and transparent confidentiality may reduce defensive self-monitoring and make disclosure tolerable (Rogers, 1957; Elliott et al., 2018). Third, disclosure and meaning-making may permit reconsideration of self-blame, perceived choices, and willingness to undertake further psychological work. Fourth, subsequent experiences of safety or threat can revise readiness again, including after a rotation or renewed bullying. These are proposed mechanisms, not demonstrated causal effects. PCT provides the relational conditions and TTM provides a provisional description of transitions and reversals; neither requires that counsellors pressure a client toward reporting, confrontation, or any externally preferred action. Table 2 illustrates potentially useful emphases rather than a prescriptive stage-matched treatment protocol.

A further distinction concerns levels of safety. Therapeutic or relational safety refers to a client's experienced freedom to speak without being judged or evaluated during counselling. Team psychological safety (Edmondson, 1999) refers to a shared workplace belief about interpersonal risk-taking. Organisational confidentiality and independence concern institutional safeguards and the credibility of service boundaries. These constructs may be related but should not be combined into one unvalidated measure; each can affect different links in the framework.

Table 2 Illustrative Mapping of TTM Positions to House Officer Experience and Person-Centred Emphases

TTM position (heuristic; specify change target)	**Possible house officer experience**	**Person-centred and service emphasis**
Precontemplation	Treats harsh or humiliating treatment as “normal training”; interprets distress as personal weakness.	Visible, non-evaluative messages that distress after mistreatment is legitimate; low-threat entry points to support.
Contemplation	Recognises harm but weighs confidentiality, stigma, and career risk against the cost of continuing alone.	Clear statements of confidentiality and its limits; empathic acknowledgement of ambivalence without pressure to act.
Preparation	Seeks information or informal reassurance; considers or books a first appointment (help-seeking readiness).	Independent, accessible services with flexible or remote scheduling; a welcoming, non-judgemental first contact.

	May still feel unready to disclose or make changes.	
Action	Attends counselling; degree of readiness for self-exploration, coping, disclosure and possible action may differ from readiness to attend.	Empathy, congruence, and unconditional positive regard sustaining exploration; client-led goals; techniques offered within the relationship.
Maintenance and recycling	Reassesses options and meanings after returning to work; renewed exposure may change willingness to disclose or undertake further work.	Continuity of care; framing setbacks as responses to context rather than failure; linkage with organisational remedies.

TTM = Transtheoretical Model. Positions are sensitising categories, not fixed stages; individuals may occupy several positions or move between them in either direction.

Organisational and Sociocultural Context

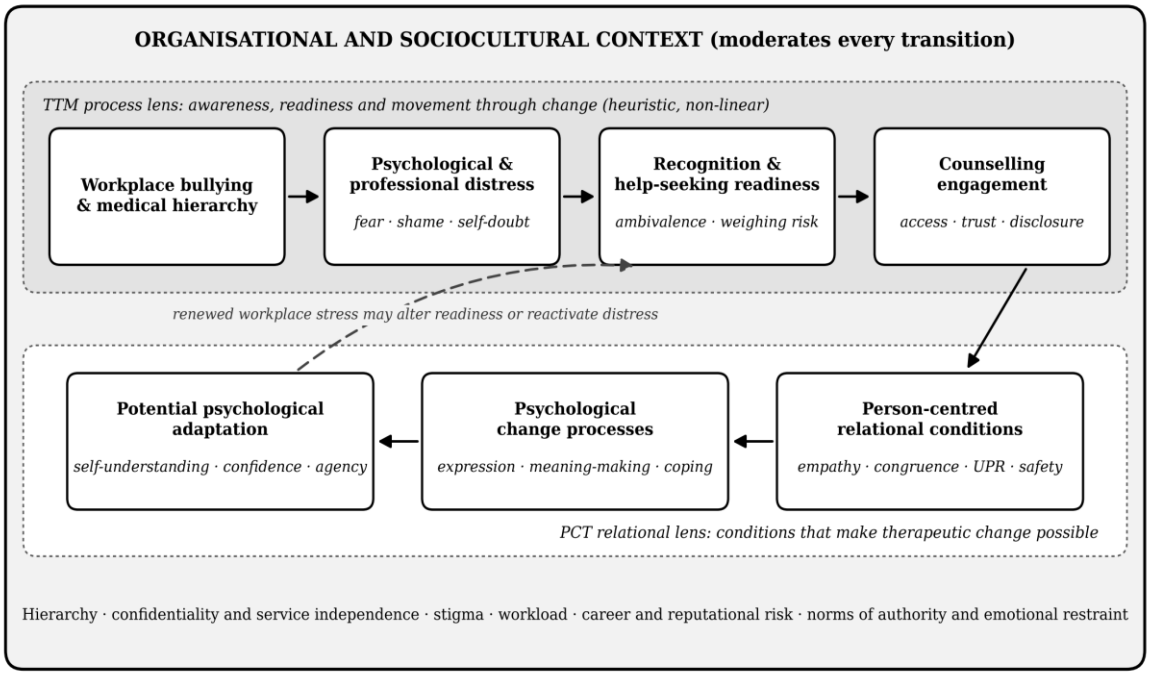
Organisational factors influence recognition of bullying, perceived safety of seeking help, practical access to counselling, and the possibility of sustaining improvements. Scheduling and heavy workloads may impede attendance; fear that a supervisor can access information may impede disclosure even where an appointment exists. Service independence must be demonstrable rather than assumed, with clear separation between counselling records, clinical training evaluations, and formal complaint investigations, subject to applicable legal and professional limits. The recent Malaysian study associating psychosocial safety climate with bullying exposure further supports treating institutional conditions as substantively relevant, although it does not directly test counselling outcomes (Mohd Rahim et al., 2026).

Sociocultural expectations can shape interpretations of authority, emotional restraint, professional competence, and the legitimacy of seeking assistance (Power et al., 2013). Malaysia's house-officer workforce is heterogeneous; ethnicity, language, religion, or training pathway should not be treated as fixed proxies for help-seeking attitudes. The framework instead proposes eliciting individual accounts of perceived obligations and risks. Context is expected to moderate key relationships, but different organisational constructs should be measured at their appropriate levels: individual confidence in confidentiality, team-level psychological safety, and hospital-level service arrangements. Cross-level claims require sufficiently sampled departments or hospitals.

The Proposed Framework

Figure 1 presents the proposed architecture. Workplace bullying within medical hierarchy may contribute to psychological distress and concerns about professional competence. Such experiences influence two analytically distinct yet interacting forms of readiness: readiness to seek counselling and readiness to engage in therapeutic change. Accessing counselling may expose the house officer to person-centred relational conditions, which could facilitate disclosure, meaning-making, and perceived agency. Importantly, greater relational safety may also feed back into readiness; conversely, renewed workplace threat may reduce either form of readiness or undermine adaptation. Organisational and sociocultural conditions are proposed moderators of help-seeking, therapeutic engagement, and sustainability, rather than mere background descriptors. Figure 1 is a simplified visual representation of these reciprocal and multilevel hypotheses; it should not be interpreted as a fixed causal chain.

Figure 1 Proposed Conceptual Framework for Counselling After Workplace Bullying Among Malaysian House Officers



Note: This framework is pre-empirical. Solid arrows represent proposed pathways, not established causal effects. The dashed feedback pathway indicates possible reactivation of distress or reassessment of readiness after renewed workplace stress; feedback between therapeutic relational safety and readiness is also hypothesised in the accompanying text. 'Readiness' encompasses separable targets: seeking support and engaging in psychological change. Organisational and sociocultural influences may moderate different links at different levels. TTM = Transtheoretical Model; PCT = Person-Centred Theory; UPR = unconditional positive regard.

Conceptual Propositions

The five propositions are conditional, probabilistic, and open to disconfirmation. To avoid conflating mechanisms, the proposed indicators distinguish individual-level professional appraisal, help-seeking readiness, within-counselling change readiness, client-perceived relational quality, and department- or hospital-level support. The propositions describe relationships to investigate rather than effects demonstrated in Malaysian house officers.

Proposition 1: Bullying-related distress is both psychological and professional.

More frequent bullying exposure is expected to be associated with greater psychological distress and poorer professional self-appraisal. Perceived threat to professional competence is proposed as one potential explanatory pathway, especially when perpetrators control evaluation or progression. This mediation claim requires temporal evidence; cross-sectional associations alone would not establish that bullying preceded changes in professional self-appraisal.

Proposition 2: Context shapes readiness for help-seeking.

Among affected house officers, stronger trust in confidentiality, lower anticipated career repercussions, and more accessible independent counselling are expected to be associated with greater readiness to seek support. Organisational trust and team psychological safety may moderate the association between distress and help-seeking readiness, but these are conceptually distinct from a client's perceived safety within counselling. Alternative explanations, including distress severity and prior service experiences, should be assessed.

Proposition 3: Relational safety enables deeper counselling engagement.

Among house officers who enter counselling, higher client-perceived empathy, congruence, and unconditional positive regard are expected to be associated with stronger alliance, disclosure, and depth of reflection. An explanatory pathway is proposed in which experienced relational safety reduces anticipated judgement and supports exploration; both temporal order and possible reverse causation should be evaluated. Attendance, disclosure, and perceived helpfulness should not be treated as interchangeable outcomes.

Proposition 4: Readiness and psychological change are iterative.

Readiness to seek help and readiness for within-counselling change are expected to vary independently and recursively across sessions, rotations, and changes in perceived workplace risk. A supportive encounter may increase willingness to disclose, whereas renewed bullying may produce cautious withdrawal without necessarily erasing prior therapeutic insight. Repeated interviews and appropriately validated measures should test whether meaningful shifts occur rather than imposing stage labels in advance.

Proposition 5: Organisational conditions govern the sustainability of counselling-related change.

Increases in self-understanding, confidence, and agency following counselling are expected to be more sustainable where organisational conditions limit recurrent bullying, provide credible protection against retaliation, and allow continuity of care. Continued harmful exposure may attenuate gains even with a strong therapeutic alliance. This proposition requires longitudinal data and sufficient organisational units for defensible multilevel inference; counselling uptake alone is not an adequate indicator of institutional recovery.

Empirical Testing Of The Propositions

Because the framework has not been validated, measures and designs in Table 3 are research candidates rather than a ready-made instrument battery. The NAQ-R has been studied among Malaysian junior doctors (Samsudin, Isahak, & Rampal, 2021), and a Malay DASS version has been reported (Musa et al., 2007). Other scales may require linguistic adaptation, cognitive interviewing, reliability testing, and structural validation in Malaysian house officers. Particular caution applies to the University of Rhode Island Change Assessment (URICA): originally designed around readiness for psychotherapy-related change, its unmodified scores should not be assumed to measure willingness to access counselling after bullying. Investigators should first specify the behavioural or psychological change target and assess content validity, comprehensibility, and measurement invariance where relevant.

Table 3 Measurable Indicators, Candidate Instruments, and Research Designs for Testing the Propositions

Proposition	Measurable indicators	Candidate instruments	Suggested design and analysis
P1: Distress is psychological and professional	Bullying exposure; depression, anxiety, stress; professional self-evaluation	NAQ-R (Einarsen et al., 2009; Malaysian validation: Samsudin, Isahak, & Rampal, 2021); DASS-21, Malay version (Musa et al., 2007); Occupational Self-Efficacy Scale, short form (Rigotti et al., 2008)	Cross-sectional survey; structural equation modelling testing self-evaluation as a mediator; interpretative phenomenological analysis
P2: Context shapes readiness	Client-perceived empathy, regard and relational safety; alliance; disclosure; within-counselling	Self-Stigma of Seeking Help Scale (Vogel et al., 2006); ATSPPH-SF (Fischer & Farina, 1995); URICA (McConnaughy et al., 1983); Team Psychological Safety Scale (Edmondson, 1999); purpose-built	Prospective session-by-session study; temporally ordered client reports, multilevel models if adequately powered; qualitative change interviews

	change readiness; perceived helpfulness	confidentiality-trust items validated by expert panel	
P3: Relational safety enables engagement	Separately defined help-seeking and change readiness; session distress; renewed bullying; reported setbacks and triggers	Cognitively tested, context-adapted readiness items; URICA only after construct validation; CORE-OM or CORE-10; repeated exposure assessment	Longitudinal repeated measures across rotations; within-person analysis or qualitative longitudinal interviews; assess feasibility before latent transition modelling
P4: Readiness and change are iterative	Fluctuation in readiness; session-to-session distress; reported setbacks and their triggers	URICA administered repeatedly; CORE-OM or CORE-10 (Evans et al., 2002)	Prospective follow-up; departments/hospitals sampled in sufficient numbers before cross-level moderation; compare ongoing exposure and perceived safety
P5: Organisation governs sustainability	Ongoing bullying exposure; departmental psychological safety; maintenance of gains at follow-up	NAQ-R; Team Psychological Safety Scale; CORE-OM at 3- and 6-month follow-up	Multilevel design with clients nested in departments or hospitals; cross-level moderation analysis

Note. Candidate instruments require evaluation for construct fit, licensing, language, and population suitability. NAQ-R = Negative Acts Questionnaire-Revised; DASS-21 = Depression Anxiety Stress Scales; ATSPPH-SF = Attitudes Toward Seeking Professional Psychological Help Scale-Short Form; URICA = University of Rhode Island Change Assessment; WAI-SR = Working Alliance Inventory-Short Revised; CORE-OM = Clinical Outcomes in Routine Evaluation-Outcome Measure. Help-seeking readiness and readiness for within-counselling change must be defined and measured separately. Cross-sectional mediation can establish associations consistent with a theory but cannot by itself demonstrate temporal or causal mediation.

A sequential research programme is proposed. Phase 1: use expert consultation and cognitive interviews with house officers, former trainees, counsellors, and educators to refine construct definitions and assess whether the two readiness targets and proposed pathways are meaningful; a Delphi exercise could establish expert agreement on candidate indicators (Hasson et al., 2000). Phase 2: conduct confidential, purposively sampled qualitative interviews with house officers with relevant bullying experiences, including those who did and did not seek counselling, to examine unanticipated pathways and barriers; research access should not depend on supervisors identifying affected trainees. Phase 3: pilot and validate adapted measures, then examine associations among exposure, professional self-appraisal, confidentiality trust, and readiness, accounting for confounding and clustered hospital samples. Phase 4: undertake prospective longitudinal work among consenting counselling clients, collecting client-rated therapeutic relationship and change indicators over sessions and follow-up; changes after rotations can be examined alongside renewed exposure. Testing contextual moderation requires an adequate number of independently sampled departments or hospitals. Pre-registration of hypotheses, clear missing-data procedures, protection of participant identities, and reporting of contradictory findings would strengthen inference. Where sampling or statistical power is insufficient, descriptive or qualitative conclusions are preferable to overfitted mediation and multilevel models.

Operationalising The Framework In Practice

An Illustrative Case

The following composite case is hypothetical and constructed for illustration only; it does not describe a real person or report data. Dr A, a house officer in a surgical rotation, is repeatedly criticised in front of patients and colleagues by a senior medical officer. Initially, Dr A regards this as part of training and concludes that the

problem is personal inadequacy (precontemplation). After weeks of poor sleep and dread before ward rounds, Dr A recognises that the treatment is harmful but hesitates to contact the hospital counselling unit, fearing that attendance will be noticed and recorded (contemplation). A hospital-wide message stating that counselling records are held separately from training files, together with an option for after-hours tele-counselling, lowers the perceived risk, and Dr A books a session (preparation).

In counselling, the counsellor first clarifies confidentiality and its limits and does not move immediately to assertiveness training. Feeling heard without evaluation, Dr A begins to separate the senior's conduct from personal competence and to articulate options, including seeking a different supervisor and documenting incidents (action). When Dr A rotates to a department with a supportive supervisor, gains in confidence are consolidated. Had the bullying continued unaddressed, the framework predicts that readiness and confidence would be more likely to erode, with Dr A returning to earlier concerns (recycling), underscoring the need for organisational action alongside counselling.

Stakeholder Actions

The case illustrates how each component of the framework translates into concrete action. Table 4 summarises examples for counsellors, hospital administrators, and medical educators.

Table 4 Examples of How Stakeholders Might Operationalise the Framework

Framework component	**Counsellors**	**Hospital administrators**	**Medical educators**
Recognition and readiness	Offer brief, low-commitment first contacts; validate ambivalence without pressing for action.	Publicise confidential pathways at orientation and on wards; state explicitly that counselling records are separate from training files.	Discuss bullying and help-seeking openly in orientation; model help-seeking as professional behaviour.
Access and engagement	Clarify confidentiality and its limits in the first session; acknowledge the power context.	Provide after-hours and tele-counselling; protect time to attend; locate or contract services independently of line management.	Allow trainees to attend counselling without justifying absence to supervisors.
Relational conditions in counselling	Prioritise empathy, congruence, and unconditional positive regard; introduce skills-based techniques once the client feels understood.	Ensure counsellors are trained in person-centred practice and in the medical training context; monitor client-rated alliance.	Include counselling staff in faculty development so supervisors understand what counselling offers.
Sustaining change	Plan for setbacks around rotation changes; support boundary-setting and informed career decisions.	Act on bullying reports independently of counselling; track departmental psychological safety; enable supervisor changes where needed.	Train supervisors to distinguish rigorous feedback from humiliation; include respectful supervision in supervisor appraisal.

Note: Examples are illustrative and should be adapted to local resources and evaluated as part of implementation.

For counsellors, the central implication is sequencing: establish perceived safety and confidentiality first, match interventions to readiness, and remain alert to whether advice is experienced as support or as another form of authority. Therapeutic goals should not be equated automatically with confrontation or formal complaint; agency

may include understanding options, seeking safe support, making deliberate career decisions, or setting boundaries where feasible.

For hospital administrators, the framework implies that counselling services must be visibly independent of performance evaluation and complaint processes, practically accessible to doctors working irregular hours, and accompanied by action on the organisational drivers of bullying. The Malaysian experience with a complaint channel that required identification (CodeBlue, 2023) underlines the importance of separating therapeutic support from reporting and of communicating that separation clearly. Trauma-informed principles of safety, trustworthiness, and choice provide a practical template for service design (SAMHSA, 2014).

For medical educators, the priorities are to change the meaning attached to help-seeking and to equip supervisors to distinguish demanding but respectful feedback from humiliating behaviour. Orientation programmes can introduce counselling as a normal professional resource, and supervisor training can address the authority gradients described in this paper. Consistent with evidence that organisational as well as individual interventions reduce physician burnout (C. P. West et al., 2016), psychological support is most credible when accompanied by accountability and leadership commitment (Shanafelt & Noseworthy, 2017).

Implementation Considerations

Implementation should begin with co-design and feasibility work, not immediate claims of clinical effectiveness. An initial pilot could assess clarity of confidentiality explanations, perceived separation of counselling from appraisal and complaints, referral accessibility, appointment timeliness, and voluntary client feedback. Subsequent evaluation could examine engagement and follow-up well-being while monitoring whether workplace bullying and perceived retaliation risk change independently of service uptake. Hospital leaders should ensure robust privacy safeguards, escalation pathways for urgent risk, appropriate referral to specialist mental-health services when indicated, and explicit limits to confidentiality. The Consolidated Framework for Implementation Research offers an organising perspective for implementation barriers and facilitators (Damschroder et al., 2009), but the present article does not establish that any particular service configuration has been tested or shown effective in Malaysia.

Limitations

Several limitations delimit the proposed contribution. First, this is a theory-synthesis article and no new empirical evidence is reported. Second, literature selection was purposive, not systematic, so relevant counterexamples or unpublished work may have been missed. Third, TTM stage boundaries are contested, and constructs designed for behavioural change may not map directly onto counselling decisions under coercive workplace conditions. Fourth, the hypothesised reciprocal influence between readiness and relational safety remains untested, and self-reported measures may be influenced by common-method bias. Fifth, institutional climate, team psychological safety, client-perceived safety, and confidentiality trust are not interchangeable; multilevel testing requires adequate sampling and measurement. Sixth, some proposed instruments lack established validation for Malaysian house officers, and short follow-up periods may miss recurrent harm. Seventh, the paper focuses on formal individual counselling rather than the full continuum of peer support, psychiatric care, advocacy, and legal or administrative remedies. Finally, perspectives of participants who avoid counselling, and of supervisors and service providers, are needed to assess whether the framework is sufficiently inclusive.

CONCLUSION

Workplace bullying among Malaysian house officers combines interpersonal harm with evaluation dependence and institutional risk. The proposed PCT-TTM synthesis contributes a specific, testable account of how relational safety and readiness may influence one another during counselling, while distinguishing readiness to seek assistance from readiness for psychological change. Organisational and sociocultural conditions may shape whether initial contact is trusted, therapeutic work becomes possible, and subsequent gains can be sustained. The framework's five propositions, operational distinctions, and phased testing plan provide a foundation for empirical critique rather than a validated clinical pathway. Counselling may support disclosure, reappraisal, and

agency; reducing harm requires equally credible organisational accountability, confidentiality safeguards, and respectful supervision.

Declarations

Ethical Approval

This conceptual paper does not report new data from human or animal participants; ethical approval was therefore not required. Ethical approval will be sought for any empirical studies arising from the framework.

Conflict of Interest

The authors declare no conflict of interest.

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Data Availability

Data sharing is not applicable to this article, as no datasets were generated or analysed. All sources discussed are cited in the reference list.

Declaration of Generative AI Use

Generative AI tools were used for language editing in preparing this manuscript. The authors reviewed all content and take full responsibility for it.

REFERENCES

1. Ajzen, I. (1991). The theory of planned behavior. Organizational Behavior and Human Decision Processes, 50(2), 179–211. https://doi.org/10.1016/0749-5978(91)90020-T
2. Bakker, A. B., & Demerouti, E. (2007). The job demands-resources model: State of the art. Journal of Managerial Psychology, 22(3), 309–328. https://doi.org/10.1108/02683940710733115
3. Barrett-Lennard, G. T. (1962). Dimensions of therapist response as causal factors in therapeutic change. Psychological Monographs: General and Applied, 76(43), 1–36. https://doi.org/10.1037/h0093918
4. Carter, M., Thompson, N., Crampton, P., Morrow, G., Burford, B., Gray, C., & Illing, J. (2013). Workplace bullying in the UK NHS: A questionnaire and interview study on prevalence, impact and barriers to reporting. BMJ Open, 3(6), Article e002628. https://doi.org/10.1136/bmjopen-2013-002628
5. Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S. L., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. Psychological Medicine, 45(1), 11–27. https://doi.org/10.1017/S0033291714000129
6. CodeBlue. (2022, August 18). Nearly quarter of supervisors in MOH admit bullying: HWCITF report. https://codeblue.galencentre.org/2022/08/nearly-quarter-of-supervisors-in-moh-admit-bullying-hwcitf-report/
7. CodeBlue. (2023, March 21). MOH's MyHelp channel doesn't allow anonymous bullying complaints. https://codeblue.galencentre.org/2023/03/mohs-myhelp-channel-doesnt-allow-anonymous-bullying-complaints/
8. Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. Implementation Science, 4, Article 50. https://doi.org/10.1186/1748-5908-4-50
9. Edmondson, A. (1999). Psychological safety and learning behavior in work teams. Administrative Science Quarterly, 44(2), 350–383. https://doi.org/10.2307/2666999

10. Einarsen, S., Hoel, H., & Notelaers, G. (2009). Measuring exposure to bullying and harassment at work: Validity, factor structure and psychometric properties of the Negative Acts Questionnaire-Revised. Work & Stress, 23(1), 24–44. https://doi.org/10.1080/02678370902815673
11. Einarsen, S. V., Hoel, H., Zapf, D., & Cooper, C. L. (Eds.). (2020). Bullying and harassment in the workplace: Theory, research and practice (3rd ed.). CRC Press.
12. Elliott, R. (2008). Research on client experiences of therapy: Introduction to the special section. Psychotherapy Research, 18(3), 239–242. https://doi.org/10.1080/10503300802074513
13. Elliott, R. (2010). Psychotherapy change process research: Realizing the promise. Psychotherapy Research, 20(2), 123–135. https://doi.org/10.1080/10503300903470743
14. Elliott, R., Bohart, A. C., Watson, J. C., & Murphy, D. (2018). Therapist empathy and client outcome: An updated meta-analysis. Psychotherapy, 55(4), 399–410. https://doi.org/10.1037/pst0000175
15. Evans, C., Connell, J., Barkham, M., Margison, F., McGrath, G., Mellor-Clark, J., & Audin, K. (2002). Towards a standardised brief outcome measure: Psychometric properties and utility of the CORE-OM. British Journal of Psychiatry, 180(1), 51–60. https://doi.org/10.1192/bjp.180.1.51
16. Fischer, E. H., & Farina, A. (1995). Attitudes toward seeking professional psychological help: A shortened form and considerations for research. Journal of College Student Development, 36(4), 368–373.
17. Fletcher, D., & Sarkar, M. (2013). Psychological resilience: A review and critique of definitions, concepts, and theory. European Psychologist, 18(1), 12–23. https://doi.org/10.1027/1016-9040/a000124
18. Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. Psychotherapy, 55(4), 316–340. https://doi.org/10.1037/pst0000172
19. Fnais, N., Soobiah, C., Chen, M. H., Lillie, E., Perrier, L., Tashkhandi, M., Straus, S. E., Mamdani, M., Al-Omran, M., & Tricco, A. C. (2014). Harassment and discrimination in medical training: A systematic review and meta-analysis. Academic Medicine, 89(5), 817–827. https://doi.org/10.1097/ACM.0000000000000200
20. Hasson, F., Keeney, S., & McKenna, H. (2000). Research guidelines for the Delphi survey technique. Journal of Advanced Nursing, 32(4), 1008–1015. https://doi.org/10.1046/j.1365-2648.2000.t01-1-01567.x
21. Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. Psychotherapy Research, 16(1), 12–25. https://doi.org/10.1080/10503300500352500
22. Hayes, A. F. (2018). Introduction to mediation, moderation, and conditional process analysis: A regression-based approach (2nd ed.). Guilford Press.
23. Hobfoll, S. E. (1989). Conservation of resources: A new attempt at conceptualizing stress. American Psychologist, 44(3), 513–524. https://doi.org/10.1037/0003-066X.44.3.513
24. Hutchinson, M., & Jackson, D. (2015). The construction and legitimation of workplace bullying in the public sector: Insight into power dynamics and organisational failures in health and social care. Nursing Inquiry, 22(1), 13–26. https://doi.org/10.1111/nin.12077
25. Jaakkola, E. (2020). Designing conceptual articles: Four approaches. AMS Review, 10(1), 18–26. https://doi.org/10.1007/s13162-020-00161-0
26. Krebs, P., Norcross, J. C., Nicholson, J. M., & Prochaska, J. O. (2018). Stages of change and psychotherapy outcomes: A review and meta-analysis. Journal of Clinical Psychology, 74(11), 1964–1979. https://doi.org/10.1002/jclp.22683
27. Lazarus, R. S., & Folkman, S. (1984). Stress, appraisal, and coping. Springer.
28. Leisy, H. B., & Ahmad, M. (2016). Altering workplace attitudes for resident education (A.W.A.R.E.): Discovering solutions for medical resident bullying through literature review. BMC Medical Education, 16, Article 127. https://doi.org/10.1186/s12909-016-0639-8
29. Leymann, H. (1996). The content and development of mobbing at work. European Journal of Work and Organizational Psychology, 5(2), 165–184. https://doi.org/10.1080/13594329608414853
30. Llewelyn, S. P. (1988). Psychological therapy as viewed by clients and therapists. British Journal of Clinical Psychology, 27(3), 223–237. https://doi.org/10.1111/j.2044-8260.1988.tb00779.x

31. McConnaughy, E. A., Prochaska, J. O., & Velicer, W. F. (1983). Stages of change in psychotherapy: Measurement and sample profiles. Psychotherapy: Theory, Research & Practice, 20(3), 368–375. https://doi.org/10.1037/h0090198
32. Mohd Rahim, S. S. Z., Thangiah, N., Baharudin, F., Rosely, M. F., & Hoe, V. C. W. (2026). Psychosocial safety climate and conflict management styles as predictors of workplace bullying among house officers in Malaysian public hospitals: A multicentre cross-sectional study. Asia-Pacific Journal of Public Health, 38(2–3), 220–227. https://doi.org/10.1177/10105395261425351
33. Musa, R., Fadzil, M. A., & Zain, Z. (2007). Translation, validation and psychometric properties of Bahasa Malaysia version of the Depression Anxiety and Stress Scales (DASS). ASEAN Journal of Psychiatry, 8(2), 82–89.
34. Nielsen, M. B., Tangen, T., Idsoe, T., Matthiesen, S. B., & Magerøy, N. (2015). Post-traumatic stress disorder as a consequence of bullying at work and at school: A literature review and meta-analysis. Aggression and Violent Behavior, 21, 17–24. https://doi.org/10.1016/j.avb.2015.01.001
35. Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy relationships that work III. Psychotherapy, 55(4), 303–315. https://doi.org/10.1037/pst0000193
36. Paice, E., & Smith, D. (2009). Bullying of trainee doctors is a patient safety issue. The Clinical Teacher, 6(1), 13–17. https://doi.org/10.1111/j.1743-498X.2008.00251.x
37. Power, J. L., Brotheridge, C. M., Blenkinsopp, J., Bowes-Sperry, L., Bozionelos, N., Buzády, Z., Chuang, A., Drnevich, D., Garzon-Vico, A., Leighton, C., Madero, S. M., Mak, W., Mathew, R., Monserrat, S. I., Mujtaba, B. G., Olivas-Lujan, M. R., Polycroniou, P., Sprigg, C. A., Axtell, C., & Holman, D. (2013). Acceptability of workplace bullying: A comparative study on six continents. Journal of Business Research, 66(3), 374–380. https://doi.org/10.1016/j.jbusres.2011.08.018
38. Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. Psychotherapy: Theory, Research & Practice, 19(3), 276–288. https://doi.org/10.1037/h0088437
39. Prochaska, J. O., & Velicer, W. F. (1997). The transtheoretical model of health behavior change. American Journal of Health Promotion, 12(1), 38–48. https://doi.org/10.4278/0890-1171-12.1.38
40. Rigotti, T., Schyns, B., & Mohr, G. (2008). A short version of the occupational self-efficacy scale: Structural and construct validity across five countries. Journal of Career Assessment, 16(2), 238–255. https://doi.org/10.1177/1069072707305763
41. Rogers, C. R. (1951). Client-centered therapy: Its current practice, implications and theory. Houghton Mifflin.
42. Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 21(2), 95–103. https://doi.org/10.1037/h0045357
43. Salin, D. (2003). Ways of explaining workplace bullying: A review of enabling, motivating and precipitating structures and processes in the work environment. Human Relations, 56(10), 1213–1232. https://doi.org/10.1177/00187267035610003
44. Samsudin, E. Z., Isahak, M., & Rampal, S. (2018). The prevalence, risk factors and outcomes of workplace bullying among junior doctors: A systematic review. European Journal of Work and Organizational Psychology, 27(6), 700–718. https://doi.org/10.1080/1359432X.2018.1502171
45. Samsudin, E. Z., Isahak, M., & Rampal, S. (2021). Measuring exposure to workplace bullying among Malaysian junior doctors: Psychometric properties of the Negative Acts Questionnaire-Revised. Journal of Health and Translational Medicine, 24(2), 110–116. https://doi.org/10.22452/jummec.vol24no2.15
46. Samsudin, E. Z., Isahak, M., Rampal, S., Ismail, R., & Zakaria, M. I. (2021). Workplace bullying among junior doctors in Malaysia: A multicentre cross-sectional study. Malaysian Journal of Medical Sciences, 28(2), 142–156. https://doi.org/10.21315/mjms2021.28.2.13
47. Shanafelt, T. D., & Noseworthy, J. H. (2017). Executive leadership and physician well-being: Nine organizational strategies to promote engagement and reduce burnout. Mayo Clinic Proceedings, 92(1), 129–146. https://doi.org/10.1016/j.mayocp.2016.10.004
48. Substance Abuse and Mental Health Services Administration. (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach (HHS Publication No. SMA 14-4884). U.S. Department of Health and Human Services.

49. Tuckey, M. R., & Neall, A. M. (2014). Workplace bullying erodes job and personal resources: Between- and within-person perspectives. Journal of Occupational Health Psychology, 19(4), 413–424. https://doi.org/10.1037/a0037728
50. Verasammy, K., & Cooper, M. (2021). Helpful aspects of counselling for young people who have experienced bullying: A thematic analysis. British Journal of Guidance & Counselling, 49(3), 468–479. https://doi.org/10.1080/03069885.2021.1900777
51. Verkuil, B., Atasayi, S., & Molendijk, M. L. (2015). Workplace bullying and mental health: A meta-analysis on cross-sectional and longitudinal data. PLOS ONE, 10(8), Article e0135225. https://doi.org/10.1371/journal.pone.0135225
52. Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. Journal of Counseling Psychology, 53(3), 325–337. https://doi.org/10.1037/0022-0167.53.3.325
53. West, C. P., Dyrbye, L. N., Erwin, P. J., & Shanafelt, T. D. (2016). Interventions to prevent and reduce physician burnout: A systematic review and meta-analysis. The Lancet, 388(10057), 2272–2281. https://doi.org/10.1016/S0140-6736(16)31279-X
54. West, R. (2005). Time for a change: Putting the Transtheoretical (Stages of Change) Model to rest. Addiction, 100(8), 1036–1039. https://doi.org/10.1111/j.1360-0443.2005.01139.x
55. Yeoh, C. M., Thong, K. S., Seed, H. F., Abdul Taib, N. I., & Husain, M. B. (2019). Psychological morbidities amongst house officers in Sarawak General Hospital Kuching. Medical Journal of Malaysia, 74(4), 307–311.