“It is acceptable, and more than acceptable, it is appropriate”

Retrospective acceptability of a trust and empowerment related pilot intervention from the perspective of the intervention recipients

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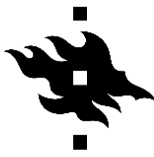

ABSTRACT

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Abstract:

Trust and empowerment are popular management practices, with many big organizations having adopted initiatives involving the two concepts. Despite the popularity of these initiatives, most of them fail. To be able to design effective behavior change interventions we need to know what made the interventions successful or unsuccessful by evaluating them. Traditionally, effectiveness was evaluated but recently knowing why an intervention worked is perceived as essential. By understanding how participants of trust and empowerment initiatives perceive their acceptability, insights can be gained into why the intervention worked as it did. Intervention acceptability refers to how the intervention providers or receivers think or feel about an intervention.

This study aims to examine the retrospective intervention acceptability, of an organizational pilot intervention focusing on trust and empowerment, from the perspective of the intervention recipients. To examine how the intervention participants perceive the acceptability of the intervention, the acceptability domains of the Theoretical Framework of Acceptability (TFA) will be used. As the TFA was developed for assessing the acceptability of healthcare interventions, the fit of the framework for assessing the acceptability of an organizational intervention will be evaluated.

The study adopts a qualitative research methodology using theory-driven content analysis with a relativist perspective. The data was collected using online semi-structured focus group interviews. The sample included 12 team- or project leaders from different parts of the world.

The results show that the intervention has high retrospective acceptability from the perspective of the intervention recipients. The participants mainly used the existing TFA domains in their construction of acceptability, with the addition of including appropriateness as a central domain. It, therefore, seems that the TFA works well for understanding how the participants of a trust and empowerment intervention conducted in an organizational setting, perceive its acceptability.

It seems that the intervention is designed to suit the target group well, which increases the likelihood for a successful full-scale intervention when and if the organization decides to roll out the training on a larger scale. This study also provides insights into the applicability of using the TFA in a new context.

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1 INTRODUCTION

Human behavior can be found at the core of many societal problems. This has in research been shown repeatedly. How we act has consequences for both physical and mental health and wellbeing as well as our interpersonal relationships and personal and societal wealth. These consequences affect individuals, organizations, or even as broadly as society. This indicates a need for behavioral solutions which has led to an increasing interest to understand the determinants of different behaviors as well as methods and strategies to change behavior. Behavior change interventions can be an effective way of changing and influencing the behavior of individuals or even whole populations. (Hagger, Cameron, Hamilton, Hankonen & Lintunen, 2020) Michie, Van Stralen, and West (2011) define behavior change interventions as “coordinated sets of activities designed to change specified behavior patterns” (p. 1).

To be able to design effective interventions we need to know what made the interventions successful or unsuccessful by evaluating them (Hagger et al., 2020). Traditionally, the effectiveness of the intervention has been decided based on the extent to which a specific planned impact was achieved or not, as well as whether the outcomes experienced by intervention participants were caused by the intervention or other factors. (Clarke, Conti, Wolters & Steventon, 2019)

More recently it has been recognized that in addition to evaluating the impact of an intervention, it is essential to know when, how, and why interventions work (Nielsen & Miraglia, 2017). The context of the intervention can give answers to when an intervention works, the change mechanisms can reveal how the intervention worked, and finally, understanding the acceptability of the intervention can shed light on why an intervention worked (Hagger et al., 2020). Intervention acceptability refers to how the intervention providers or receivers think or feel about an intervention (Sekhon, Cartwright & Francis, 2017). Finding an intervention acceptable makes it more likely that individuals will participate in the intervention and it will increase the retention rate throughout the whole intervention. Intervention acceptability thus plays an important part in making an intervention effective. (Chen, 2019) The aim of this study is to examine the retrospective intervention acceptability, of an organizational pilot intervention focusing on trust and empowerment, from the perspective of the intervention recipients.

When it comes to designing, implementing, and evaluating evidence-based interventions the field of health promotion research is at the forefront (Hagger et al., 2020). This is e.g., shown by the fact that there is a theoretically derived framework of acceptability designed for assessing healthcare interventions (Sekhon et al., 2017), while the organizational field lacks a framework of acceptability specifically designed for organizational interventions. In the Theoretical Framework of Acceptability (TFA) by Sekhon et al. (2017), acceptability is conceptualized through seven cognitive and emotional domains, which are assumed to indicate an individual's willingness to participate in an intervention and behave as intended by the intervention.

In the organizational field, trust and especially empowerment are popular concepts when we talk about management practices since they are believed to enhance employee performance, well-being, and positive attitudes (Maynard, Gilson & Mathieu, 2012). Out of the Fortune 1000 companies 70 % report adopting some sort of empowerment initiatives, showing their popularity (Lawler, Mohrman & Benson, 2001). What is interesting to notice is that despite the popularity of these kinds of initiatives, most of them fail. Maynard et al. (2012) recognizes the lack of successful empowerment interventions and plead for more research on the topic. To be able to turn this around, we need to understand what makes the trust and empowerment initiatives fail. Understanding how the participants of these kinds of initiatives perceive the acceptability of the initiatives might help us solve this. I will therefore in this study adopt the TFA to understand how the participants of an organizational intervention perceive its acceptability.

In addition to understanding how acceptable the participants find the intervention, I also want to know if the participants use the acceptability domains of the TFA or if they construct their view of acceptability in a differing way. As the TFA was developed for assessing the acceptability of healthcare interventions it is important to understand how suitable the framework is outside the healthcare sector. In this study, I will therefore evaluate how well the TFA can be adopted for assessing the acceptability of an organizational intervention.

The trust and empowerment pilot intervention that my study center around is executed in a big, global manufacturing organization. The organization has been going through big decentralizing organizational changes and the management of the organization has realized that the decentralization of power and decision making brings new demands for both

supervisors and subordinates. To be able to realign with these new demands a trust and empowerment training has been designed.

In the following chapters, I will first review previous research and present the theoretical background of the thesis. I start by exploring what behavior change interventions are, how interventions have been applied in the organizational setting as well as reviewing trust and empowerment interventions, before ending the chapter by presenting how interventions can be evaluated. After this, I move on to present intervention acceptability and the theoretical framework of acceptability and review both studies applying and not applying the TFA to assess acceptability. I continue by stating the research questions and shortly describe the case intervention of this study. Following this, I explain the methodology of the study. In the final part of the thesis, I present the results of the study. The results are divided into a descriptive analysis and an interpretative analysis. I end this thesis by discussing the study and the results as well as drawing conclusions.

2 BEHAVIOR CHANGE INTERVENTIONS

In this chapter, I will first define and give a general introduction to what behavior change interventions are. After that, I will focus on presenting organizational interventions, showcasing how interventions have been applied in the organizational setting. I continue by focusing on trust and empowerment interventions, which is the type of intervention featured in this study. I end this chapter, by giving an overview of how interventions have been evaluated both in the management and organizational science as well as the health promotion field.

So far, the most successful way to change the behavior of a population has been through legislation and regulations. Even though effective in some cases it doesn't apply for all situations, since it depends on what behaviors we want to change and what the target groups for the changes are. We thus, in addition, need alternative strategies that can be adopted to different needs, and it is here behavior change interventions come into play. (Hagger et al., 2020)

To be able to find effective solutions for changing behavior and obtain the adaptive outcomes wanted, we need to understand the different mechanisms that are affecting and driving the behaviors, so-called determinants (Araújo-Soares et al., 2019). A science of behavior change

has emerged with researchers from the fields of psychology, sociology, behavioral economics, philosophy, implementation science, and political science at the forefront. Behavioral theories developed in these fields are used to predict, understand, and change behavior. These behavioral theories help practitioners design interventions in ways that will facilitate behavior change as well as help them to understand individual, social, contextual, and environmental conditions that either boost or decrease the effects of the intervention. (Hagger et al., 2020)

Expanding on the definition of behavior change interventions by Michie, van Straalen and West (2011) presented in the introduction, Hagger et al. (2020) specify that behavior change interventions change the behaviors of a certain target group or population to address different societal problems. Araújo-Soares, Hankonen, Presseau et al. (2019) complete the definition by adding that the coordinated sets of activities and techniques are performed at a designated time and place, can target individuals and communities in addition to populations and works through either a hypothesized or know mechanism adding the scientific link to theory.

As we saw from these above definitions, behavior change interventions can be targeted at many different levels. In addition to the population, community, and individual levels the interventions can target policy (e.g., laws and regulations), macro-environments (e.g., society), micro-environments (e.g., neighborhoods), and institutions (e.g., hospitals, schools, or organizations). The individual level can also be divided into an interpersonal level, focusing on groups of socially close individuals like families, and an intrapersonal level focusing on specific individuals. (Araújo-Soares et al., 2019) The focus of my study is on individuals within a manufacturing organization, meaning that the intervention targets the intrapersonal level in combination with the focus on institutions.

Although it is recognized that basing interventions on theory can provide many benefits in developing efficient interventions, practitioners are struggling to describe how they have been applying the theory and moreover how the elements of the theory change alongside the changes in behavior and outcomes. (Hagger et al., 2020) To help practitioners describe their interventions, methods or techniques used to change behavior derived from behavioral theories have been listed by e.g., Abraham and Michie (2008), Kok, Gottlieb, Peters et al. (2016), Michie, Richardson, Johnston et al. (2013) and Michie, Wood, Johnston et al. (2015). These different behavior change techniques (BCTs), have been categorized in taxonomies grouping together similar techniques to facilitate and streamline the reporting of different

types of interventions and to enable reliable measurement of their effectiveness (Michie et al., 2013).

Among the first fields that recognized the importance of evidence-based behavior change interventions were medicine (Hagger et al., 2020), leading most of the research on behavior change interventions to be focused on typical and well-known health-related behaviors and finding solutions for common health-related issues (Kok, Peters & Ruiter, 2017). Johnson, Scott-Sheldon, and Carey (2010) summarized in their meta-synthesis six common behavioral domains related to health where interventions have been conducted, including addictions (e.g., alcohol, drugs, and smoking), eating and physical activity (e.g., diet and weight loss), sexual behaviors (e.g., pregnancy prevention, HIV prevention, and contraceptive use), screening and treatment behaviors for women (e.g., mammography screening and increasing treatment after abnormal pap-smears), stress management and improving participation in Health Services.

Kok et al. (2017) add to this list adherence to medication or treatment, participation in vaccination, returning to work after illness or disability, professional decision making in medicine, doctor-patient communication, psychiatric treatment, violence prevention, injury prevention, and safety promotion. Other fields are slowly jumping on the bandwagon and we can see interventions emerging in urban regeneration, energy conservation, education (e.g., promotion of students' interest and competence), as well as community empowerment (Kok et al., 2017). In addition to solving societal problems with healthcare related issues at the forefront, interventions are also used in organizations to improve individual, group, and organizational outcomes (von Thiele Schwarz, Nielsen, Edwards, et al., 2021).

2.1 Organizational interventions

As this study focuses on an organizational intervention, I will in this chapter specify how interventions have been applied in organizations by presenting ways of changing behavior in the workplace. I will describe common change initiatives and the concept of organizational development.

In today's fast-paced world of technological innovations, evolving customer needs, and changing global economy, organizations need to continuously adopt and change to be able to stay profitable and competitive in the market. This means that employees in organizations

constantly are exposed to change initiatives. (Onyeneke & Abe, 2021; Kern & Zapf, 2021) These change initiatives are most often referred to as organizational development.

Huffington, Brunning, and Cole (1997) define organizational development as planned organization-wide change processes targeting, e.g., the structure of how work is organized, the company strategy and direction, the ways of working, the culture or overall climate in the organization. In many cases, the goal is to change people's behavior concerning communication, teamwork, decision-making, problem-solving, or leadership. Anderson (2017) further adds that organizational development aims at increasing the effectiveness of the organization and that these initiatives are executed by using interventions to facilitate both personal and organizational change. The interventions should according to Anderson (2017) be based on social and behavioral science knowledge.

There are many types of organizational development interventions. Cummings and Worley (2009) identify four main categories of interventions: human process interventions, technostructural interventions, Human Resource Management interventions, and strategic change interventions. Human process interventions focus on social processes within the organization and include change programs related to interpersonal relations, group and organizational dynamics. Technostructural interventions refer to change programs helping organizations restructure themselves as well as better integrating people and technology. These types of interventions include employee involvement programs and work re-design programs including job enrichment programs. (Cummings & Worley, 2009)

Human Resource Management interventions focus on developing, integrating, and supporting individuals in organizations and include programs focusing on performance management, developing talent, managing workforce diversity as well as health and wellness. Finally, strategic change interventions refer to interventions that aim to transform and align an organization's strategy and design with its external environment, to keep up with changing conditions. Interventions in this category include strategic change interventions (e.g., organizational re-design or culture change initiatives), and trans-organizational interventions (e.g., mergers or acquisitions). (Cummings & Worley, 2009)

Interventions in the workplace mainly focus on changing the way work is organized, designed, or managed to achieve the intended outcomes (von Thiele Schwarz, Nielsen, Edwards, et al., 2021) More concretely the before mentioned efforts include changing task

characteristics e.g., making the task more challenging or interesting, changing work conditions e.g., reducing workload or improving ergonomics and improving social relations e.g. increasing social support or boosting leadership (Semmer, 2007).

Maybe the two most common organizational interventions include job redesign interventions (e.g., Holman & Axtell, 2016) and participatory occupational health interventions (e.g., Framke & Sørensen, 2015). Job redesign interventions are initiatives that modify job characteristics to impact the feelings, behaviors, and attitudes of employees, in hopes of improving employee outcomes like well-being and performance (Holman & Axtell, 2016).

Participatory occupational health interventions are used to combat unhealthy psychosocial working conditions by improving and changing the work environment (Abildgaard, Hasson, von Thiele Schwarz, et al., 2020). As the name suggests both employees and line managers participate in designing the intervention. Together they analyze the problems and challenges causing negative outcomes, and jointly develop and implement initiatives to help solve them. The core idea in participatory occupational health interventions is that employees play an important role in designing the intervention and should therefore not only be treated as passive recipients. (Nielsen, 2013)

In the organizational intervention field, the focus in the past has been on individual-level interventions targeting individual factors like attitudes and affect, while the trend more recently has been turning to focus on organizational-level interventions targeting changes in the environment as a way of achieving behavior change (Semmer, 2007). This change in focus has its roots in the belief that changing the environment may generate better outcomes in terms of health than what the individual-level interventions can, but scientifically proving this has been rather vague and inconsistent (Montano, Hoven & Siegrist, 2014; Semmer, 2007). On the other hand, several meta-analyses are showing compelling effects of individual-level interventions (see e.g., physical activity by Conn, Hafdahl, Cooper, et al., 2009; depression and anxiety symptoms by Martin, Sanderson & Cocker, 2009; stress management by Richardson & Rothstein, 2008).

Tafvelin, von Thiele Schwarz, Nielsen et al. (2019) recognize that employees and managers play an important role in determining how and why interventions work and they, therefore, recommend understanding how they perceive and appraise the intervention to be able to design successful interventions. Even though the intervention in this study focuses on the

intrapersonal level, meaning that it targets individual persons, it has features of an organizational-level intervention, namely targeting changes in the environment. The intervention is trying to contribute to a change in the organizational culture, by changing the psychosocial environment for its employees. This study will, therefore, at least partly, contribute to the field of organizational-level interventions by investigating how the participants of an intervention perceive it, as recommended by Tafvelin et al. (2019).

Trust and empowerment are concepts that have been used to change behavior in organizations and in the next chapter, I will reflect on different trust and empowerment interventions.

2.2 Trust and empowerment interventions

In this chapter, I will start by defining trust and empowerment and give a brief overview of common theories for building trust and empowerment. I will then continue with reviewing trust and empowerment interventions conducted in an organizational setting before ending the chapter with broadening the view into trust and empowerment interventions conducted in relation to health promotion.

Trust and empowerment are concepts that intrigue many fields, including social work, sociology, psychology (Robbins, 2016; Cattaneo & Chapman, 2010), health promotion research (Rolfe, Cash-Gibson, Car, et al., 2014; Wallerstein, 2006), economics as well as management and organizational science (Schoorman, Mayer & Davis, 2007; Maynard et al., 2012). They are two closely connected concepts and trust is often seen as a prerequisite for empowerment (Schoorman, Mayer & Davis, 2016).

There is no consensus on how trust should be defined, and different researchers use a variety of different definitions (Evans & Krueger, 2009). When looking at the most popular definitions of trust, we can see that they include a set of similar elements. Curall and Inkpen (2006) call these common elements reliance and risk, while Evans and Krueger (2009) call them vulnerability and expectation. Crucial for trust seems to be that individuals are willing to take a risk by putting themselves in a vulnerable position by handing over their fate to another person. The expectation is that nobody would be willing to hand over their fate to another person and rely on them without expecting that this person will treat them nicely and not betray them. For trust to form between two individuals there thus needs to be a mutual

positive expectation that the individuals will not act egoistically and that the other individual's future actions will produce a positive outcome. (Curall & Inkpen, 2006; Evans & Krueger, 2009)

Empowerment on the other hand is seen as a motivational concept that has evolved from two distinct frameworks: the job characteristics model by Hackman and Oldham (1980) and the theory of self-efficacy by Bandura (1977). These different perspectives have led empowerment to be split into two different conceptualizations: structural and psychological empowerment (Maynard et al., 2012). The branch of structural empowerment relies on research on job design and job characteristics, with the belief that certain organizational conditions will lead to power-sharing and decision making, which in turn will lead to empowerment. In the structural empowerment perspective, power-sharing is seen as essential, and the main focus is on the transition of authority and responsibility from higher hierarchical levels in the organization to lower levels. (Maynard et al., 2012)

Psychological empowerment, on the other hand, relies on self-efficacy research and thus focuses on individuals and teams and whether they feel being in control of their work (Maynard et al., 2012). Psychological empowerment can be defined as "intrinsic task motivation reflecting a sense of self-control in relation to one's work and an active involvement with one's work role" (Seibert, Wang & Courtright, 2011, p. 981). The perspective of psychological empowerment goes beyond power-sharing and instead focuses on individual perceptions or cognitive states related to empowerment (Maynard et al., 2012).

A lot of research has been conducted to discover the antecedents and outcomes of trust and empowerment, how to develop the concepts and how the concepts are interrelated (e.g., Nienaber, Romeike, Searle, et al., 2015; Maynard et al., 2012). Also, the behavioral link to both trust and empowerment has been studied (Mayer et al., 1995; Conger & Kanungo, 1988). Because of the strong evidence of trust and empowerment leading to positive outcomes, researchers, practitioners, and organizations have tried to utilize either the power of trust or empowerment. One more recent way to do this has been through interventions.

Empowerment, as a concept in organizational science, can be traced back around 70 years to research on employee involvement and participation as well as the quality of work-life (Maynard et al., 2012). The first attempts to achieve empowerment and the behaviors related to it, in an organizational setting, were mainly through total quality management programs

(e.g., Coyle-Shapiro, 1999) and work redesign interventions (e.g., Champion & McClelland, 1993).

Parker, Morgeson, and Johns (2017) divide work redesign into five perspectives: sociotechnical systems and autonomous workgroups, job characteristics model, job demands-control model, job demands-resources model, and role theory. Of these perspectives the job characteristics model developed by Hackman & Oldham (1980) is most commonly associated with empowerment, but also both of the job demands models can be linked to the concept (e.g., Livne & Rashkovits, 2018). Job crafting, which is considered to belong to the job demands-resource model, is often used when developing empowerment or concepts closely related to it like e.g., self-efficacy and control (Hulshof, Demerouti & Le Blanc, 2020).

Moving on to the 1990s, we can spot empowerment-related initiatives, that at the time went by the name of employee involvement and participation (e.g., Coyle-Shapiro, 1999), or leadership development (e.g., Spreitzer & Quinn, 1996). It is important not to confuse employee involvement with employee engagement, which currently is popular in many organizations, as engagement refers to the work experience of an employee, while involvement refers to increasing an employee's participation in decision making (Cummings & Worley, 2009).

At the end of the 1990s and the beginning of the 2000s, studies resembling empowerment interventions in the form of evaluating empowerment programs and trainings started appearing (e.g., Foster-Fishman & Keys, 1997; Peccei & Rosenthal, 2001). The first randomized field experiment using an individual-level empowerment intervention in a workplace setting was conducted in 2007 by Logan and Ganster.

The psychological empowerment intervention by Logan and Ganster (2007), was designed to increase the personal control and self-efficacy related to key aspects of the jobs for unit managers in a large trucking company. The personal control and control beliefs were addressed by allowing the unit managers more control concerning important aspects of their job by increasing their role in decision making. The self-efficacy on, the other hand, was addressed with a 10-hour training program targeting the areas where control had been augmented and by increasing the access to resources and information for the participants.

When Maynard et al. conducted their review of psychological empowerment in 2012, they found only one randomized field experiment using an individual level empowerment intervention conducted in an organizational setting, the one by Logan & Ganster (2007). Now, almost 10 years later, the situation is not much better. I was only able to find one randomized controlled trial, conducted during the last 10 years, a study by Cougot, Gauvin, Gillet, et al. (2019). The study was conducted in a large French hospital, but it focuses on evaluating the effectiveness of a managerial and organizational transformation program concerned with improving both the structural and psychological empowerment of hospital workers. All other randomized controlled trials I found related to empowerment, were connected to health promotion (e.g., Anderson, Funnell, Butler et al., 1995) or community psychology (e.g., Karimli, Lecoutere, Wells, et al., 2021). What can be found in the organizational setting are studies using quasi-experimental designs either using a pretest-posttest set-up (e.g., Sisk, Mosier, Williams, et al., 2021) or a test group and control group set-up (e.g., Hulshof et al., 2020).

Looking at the concept of trust, we can see that it has been studied from many different perspectives, with a special interest in trust-building and development. Lewicki, Tomlinson & Gillespie (2006) divide models of interpersonal trust development into behavioral approaches that focus on rational choice behavior and psychological approaches that focus on trust expectations, intentions, and dispositions. Some of the most famous trust-building theories are cognition and affect-based trust by McAllister (1995), the stage-based trust model categorizing trust in calculus-, knowledge-, and identification-based trust by Lewicki and Bunker (1995) and the integrative model of organizational trust by Mayer et al. (1995).

On the empowerment side, there were only a few interventions conducted in the organizational setting to be found, but when it comes to trust interventions, the situation is even worse. The only studies that come close to being called interventions and target organizational trust are studies by Ladegård and Gjerde (2014) and Johannsen and Zak (2021). Ladegård and Gjerde (2014) tested in their study the impact of a coaching program on increased leader role-efficacy and leader trust in the subordinates. While Johannsen and Zak (2021) performed a longitudinal intervention to increase organizational trust in a large online retailer facing high turnover rates. One thing to notice is that these trust interventions aren’t based on common trust-building theories or models, but instead rely on other types of

research. It is safe to say that there is a big gap in trust research when it comes to turning the theories and models into practice.

In addition to these trust or empowerment interventions that only focus on one of the concepts, Spence Laschinger, Leiter, Day, et al. (2012) combine in their CREW intervention both trust and empowerment. The intervention program was designed to promote positive interpersonal working relationships among healthcare workers to improve structural empowerment, workplace incivility, and trust in management. Only being able to find one intervention combining both trust and empowerment, while the literature clearly states that the two concepts are inter-linked, trust being proposed as an antecedent to empowerment, a clear gap can be identified in the literature. As my study focuses on assessing the acceptability of a trust and empowerment intervention, it can provide useful information for researchers in the future in terms of what makes these kinds of combined interventions successful or unsuccessful.

It is interesting to notice that although many organizations have adopted trust or empowerment initiatives (Lawler et al., 2001), and both concepts have been popular management and leadership trends since the 1990s (Samul, 2020; Seibert et al., 2011), the fields of management and organizational science lack scientifically based interventions. This would indicate that initiatives aiming at building trust within the workplace or empowering the workforce have been conducted without the involvement of researchers and thus have not been based on research and theory but rather on non-scientific methods and common sense. Another possible explanation could be that especially structural empowerment initiatives often are combined with various human resource practices, and it might, therefore, be challenging to evaluate the effectiveness of these initiatives (Maynard et al., 2012).

It, therefore, seems that the practical application and implementation of the scientific knowledge that has been collected regarding both trust and empowerment is lagging in the organizational field. Due to a shortage of high-quality research in the workplace setting, I have therefore reviewed trust and empowerment interventions in other contexts as well.

The majority of empowerment interventions have been conducted in relation to improving health and wellbeing. Tveiten (2021) states that empowerment is a central concept in health promotion work and interventions have been performed in a variety of contexts focusing on many different health-related outcomes. These outcomes include mental health and

HIV/AIDS-related behavior (Wallerstein, 2006), healthy food, and physical activity habits (Holmberg, Larsson, Korp, et al., 2018), and smoking reduction (Coppo, Gattino, Faggiano, et al., 2020), as well as psychosocial factors linked to health like patient self-care strategy, coping skills, access and effective use of health services (Wallerstein, 2006).

To guide interventions for improving the health and wellbeing of individuals and communities, community psychology and social work is using a theory called empowerment theory (Zimmerman & Eisman, 2017). In empowerment theory, there are three levels of analysis: individual or psychological, organizational, and community (Zimmerman, 1995; 2000). Even though Zimmerman is using the same name "psychological empowerment" as Spreitzer (1995) they conceptualize them differently. According to Zimmerman (1995; 2000), psychological empowerment includes intrapersonal, interactional, and behavioral components, while Spreitzer (1995) divides psychological empowerment into four cognitions, more commonly used within the organizational field: a sense of meaning, competence, self-determination, and impact). The empowerment interventions in community psychology are often used to address health inequities and promote social justice for marginalized groups, women, and the young (Zimmerman & Eisman, 2017).

Examples of contexts where empowerment interventions in the community setting have been conducted include youth development (Forenza, 2017; Zimmerman et al., 2018), homelessness prevention and rehabilitation (O'Shaughnessy & Greenwood, 2020), decreasing the economic vulnerability of women (Stark, Seff, Assezenew, et al., 2018; Karimli et al, 2020), and preventing HIV and STI's among sex workers (Lippman, Donini, Díaz, Chinaglia, Reingold & Kerrigan, 2010).

According to Coppo et al. (2020) empowerment is often characterized as a process that increases a sense of control and participation among individuals, groups, or communities to obtain positive health outcomes. In their systematic review, they however discovered that in empowerment interventions for smoking reduction, empowerment was treated in two separate ways: as a process and a tool to achieve positive health outcomes, and as an outcome in the same way as the health outcomes. Treating empowerment as a process in an intervention means that the purpose of the intervention is to increase an individual's sense of empowerment while treating empowerment as an outcome means that there is a measurable increase detected in the level of empowerment (Anderson & Funnell, 2010).

We can also see examples of this dual categorization of empowerment in interventions from other contexts. Interventions treating empowerment as a process include e.g., Holmberg et al. (2018) who in their intervention aim at improving healthy food and physical activity habits, as well as the YES intervention by Zimmerman et al. (2018) aiming at engaging middle school students in community change. Interventions treating empowerment as an outcome include e.g., Hulshof et al. (2020) who in their job crafting intervention aim at preventing a decrease in employee empowerment, as well as an art intervention by Forenza (2017) aiming at understanding the empowering effects of the intervention on the participants.

Empowerment is used in the healthcare field as a way of decreasing patient's feelings of powerlessness and as a tool to gain control over their life, illnesses, or health. Many health promotion activities focus on increasing patients' participation in their treatment and care or helping them cope with their health challenges and attendant consequences. (Tveiten, 2021) These initiatives are often called patient empowerment (Coppo et al., 2020).

Compared to being able to find more empowerment interventions when looking into other contexts than the organizational setting, I was only able to find one old trust intervention from the health promotion field, a study by Thom, Bloch and, Segal (1999). They studied the impact of an intervention to increase patients' trust in their physicians. There seems to be a gap in the trust literature, not only in the organizational field but overall as well, making it especially important to conduct this study. Next, I will review how interventions can be evaluated.

2.3 Evaluating interventions

In this chapter, I will give an overview of how interventions have been evaluated both in the management and organizational science as well as the health promotion field. I will show how the evaluation of interventions has moved from assessing only effectiveness or efficacy to evaluating the implementation process by using process evaluation. I will also define three common outcomes related to process evaluation, that often become mixed: acceptability, fidelity, and feasibility.

To understand whether interventions are effective and cause people to change their behavior and achieve the positive outcomes targeted, they must be evaluated (Hagger et al., 2020). Even the RE-AIM framework, which is one of the most frequently applied intervention

implementation frameworks, emphasizes the importance of evaluating how well the intervention reaches the targeted individuals, how well it can be adopted in different settings by different intervention agents, how easily it can be implemented by the people delivering the intervention, and whether the intervention outcome can be maintained over a longer period of time (Glasgow, Harden, Gaglio, et al., 2019). In addition to evaluating the effectiveness of an intervention, the change mechanisms, and the delivery, also the acceptability of the intervention can be evaluated to gain a broader understanding of what made the intervention successful or unsuccessful (Hagger et al., 2020).

The randomized controlled trial (RCT) has traditionally been seen as the “gold standard” method when it comes to evaluating interventions (Matthews & Simpson 2020; Nielsen & Miraglia, 2017). Little by little also other methods are gaining prestige and are seen as producing reliable scientific knowledge. This shift in methods is partly driven by the urge to find scientific evidence that can be applied in practice, instead of only striving for results produced in tightly controlled environments. (Matthews & Simpson 2020)

Today there are three main categories of study designs used: experimental, quasi-experimental, and nonexperimental. The experimental and quasi-experimental designs can be used to assess the efficacy and effectiveness of interventions, while nonexperimental designs can be used to collect post hoc data about an intervention or information about the feasibility of the intervention. Nonexperimental designs can also give insights into the barriers and facilitators of change experienced by the intervention recipients. Common experimental, quasi-experimental and non-experimental designs respectively are, the randomized controlled trial, interrupted time series (pre-test and post-test designs), and qualitative methods like interviews. (Matthews & Simpson, 2020)

Nonexperimental designs should never be used as the sole evaluation method as they cannot determine causal effects, and they are therefore often used in combination with either experimental or quasi-experimental designs to support the understanding of the main evaluation findings. The qualitative methods commonly used in non-experimental designs include interviews, focus groups, and observations. (Matthews & Simpson, 2020)

To indicate whether an intervention has been performed under experimental or “ideal” circumstances or in a real-world everyday setting, Singal, Higgins, and Waljee (2014) differentiate between efficacy and effectiveness studies. The former indicating ideal

circumstances and the latter real-world settings. In addition to the efficacy and effectiveness studies, Matthews and Simpson (2020) identify two further evaluation approaches, namely the realist and systems approaches. The realist approach takes a broad view and evaluates how, for whom, under what circumstances, and why an intervention worked, while the systems approach evaluates how elements in the setting or system interact with the change mechanisms of the intervention.

Traditionally researchers have been interested in knowing whether an intervention works or not. To assess this, outcome evaluation is often the go-to method. More recently researchers have become aware that knowing what works is not enough. (Kompier & Aust, 2016) Nielsen and Miraglia (2017) are lobbying researchers to instead focus on asking when, how, and why interventions work. When refers to the context of the intervention, how means through which mechanisms an intervention work and why represents the drivers that caused the change to happen. Only evaluating intervention effects may hide effects that are sensitive to variations in the intervention process or the way the intervention was delivered. It thus becomes important to know how interventions were implemented to fully understand if they work or not (Nielsen & Randall, 2013).

Nielsen and Miraglia (2017) further propose that by investigating the content of the intervention in combination with the process mechanisms and contextual conditions, researchers are better able to understand how interventions achieved their desired outcomes. Nielsen, Taris, and Cox (2010) add that the appropriateness of interventions should be evaluated to ensure that they are targeting the right set of problems. This has caused a shift from classical effect evaluation to process evaluation (Durlak, 2015).

To demonstrate the need for process evaluation, Kristensen (2005) used the striking metaphor of a patient taking medicine: “It does not help that the pill has an effect if the patient does not take it, and it does not help that the patient takes the pill if it has no effect” (p. 207). To be able to understand which of the scenarios is true for an intervention, process evaluation is needed. In the first scenario, the implementation failed as the patient didn’t take the medicine, making it impossible to know whether the intervention program works, and the medicine has an effect on the patient. The theory that the program is based on might be right, but without evaluating the implementation it could erroneously be concluded that the theory is wrong causing the intervention to fail. In the second scenario, the implementation worked fine, but

the medicine had no effect, meaning that it, in this case, rightfully can be concluded that the theory behind the program doesn't work and thus needs to be reconsidered.

Process evaluation is also needed to be able to generalize an intervention. Understanding under what circumstances an intervention works and what the factors are that either hinder or facilitate the change will enable interventions to be implemented successfully in many different settings (Kompier & Aust, 2016).

In addition to using efficacy and effectiveness measures to evaluate the success of interventions, also other implementation outcomes can be used. Proctor, Silmere, Raghavan et al. (2011) identify eight different ones: acceptability, adoption, appropriateness, costs, feasibility, fidelity, penetration, and sustainability. Acceptability is defined as the perception that an intervention is agreeable, palatable, or satisfactory in the eyes of the implementation stakeholders. Adoption refers to the uptake of an intervention or the intention to try to employ an intervention. Appropriateness is defined as the perceived fit, relevance, or compatibility of an intervention for a given setting or stakeholder as well as the perceived fit of the intervention for addressing a specific problem. Proctor et al. (2011) mention that appropriateness and acceptability are treated as conceptually similar in the literature, but that they feel they are different from each other and shouldn't be intertwined.

Cost refers to the implementation cost of an intervention. Feasibility is an outcome that reflects the extent to which an intervention can be executed successfully in a given setting. Fidelity is defined as whether an intervention was implemented as planned by the protocol and intended by the intervention designers. Penetration refers to the level of integration of the intervention in a service setting, while finally, sustainability reflects the extent to which an intervention is maintained in the real world. (Proctor et al., 2011)

Acceptability, feasibility, and fidelity are the most common implementation outcomes and can be found in the healthcare sector and the organizational sector. Although they are present in both fields the most convincing and theoretically driven definitions and frameworks can be found in the healthcare sector. I, therefore, start by discussing frameworks found in the healthcare sector and then continue with frameworks found in the organizational setting.

Intervention evaluation usually takes place in two stages of the intervention process: first in the piloting or feasibility stage where the intervention is tested on a small sample to see how well the intended intervention works and to evaluate whether changes need to be

implemented for the full-scale intervention, and secondly at the full evaluation stage when assessing the final intervention (Shahsavari, Matourypour, Ghiyasvandian & Nejad, 2020). As we can see, feasibility studies and full-scale evaluations have different purposes and goals. Feasibility studies can be divided into two main categories: one where the intervention design is investigated, and the second where the focus is on the evaluation design (Moore, Hallingberg, Wight, et al., 2018; Hagger et al., 2020). While a full-scale evaluation on the other hand most often focuses on assessing the efficacy or effectiveness of the intervention (Moore et al., 2018).

Feasibility and pilot studies are often used interchangeably, but according to Eldrige, Lancaster, Campbell et al. (2016) a feasibility study is an attempt to understand whether a full-scale trial can be done or if it is feasible to continue with an intervention and if so, how it should be done. A pilot study on the other hand is a subset of a feasibility study, that tests how a future trial or part of a future trial works on a smaller scale. This study is a pilot study, as it tests the trust and empowerment intervention on a small scale to see if it works, before moving on to a full-scale intervention.

Acceptability has been recognized as an important concept when trying to understand why some interventions work while others don't (Diepeveen, Ling, Suhrcke, et al., 2013). Acceptability refers to how the intervention providers or receivers think or feel about an intervention. Sekhon et al. (2017) define acceptability as "a multi-faceted construct that reflects the extent to which people delivering or receiving a healthcare intervention consider it to be appropriate, based on anticipated or experiential cognitive and emotional responses to the intervention" (p. 4). The only established model conceptualizing acceptability is by Sekhon et al. (2017) in their Theoretical Framework of Acceptability (TFA). I will be applying the TFA in my study as the theoretical framework and will be discussing it in more detail in the following chapter (see more in chapter 3).

When conducting an intervention, not sticking to the intervention protocol could impact the effectiveness of the intervention. This makes it important to assess to which extent the components of the intervention were delivered as planned, as well as conducted as intended by the intervention protocol. This is referred to as intervention fidelity. (Gearing, El-Bassel, Ghesquiere, et al., 2011)

According to Bellg, Borrelli, Resnick, et al. (2004) fidelity includes five components: design, training, delivery, receipt, and enactment. The design component refers to whether an intervention operationalizes the underlying theory and adequately can test its hypothesis. Training refers to whether it was ensured that the intervention providers have been satisfactorily trained to acquire and maintain the requisite skills needed to deliver the intervention to participants. Delivery refers to the extent that intervention providers adhered to the intervention protocol in terms of the content and way of delivery. Receipt reflects the extent of engagement with the intervention and whether the participants understand the intervention and are able to use the behavioral and cognitive skills taught. Finally, enactment refers to whether the participants use those skills in a real-life setting.

The only frameworks to be found in the organizational setting were frameworks designed for evaluating organizational-level occupational health interventions (see e.g., Biron & Karanika-Murray, 2014; Nielsen & Abildgaard, 2013; Nielsen & Randall, 2013). In the framework by Nielsen and Randall (2013) they include taking into consideration the intervention design and implementation, the context, and the mental models of the participants. Many of the same factors previously described in the frameworks for evaluating health behavior change interventions, can be found, such as understanding whether the intervention reached the target group or not, the drivers of change as well as understanding the hindering or facilitating factors of the context. It is also interesting to see that this framework includes the mental models of the participants in terms of understanding the participants' readiness for change and their perceptions of the intervention activities. (Nielsen & Randall, 2013) These mental models have some similarities with intervention acceptability, but the model lacks the scientific rigor that the acceptability framework by Sekhon et al. (2017) has (see more in chapter 3 intervention acceptability).

In a more recent framework by von Thiele Schwarz, Lundmark, and Hasson (2016), called the Dynamic Integrated Evaluation Model (DIEM), they recognize acceptability as one implementation outcome, but they define the concept only as attitudes towards the intervention or as satisfaction. This undermines the complexity of intervention acceptability that is recognized in the healthcare setting. von Thiele Schwarz et al. (2016) also include other implementation outcomes like the fit of the intervention, direction, competence, opportunity, support, participation frequency as well as quality, integration, alterations, and deviations. These outcomes resemble some of the domains of acceptability defined by

Sekhon et al. (2017) and some of the domains of fidelity defined by Bellg et al. (2004). Support is the only novel outcome that can't be placed under either framework.

The TFA by Sekhon et al. (2017) was developed for assessing the acceptability of healthcare interventions and it has thus been used for that purpose. It has not yet been used for assessing the acceptability of other types of interventions. Since the importance of understanding the confounding factors surrounding interventions also in the organizational settings is increasing, I think it is justified to adopt the TFA and apply it in another setting than what it was originally intended for, especially when there isn't an as rigorous framework to be found in the management and organizational science to assess acceptability.

3 INTERVENTION ACCEPTABILITY

In this chapter, I will start by reviewing the concept of intervention acceptability in more detail. After that, I will give a comprehensive overview of the Theoretical Framework of Acceptability (TFA), which I am using as the theoretical reference in this study. Thereafter, I will review interventions evaluating the acceptability of empowerment interventions without using the TFA as a theoretical reference. Only empowerment interventions are featured here due to the lack of trust interventions. I end the chapter by reviewing studies using the TFA to assess acceptability. As there were no studies evaluating the acceptability of trust and/or empowerment interventions applying the TFA to be found, this section instead features different types of interventions from the healthcare setting.

Acceptability is a concept with growing interest in the realm of assessing health behavior change interventions and it has quickly become an important aspect to consider when designing, evaluating, and implementing healthcare interventions (Sekhon et al., 2017). This can be seen in that many leading guidances, such as the Medical Research Council (MRC) guidance for developing and evaluating complex interventions (Craig, Dieppe, Macintyre, et al., 2008), the conceptual framework of feasibility and pilot studies (Eldridge et al., 2016) and the MRC guidance for process evaluation of complex interventions (Moore, Audrey, Barker, et al., 2015), highlight the importance of evaluating acceptability.

The emergence of acceptability can be traced back to the beginning of the 21st century, making it a fairly new concept. The evolution of acceptability can be seen in the three editions of the MRC guidance. In the first guidance published in 2000 (MRC, 2000) there

wasn't yet any mention of acceptability, while there in the second edition published in 2008 (Craig et al., 2008) was three mentions. The mentions concerned setting the research agenda by highlighting the importance of assessing acceptability in the piloting and feasibility stage as well as stating that evaluations often are undermined by problems caused by poor acceptability. In the third edition published in 2015 (Moore et al., 2015) the number had already multiplied to 14. These mentions were related to improving acceptability by using strategies from process evaluation as well as mentioning that acceptability can be assessed with both quantitative and qualitative methods.

These before-mentioned guidances and other empirical articles have failed to provide an explicit definition of acceptability, causing the concept to be operationalized in a variety of ways (Sekhon et al., 2017). Even though the MRC guidance published in 2015 (Moore et al., 2015) offers examples of how acceptability can be evaluated using both quantitively and qualitative methods, it still fails to give clear instructions on how to operationalize the concept to be able to evaluate it

Two examples of definitions of acceptability from the past include treatment acceptability (Carter, 2007)) and social acceptability (Dillip, Alba, Mshana, et al., 2012). Treatment acceptability can be defined as a positive attitude towards a treatment method and is judged before participating in the intervention (Sidani, Epstein, Bootzin, et al., 2009). While social acceptability can be defined as "patients' assessment of the acceptability, suitability, adequacy or effectiveness of care and treatment" (Staniszewska, Crowe, Badenoch, et al., 2010, p. 313). Treatment acceptability reflects an individual perspective while social acceptability, on the other hand, reflects a collective perspective, suggesting there can be shared judgments about an intervention. Proctor et al. (2011) define acceptability in a way that isn't tied to the healthcare setting. They treat acceptability as an implementation outcome that reflects the knowledge of or direct experience with different aspects of the intervention, including content, complexity, comfort, delivery, and credibility, by either the intervention providers or receivers (Proctor et al., 2011).

Due to a fragmented field of acceptability definitions, the research community recognized the need for theoretical development. Mantell et al. proposed already in 2005 that "grounding the study of acceptability in a theoretical framework could help to identify predictors of acceptability and suggest intervention components to promote [engagement]" (p. 327), while Dillip et al. still in 2012 complained that acceptability is poorly conceptualized. As an answer

to this Sekhon et al. (2017) set out to, once and for all, understand how acceptability of healthcare interventions have been defined in the past to be able to unify the research field and develop a theoretical framework around the concept.

3.1 Presenting the Theoretical Framework of Acceptability

Sekhon et al. (2017) set out to examine 43 reviews claiming to define, theorize, or assess the acceptability of healthcare interventions. What they discovered was that only one review provided a conceptual definition, meaning a definition that is proposing what acceptability is either in abstract or theoretical terms. This definition was related to judging the satisfactoriness of the intervention and the participants' willingness to use the intervention. This means that there were no theory-informed definitions to be found in the literature. On the other hand, Sekhon et al. (2017) found several operational definitions, meaning definitions that show how and with what procedures acceptability can be measured. The operational definitions included asking for example if participants would accept or agree with the intervention, if they were satisfied with it, measuring the rate of treatment discontinuation or intervention dropouts. As many of the measures were behavioral it meant that acceptability was being assessed at the end of a full trial.

Much of the acceptability research has used vague and varying definitions of the concept as well as basing the acceptability measures on common knowledge instead of theory (Sekhon et al., 2017). To find consensus on what acceptability is and how it should be measured, Sekhon et al. (2017) have based on their systematic review of acceptability developed a theoretical framework of Acceptability (TFA).

Intention has been recognized as an important predictor of behavior and the domains in the TFA can all be seen as predictors of intention. Acceptability thus functions as a way of defining an individual’s willingness to participate in an intervention and behave in the intended ways. In the TFA, acceptability is seen to consist of different dimensions including affective attitude, burden, ethicality, intervention coherence, opportunity costs, perceived effectiveness, and self-efficacy. An overview of the TFA can be seen in figure 1.

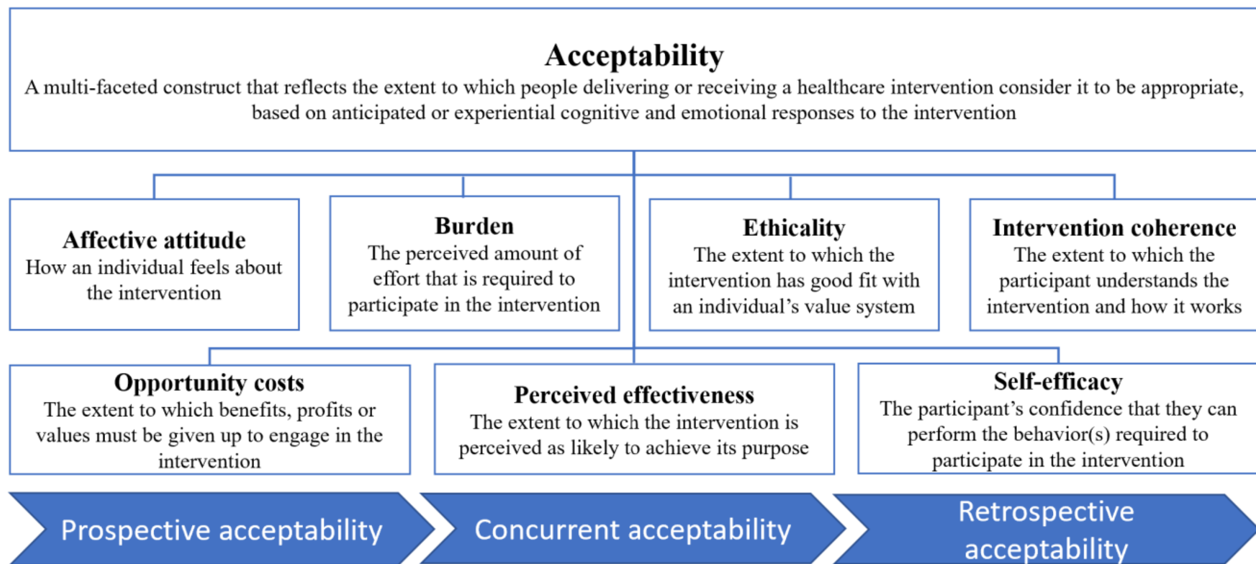


Figure 1. *The theoretical framework of acceptability* by Sekhon et al. (2017).

The dimension of *affective attitude* describes how an individual feels about participating in the intervention. The dimension was created as a synthesis of different attitude measures used in assessing the acceptability of healthcare interventions. *Burden* is defined as how taxing the effort to participate in the intervention is perceived. The effort includes e.g., too much time or cognitive effort and is not to be confused with the confidence of engaging in the intervention (see definition of self-efficacy below). If the intervention is perceived to require e.g., too much time, the burden of the intervention can be seen as too high and lead to discontinuation of the intervention. The domain of burden functions as a way of understanding reasons for discontinuation or dropout. *Ethicality* reflects how well the intervention fits with an individual's values. This domain reflects the previously used notion of associated side effects with the intervention, that in the past has been used to measure acceptability. (Sekhon et al., 2017)

Intervention coherence shows how intervention receivers and/or providers understand the intervention and how it is supposed to help solve the issue at hand. Intervention coherence can thus be seen as representing the face validity of the intervention. Intervention coherence is not to be confused with the dimension of perceived effectiveness (see definition of perceived effectiveness below). *Opportunity costs* is the dimension that shows the degree of benefits, profits, or values the individual feels must be sacrificed to engage in the intervention. This domain encompasses the influence on adherence and participation found in previous studies. The dimension of *perceived effectiveness* further elaborates the dimension of intervention coherence, since it examines whether the individual thinks that the

intervention will achieve its goal. The last dimension, *self-efficacy* reflects the participants' perceived confidence and control in being able to perform the required behaviors in the intervention. (Sekhon et al., 2017)

If we compare the definition of treatment acceptability by Sidani et al. (2009) with the acceptability framework created by Sekhon et al. (2017) we can find similarities. Sidani et al. (2009) propose that perceived treatment acceptability includes an element of appropriateness in relation to addressing the clinical problem. Appropriateness is mentioned in the definition of acceptability provided by Sekhon et al. (2017). Another element that Sidani et al. (2009) propose is the level of match or suitability to the participants' lifestyle, which is very close to ethicality in the TFA by Sekhon et al. (2017). And finally, Sidani et al. (2009) propose that perceived treatment acceptability includes the convenience and effectiveness in relation to managing the clinical problem, which matches burden and perceived effectiveness respectively in the TFA by Sekhon et al. (2017). As we can see the TFA builds upon previous acceptability studies, but it is also influenced by influential theories from both the healthcare and behavior change fields.

3.2 Evaluating acceptability

In this chapter, I will present how acceptability can be evaluated. I will start by describing from what perspectives acceptability can be assessed. I then continue with, when it can be evaluated and end the chapter by reviewing what kind of methods can be used.

Acceptability can be studied from two perspectives: either from the perspective of the intervention providers, the people who are guiding and delivering the intervention, or from the perspective of intervention recipients, the people who are experiencing and participating in the intervention (Sekhon et al., 2017). In this study, the focus is on studying the acceptability from the perspective of the intervention recipients.

Studying acceptability can be done at three different time points during the intervention delivery period. It can be measured prospectively before participating in the intervention (prospective acceptability), during the intervention when some exposure to the intervention has been obtained (concurrent acceptability), or retrospectively after having participated in the intervention (retrospective acceptability) (Sekhon et al., 2017). In this study, retrospective acceptability will be evaluated.

When it comes to evaluating acceptability, it can be done for all the development phases outlined by the MRC (Craig et al., 2008) including the development-, pilot and feasibility-, evaluation-, and implementation phases (Sekhon et al., 2017). Measuring acceptability in the development phase of an intervention helps designers tailor the form, content, and delivery mode of the intervention components to the likings of the participants. In the pilot and feasibility phase acceptability can be used to determine whether anticipated acceptability aligns with the experienced acceptability of the intervention deliverers or participants, but it can also be used to spot changes needed to be made before moving to a full-scale trial.

In the evaluation phase, acceptability can be used to interpret whether unexpected intervention effects were due to low acceptability and thus causing low engagement or if the intervention itself was ineffective. As an example, acceptability in this phase can be measured at different stages of intervention delivery to cast light on possible reasons for low participant retention and provide insights on implications for the fidelity of both delivery and receipt of the intervention. Finally, acceptability can be used to facilitate scale-up when implementing the intervention in a “real world” setting. (Sekhon et al., 2017) In this study, acceptability will be examined during the pilot phase of the intervention.

When evaluating acceptability both qualitative and quantitative methods can be used. Sekhon et al. (2017) recommend using semi-structured interviews, focus groups, or even reflective diary entries when considering qualitative methods. On the quantitative side, Sekhon et al. (2017) recommend using questionnaires or visual analog rating scales. Weiner et al. (2017) have also developed a quantitative Acceptability of Intervention Measure (AIM). This measure is not based on the TFA and instead uses the acceptability definition by Proctor et al. (2011), treating acceptability as agreeableness or satisfaction. Also, longitudinal research designs are possible e.g., when assessing acceptability in the evaluation phase. In this case, Sekhon et al (2017) recommends measuring acceptability before the intervention, during it, and after it.

3.3 Assessing the acceptability of empowerment interventions

In this chapter, I will review studies evaluating the acceptability of empowerment interventions. Due to a lack of trust interventions, it, unfortunately, isn’t possible to review these kinds of studies. None of the empowerment studies found, use the TFA as a theoretical reference and instead rely on vague or non-existent conceptualizations of acceptability.

One pilot study from the health promotion field by Jiménez-Chávez, Rosario-Maldonado, Torres et al. (2018) assessed both the acceptability, feasibility, and the preliminary effectiveness of a community-based participatory research curriculum with the aim of raising community empowerment in terms of actively involving community members in research activities. Jiménez-Chávez et al. (2018) didn't use the TFA but instead assessed both acceptability and feasibility by conducting cognitive debriefing sessions after the intervention workshops.

Jiménez-Chávez et al. (2018) asked questions about the participant's general thoughts, what they thought about the content, if there was any confusion with the content, their thoughts about the speaker styles, whether controversial topics were discussed, their experience with the practical activity and their readiness level to educate the community. As we can see, some of these questions are similar to the domains found in the TFA (Sekhon et al., 2017) such as self-efficacy (readiness level to educate the community), affective attitude (experience with the practical activity), and ethicality (whether controversial topics were discussed), while other questions used more align with the fidelity domains (Bellg et al., 2004) delivery, (speaker style) and receipt (if there was any confusion with the content).

Another study where both acceptability and empowerment can be found is a study by Bermejo-Caja, Koatz, Orrego et al. (2019). Bermejo-Caja et al. (2019) assessed in their pilot study the acceptability and feasibility of a virtual community of practice for improving healthcare professional's attitudes towards patient empowerment. Bermejo-Caja et al. (2019), also didn't use the TFA and instead assessed acceptability by asking questions related to barriers to participation, reasons for participating or not participating, barriers for achieving the goal of the intervention, how the participants would like to change the intervention and the role of the facilitator. In neither of these two studies by Jiménez-Chávez et al. (2018) and Bermejo-Caja et al. (2019), there was no mention of how they conceptualized acceptability or even a reasoning why they operationalized the concept as they did.

Two further studies combining both empowerment and acceptability are by Basset, Brody, Jack et al. (2021), and Stoddard et al. (2020). These studies venture into community- and gender empowerment but still stay in the health promotion field. Basset et al. (2021) assessed in their study the feasibility and acceptability of a program with the aim of promoting positive affect, well-being, and gender empowerment for black women living with HIV. Stoddard, Hughesdon, Khan, and Zimmerman (2020) also assessed the feasibility and

acceptability but now in the context of a future-oriented empowerment program with the aim of preventing substance use and school dropout among youths. Neither one of these studies used the TFA and once again there was no conceptualization of acceptability to be found, causing the operationalization of acceptability to be very different in the two studies.

3.4 Studies applying the TFA to assess acceptability

In this chapter, I will focus on studies using the TFA as a theoretical reference. As no trust and/or empowerment interventions have been evaluated by using the TFA, a set of different healthcare-related interventions will be reviewed.

As we saw in the previous chapter, the TFA by Sekhon et al. (2017) hasn't reached far enough, making it important to increase the awareness of the framework even further. On the other hand, the situation isn't as grim as it might seem. Since its publication in 2017, the TFA by Sekhon et al. has been applied at an increasing pace with only a couple of studies to be found in 2019 and 2020, but with a clear multiplication of studies published in 2021, indicating a gain in both popularity and awareness of the framework. Studies using the TFA has been conducted in a variety of different contexts, ranging from an intervention enhancing teachers' skills in physical activity promotion (Renko, Knittle, Palsola, et al., 2020), an oral health intervention (Bhatti, Gray-Burrows, Giles, et al., 2021), a mental health promotion program (Murphy & Gardner, 2019), pediatric critical care intervention (Deja, Peters, Khan, et al., 2021). The framework has also been applied to understand the acceptability of a postnatal walking group (Pavlova, Teychenne & Olander, 2020) and mobile health application usage among adolescents (Chen, 2019).

Most studies using the TFA have been using qualitative methods or mixed-method designs when assessing acceptability. I was able to find a few studies that alone would have used quantitative methods and that is the study by Renko et al. (2020), who used quantitative questionnaires as their data collection method. As they also evaluated the reach and implementation of their intervention, they supplemented by additionally using qualitative open-ended questions. This makes it easy to confuse the study for a mixed-method one. Also, Chen (2019) uses a quantitative questionnaire in one of the studies for her Ph.D. dissertation.

The most common data collection methods when using qualitative designs are semi-structured interviews and focus group interviews (see e.g., Ndejjo, Musinguzi, Nuwaha, et al.,

2020; Rance, Lafferty, Treloar, et al., 2021). There are also two longitudinal studies to be found, Renko et al. (2020) and Deja et al. (2020) who both use mixed methods. In this study, qualitative methods will be used.

The three time perspectives, prospective, concurrent, and retrospective acceptability, have all been evaluated in previous studies. An example of a study that has assessed prospective acceptability is Sekhon et al. (2021), while Pavlova et al. (2020) assessed concurrent acceptability in their study, and Murphy & Gardner (2019) investigated retrospective acceptability in theirs. There are also a few studies where two or several time-perspectives have been taken into account e.g., Renko et al. (2020) who assess both the prospective and retrospective acceptability, and Gerbild, Areskoug-Josefsson, Larsen et al. (2021) who took into account all three time perspectives.

4 RESEARCH QUESTIONS AND CASE INTERVENTION

In this chapter, I will describe the purpose of the study as well as state the research questions. After that, I continue by describing the trust and empowerment intervention I am evaluating in this study. I will end the chapter by presenting the sample of the study as well as describing the intervention procedure.

4.1 Research questions

The aim of this study is to examine the retrospective intervention acceptability of a trust and empowerment pilot intervention from the perspective of the intervention recipients. To examine the acceptability of the intervention, the domains of the theoretical framework of acceptability (TFA) developed by Sekhon et al. (2017) will be used. The intervention acceptability will be assessed from the perspective of the intervention recipients, excluding the intervention providers. As this study is focusing on retrospective acceptability, the participants are describing their perceptions of the intervention after having participated in it.

Further, I will investigate how well the different acceptability domains in the TFA reflect the participants' construction of acceptability. In other words, if the participants use the acceptability domains of the TFA or if they construct their view of acceptability in a differing way. In addition, I will assess how well the TFA, originally designed for assessing the acceptability of healthcare interventions, can be applied for assessing the acceptability of an

organizational intervention. To be able to evaluate the intervention acceptability, I need to understand how the participants of this study construct their view of acceptability. The first research question is:

1. how do the recipients of the intervention perceive the acceptability of the intervention in the different acceptability domains of the TFA (affective attitude, burden, ethicality, intervention coherence, opportunity costs, perceived effectiveness, and self-efficacy)?

Based on the findings of the first research question, I will be able to assess whether the TFA could be a framework suitable for evaluating the acceptability of an organizational intervention. The second research question is thus:

2. how well can the TFA be applied for assessing the acceptability of an organizational intervention?

4.2 Presenting the intervention

The intervention in this study was developed for a section of a global manufacturing organization. I will be using both intervention and training interchangeably when referring to the activities performed in this study with the aim of changing the behaviors of the participants. The intervention was created as a way of implementing the new company strategy that was imposed due to big decentralizing organizational changes. To be able to implement the new strategy, the management of the organization decided that changes to the corporate culture were needed. As a first step in the direction of changing the organizational culture, a pilot intervention combining theory of both trust and empowerment was designed. The purpose of the pilot intervention was to support the participants in adopting and strengthening trust and empowerment in their way of working, thus improving the work atmosphere in the organization.

The pilot intervention was built around a two-hour training program targeted for middle- and first-line management, meaning team- and project leaders. The pilot was run for a small sample to be able to test how the intervention works and how it is received by the participants. After getting feedback from the pilot, the plan is to move to the evaluation and implementation phases outlined by the MRC (Craig et al., 2008).

The intervention is built around a train the trainer concept, which is a commonly used method in workforce development (Yarber, Brownson, Jacob, et al., 2015). The train the trainer concept means that potential instructors or trainers will be trained to enable them to pass their knowledge to other people in an organization. In this intervention, it means that team- and project leaders were trained to be able to run the training with their teams afterward.

Self-determination theory (SDT) by Deci and Ryan (2000) is used as a theoretical framework for the intervention. SDT is a commonly used theory for changing behavior both in the context of healthcare (Hagger, Hankonen, Chatzisarantis & Ryan, 2020) and in the workplace (Deci, Olafsen & Ryan, 2017). SDT is a theory that explains human motivation by understanding the underlying needs and conditions within an individual. The theory builds upon the concept of satisfying three basic psychological needs: autonomy, competence, and relatedness, as well as differentiating between the quality of motivation being either intrinsic or extrinsic. Intrinsically motivated individuals feel a sense of choice, interest, engagement, competence, and enjoyment when performing a certain behavior, while extrinsically motivated individuals are driven by rewards, contingencies, or reinforcement. (Deci & Ryan, 2000)

SDT based mechanisms in the training aim at increasing the autonomous motivation of the intervention recipients by satisfying their basic psychological needs for autonomy, competence, and relatedness. These three basic psychological needs are closely linked to the four cognitions (meaning, competence, self-determination, and impact) of psychological empowerment by Spreitzer (1995). The training is designed to decentralize power by teaching the participants delegation and sharing of responsibility, enabling higher levels of autonomy for the participants. The competence of the participants is strengthened by getting to practice what they learn as a part of the training, as well as reaching their improvement areas and goals set in one of the training activities. The training activities are designed around group discussions and peer support, which satisfies the need for relatedness.

Some of the behavior change techniques that the intervention is built around include:

- *consciousness-raising* (Kok et al., 2016) in relation to the theoretical part of the training where tools for trust and empowerment building are presented
- *goal setting, action planning, and public commitment* (Kok et al., 2016) in relation to the training activity of goal setting and action planning

- *participation, active learning, discussion, and providing opportunities for social comparison* (Kok et al., 2016) in relation to the interactive group tasks performed in the training

4.3 Participants

26 participants took part in the pilot training program. The participants were split into two groups. The first group had 19 participants whereas the second only had seven participants. The participants in the first group consisted of participants from an ongoing team management training program and the workshop was therefore integrated into the training program by utilizing an already scheduled session. The workshop of the first group thus included elements of listening skills in addition to the activities of the trust and empowerment intervention. The workshop of the second group was freestanding and focused only on the trust and empowerment topic. The participants for this study were recruited from these 26 participants that took part in the training program, by contacting them by email and inviting them to the focus group interviews.

The final sample of this study includes the 12 participants that participated in the focus group interviews, of which nine are men and three are women. Four interviews were conducted in total, with two persons in the first interview, four persons in the second, and three persons in both the third and fourth interviews. The participation in the study was not rewarded in any way.

The target group of my study includes team- or project leaders representing middle- or first-line management. All the participants are in a leadership position. The sample is global, with participants from Asia, Europe as well as North and South America. No further background information was collected about the participants.

The company wished for a global sample, with participants from other locations than those often used for piloting learning concepts in the company. This wish guided the sampling. The sample was obtained using convenience sampling. On one hand, the team responsible for learning and development in the target company provided suitable candidates for the study and on the other hand, a project manager nominated candidates.

The inclusion criteria were middle-, first-line- or project manager role, computer access as well as time and interest to participate. The target group of middle-, first-line- or project

managers was chosen because their role was seen as important gatekeepers between management and the employees by the target company. Supporting this, research indicates that direct supervisors might play a more important role when it comes to influencing employees' attitudes and behaviors than for example the top management (Lipponen, Steffens & Holtz, 2018).

4.4 Intervention procedure

After recruiting the pilot sample, the participants started their training path in the trust and empowerment training program. The training path consisted of a three-phase process starting with pre-work, continuing with a 2-hour virtual workshop, and ending with a possibility of self-studying extra materials. The pre-work consisted of two e-learning modules, the first one focusing on why trust and empowerment are important for the target company and the second one focusing on what trust and empowerment are, providing some tool for developing trust and empowerment in themselves as well as others.

The workshop functioned on the one hand as a traditional training session where the participants learned about the background and motivation for the training, the trust and empowerment behaviors wanted, and the channels to facilitate them. On the other hand, it also included interactive tasks built around team level and individual level development of trust and empowerment by assessing the as-is and to-be states as well as making action plans and commitments. The team-level development activities were performed in pre-determined ad hoc groups, to give the participants an indication of how to run the activities with their teams later on. The workshop ended by covering the topics of further implementation and follow-up of the training program.

The learning material for the training program was based on factors of trustworthiness (Mayer et al., 1995), empowering leadership behaviors (Amundsen & Martinsen, 2014), the characteristics of psychological empowerment (Spreitzer, 1995) as well as organizational characteristics for creating an empowering organizational climate (Quinn & Spreitzer, 1997). The extra material for self-studying consisted of articles and videos covering trust and empowerment, tables of examples of different focus areas for improving trust and empowerment behaviors, and a template library for different activities to develop a specific area within trust and empowerment.

At the end of the workshops, all participants were asked to fill in a feedback survey consisting of open-ended and scale-type questions evaluating the workshop. The data from the feedback survey will not be used in this study because of the low response rate and short answers in the open-ended questions. In addition to the feedback survey, some of the participants from the workshop were asked to participate in focus group interviews to collect more in-depth experiences and feedback.

5 METHODOLOGY

In this chapter, the methodology of this study will be described. A detailed description of the research data and data collection process will be provided. The chapter ends with a comprehensive explanation of how I conducted the data analysis.

This study is a qualitative study using online semi-structured focus group interviews as the data collection method. Sekhon and colleagues (2017) identify semi-structured interviews as well as focus group interviews as suitable methods for collecting data evaluating intervention acceptability qualitatively.

5.1 Research Data and data collection

Focus group interviews were used as the data collection method. The interviews were conducted in March 2021. The duration of the interviews varied between 47 and 59 minutes, with an average duration of 53 minutes.

To assess intervention acceptability an interview guide was developed in accordance with the TFA by Sekhon et al. (2017). The interview guide included in total 9 questions or statements that targeted each of the seven constructs of the TFA (affective attitude, burden, ethicality, intervention coherence, opportunity costs, perceived effectiveness, and self-efficacy) as well as one question targeting the concept of general acceptability and one question reflecting improvement ideas. The interview prompts included both open- and close-ended questions as well as both positively and negatively phrased statements.

Interview Prompts

- Affective attitude:
  - How do you feel about the training? Did it live up to your expectations?
- Burden:

  - The training demanded too much time and effort from the participants.

- Ethicality:
  - The training was a good fit with my personal values and beliefs.

- Intervention coherence:
  - It was easy to understand the purpose and nature of the training.

- Opportunity costs:
  - Do you think that the training has interfered with your other priorities and interests?

- Perceived effectiveness:
  - Did the training achieve its purposes and goals?

- Self-efficacy:
  - I feel confident in being able to perform the trust and empowerment related behaviors required in the training.

- General acceptability:
  - Do you find the training, in all, acceptable and appropriate?

- Improvement suggestions:
  - Is there anything you would have changed about the training? Anything that we could have done differently?

The interviews were conducted virtually using Microsoft Teams. To test-drive the interview schedule, a pilot interview was conducted with four participants. Based on the input from the test interview, I made some changes to the interview prompts. During the interview process, the interview schedule evolved into its final form. The whole interview schedule is displayed in appendix 1 (p.103).

The data from the test interview will not be used in this study, since the participants in the test interview didn't have a chance to participate in the workshop and only got a presentation of what the workshop includes and how it is supposed to work. The participants also represented the perspective of future intervention providers, which may have colored their answers in a different way than actual intervention recipients.

In the first two interviews, the participants didn't have the camera on, while in the last 2 interviews the participant had it on. At the beginning of the interview, the confidentiality of the participant's identity was assured by informing the participants that all data arising from the focus group will remain confidential. The data was promised to be securely stored. All

information has been completely anonymized and none of what was said in the interviews can thus be linked back to the participants.

Informed consent was obtained from all the participants by asking them to raise their virtual hand, give a thumbs up or indicate in any other way that they agree with the following three statements that were read out loud by the interviewer:

- The purpose and research methods of the study have been explained to you.
- You are aware that participation in the research is voluntary and that you can withdraw your participation at any time without having to justify your decision.
- You agree to be interviewed and that the information you provide will be used for the purposes of this study.

The interviews were recorded and the permission for this was also obtained before the interview started. All participants gave consent for recording the interviews. The recordings were transcribed in clean verbatim by an external transcriber. To validate the transcriptions, I reviewed them once more and made slight corrections where needed. The interviews resulted in about 57,5 pages of transcribed data.

5.2 Data analysis

The method of analysis is theory-driven content analysis. The transcribed material was analyzed with the help of the ATLAS.ti qualitative data analysis software. Theory-driven content analysis means using predetermined categories based on previous research or theory to guide the analysis (Tuomi & Sarajärvi, 2018). Theory-driven content analysis is a fitting method of analysis for this study since the theoretical framework of acceptability (TFA) by Sekhon et al. (2017) is used as a starting point.

In the analysis I have approached the data from a relativist perspective, meaning that many parallel realities are possible. To understand these different realities, it is essential to analyze the meanings produced by the research participants about the subject under study, intervention acceptability in this case. My study can thus be characterized as falling into the constructivist research paradigm, as my research centers around the meanings built by the intervention recipients around the topic of intervention acceptability in the context of a training intervention focused on trust and empowerment. I am also interested in

what kind of social reality these meanings create and what kind of implication they have for the target organization in terms of their organizational culture change process. (Mason, 2002)

Content analysis is a suitable method for analyzing social reality, as the core of the method is to understand what the phenomenon under study means to the research participants. The analysis begins with selecting an appropriate unit of analysis that suits the data and the research questions. The analysis then flows through phases of reduction, grouping, and abstraction and is tied together at the end by compiling the data into a logical entity. (Tuomi & Sarajärvi, 2018.)

The phase of reduction means excluding data that is irrelevant to the research question and searching for and coding expressions related to the research task (Tuomi & Sarajärvi, 2018). Hatch (2002) points out that interesting parts in the data that seem not to be directly related to the research question should not be overseen in the phase of reduction but stored for possible later use. These parts could come to have a significant impact on the analysis that can be hard to identify early on. This is also a way to ensure that the analysis stays close to the data. (Hatch, 2002)

In the grouping phase, similar expressions are grouped into categories to summarize and condense the data. This phase lays the foundation for the preliminary descriptions of the studied phenomenon (Tuomi & Sarajärvi, 2018) and the aim is to capture the richness of the data (Hatch, 2002). In the final phase of abstraction, the most important findings are distinguished and conceptualized. The analysis has moved from the original expressions in the data into theoretical concepts. (Tuomi & Sarajärvi, 2018.)

In line with the general guidelines of how to conduct qualitative content analysis provided by Tuomi and Sarajärvi (2018), I have in this study applied Braun and Clarke’s (2006) six-phase step-by-step procedure for conducting thematic analysis, which is one form of content analysis. The phases suggested by Braun and Clarke (2006) include:

1. Familiarizing yourself with the data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the research report

The phase of familiarizing myself with the data started already during the data collection, as I conducted the focus group interviews. I also took notes during and straight after the interview on interesting topics that were discussed. The familiarizing continued further during the transcription of the data as I reviewed, corrected, and validated the transcriptions made by an external transcriber.

Moving to the second phase of generating initial codes I started with searching for data describing the TFA's acceptability domains as well as trying to understand how the participants describe the different domains. This initial coding had characteristics of both deductive and inductive reasoning.

The deductive part of the coding is tied to the fact that I treated the answers that the participants gave for each question or statement as representing the TFA domain that the question was based on. The inductive part on the other hand describes the codes in themselves, as the codes that I produced were very data-driven and named after what the participant was talking about. Having said this, it is important to notice that also this more data-driven coding was shadowed by trying to understand if and how the different topics that the participants talked about were related to the TFA domain in question.

After having initially coded the entire data I started searching for themes within each of the TFA domains. I also started cleaning up the code list by merging similar codes and renaming codes as needed. I linked together codes touching upon the same theme using the networking tool in Altas.ti. Visualizing the connections between different codes enabled me to see how the codes were similar or how they differentiated from each other. For each TFA domain, some clear themes started to form as well as a lot of sub-themes.

The reviewing of themes included two levels of refining my themes. At first, I started by reviewing the coded data extracts for each theme, to understand if they appeared to form a coherent pattern. When the pattern wasn't clear, I needed to understand whether the theme itself wasn't working or if the extract just didn't fit the theme. Depending on where the problem lied I either reworked the theme, created a new one, found the extract a new place, or left it out of the analysis altogether. Secondly, I did the same process but this time with the entire data set. I wanted to see how well the themes work in relation to the whole data set. By doing this I realized that I needed to add some codes, that I felt were related to the themes derived from a certain TFA domain, that came from other parts of the interview than where

the specific questions had been asked. The phase of searching for themes and reviewing the themes was in my analysis closely linked and I alternated between these two phases.

I continued with defining and naming the themes that I had formed. This was done by ongoing analysis to refine the specifics of each theme and the overall picture that the analysis tells. I tried to identify the essence of each theme as well as the overall picture they paint by identifying what was interesting about the data extracts in the themes and why. The phase of defining and naming the themes was done simultaneously with producing the final report for my thesis. While writing the report, I realized that I needed to abandon the names that I had given the themes, since they complicated the storyline of the analysis. I instead focused on the content of each theme and what consequences it had for the bigger picture.

The analysis of my data led me to divide the results of this study into two separate chapters. The first section presents the descriptive analysis of the data, where I painted the picture of how the participants talked about the different TFA domains. The second section includes the interpretative analysis, where I describe how the participants constructed their view of the acceptability of the trust and empowerment intervention as well as assess the suitability of the TFA for evaluating the acceptability of an organizational intervention. While writing the report, I many times had to go back to previous steps in the analysis and rework codes, extracts as well as themes. My analysis was therefore by no means a linear process, even though I have tried to depict it here more straightforwardly for the ease of reading.

6 RESULTS

In this chapter, I will present the results of this study. I will begin by presenting the results of the descriptive analysis by depicting the participants' comments on each TFA domain. This part of the analysis functions as the base for the interpretive analysis and therefore a big proportion of the result chapter is reserved for this section. After that, I will move on to the interpretative analysis, where I first will compare the participants' perceptions of the individual TFA domains against their perceptions of general acceptability. Secondly, I will evaluate the suitability of assessing the acceptability of an organizational intervention by using the TFA. The interpretive analysis complements the descriptive analysis. The quotes from the data in the results chapter are added as is and are not corrected grammatically. The quotes also include a code for identifying from which participant the quotation is coming from. These codes have been assigned to the participants at the beginning of the study when

transcribing the data. The first part of the code represents what interview the quote is coming from and the second part represents which participants were speaking.

6.1 Descriptive analysis: participants' perceptions of the TFA domains

The participants' perceptions of the TFA domains will be presented in alphabetical order starting from affective attitude moving all the way to self-efficacy. The general acceptability of the participants will be presented last due to its aggregating character.

6.1.1 Affective Attitude

The TFA domain of affective attitude reflects how an individual feels about the intervention (Sekhon et al., 2017). To understand how the participants felt about the intervention they participated in, they were asked to comment how they felt about the training and if it lived up to their expectations.

All participants expressed that they liked the training, although some participants expressed their feelings a little more reserved because they felt that some things still could improve the training. In general, the participants had more positive comments about the training than negative. The things that the participants talked about in a positive way, were linked to the overall experience of the training, the training content and tasks, as well as the perceived effectiveness of the training, *"the training, the content, the discussion, everything was good, and it was having like the effect in the day to day life" (I1-P2).*

The participants also talked positively about the nature of the training. They constructed their opinion about the training by talking about what they thought the training was supposed to accomplish and what they felt they got out of the training. Many participants also expressed positive sentiments about being able to take away some things from the training that they could utilize in their daily lives. They especially highlighted that they would be applying their learnings to their teams, *"I'm taking away some things I learned from this team that I would like to use with my teams." (I4-P1)*

The more negatively toned sentiments were also linked to the nature of the training. The participants showcased dissatisfaction due to the lack of a more practical side in the training. All participants felt that the training lacked the more practical side in addition to the theoretical side, *"So, we're now coming from the more theoretical part and I missed a bit this*

practical part" (I3-P4). More about how the participants talked about the nature of the training can be found in chapter 6.1.4 Intervention Coherence.

In addition to their opinions about the training, the participants talked about their expectations for the training. The participants were divided between having clear expectations going into the training and going in with an open mind without expectations or not knowing what to expect, *"I went in not really knowing what to expect, but I thought it was a really good experience" (I4-P1).* The participants were also divided whether the training lived up to their expectations. Some felt that it did, *"yes, this training meets my expectations" (I2-P4),* while others felt that it didn't, *"I had a completely different expectation of the training"(I3-P3).*

The expectations that the participants had were related to how to improve as a leader, getting practical tips on how to apply the learning into their daily life, and developing trust and empowerment on a broader business and not interpersonal level. One participant wanted to evaluate his behavior and he was on the one hand looking for approval of the way he is doing things at the moment and on the other hand looking for ways of improving his ways of leading, *"my management style is actually quite much on this trust or transparency, I would rather say. And I was more interested in learning where I could do even step better." (I4-P3)*

Some other participants expressed that they wanted to learn how to use trust or empowerment in challenging day-to-day situations by getting practical tips and examples, but that this was not quite achieved.

> *"When we were talking about what is important to people and to give people some trustable environment and other things, I was thinking of a different type of a training, like how we do that, how we manage to do that?" (I3-P3)*

One participant stated that he was expecting to learn how to develop trust and empowerment in the work context as he felt that developing trust was different depending on if the trust-partner was a colleague or a friend, *"I mean this is what I was looking for, professional trust and empowerment that might be described the best what I want to express" (I3-P4).*

It can be concluded that the participants overall liked the training and were content with it. The positive sentiments were related to the overall experience of the training, the training content, and tasks, the perceived effectiveness of the training as well as the nature of the training, while the more negatively toned sentiments were related to a lack of a more practical side in the training. Most of the participants didn't have expectations going into the training.

The few participants that had said that they had expected the training to improve them as a leader, give practical tips on how to apply the learnings into their daily life, and show them how to develop trust and empowerment on a broader business level.

6.1.2 Burden

The TFA domain of burden reflects how much effort the participants perceived that participating in the intervention require (Sekhon et al., 2017). To understand how the participants perceived the burden of the trust and empowerment related training, they were asked to comment on the following statement: "the training demanded too much time and effort from the participants".

All participants felt that the training overall didn't require too much time and effort.

> *On my side, I think it was not too much time or effort. I think that we were having the e-learning preparation and I think it was just a, I think well, on my side the time and effort that we put for the participants, on my side, I think it was perfect. (I4-P2)*

Although the overall burden didn't feel too big the participants mentioned some aspects that contributed to some level of burden as well as some aspects that could increase the feeling of burden. The participants felt that the 2-hour duration of the training was suitable, but some commented that there was room for improvement when coming to the time distribution within the training. They felt that they were being rushed and would have liked to dedicate even more time to discussions and interactive, practical tasks.

> *I feel that yesterday we were a little bit rushed at the end, and the reason for that may be the timekeeper for the activities (I4-P2)*

Another aspect that was highlighted as a cause of burden was the uneven distribution of passive and active involvement of the participants. The participants felt that one of the most important aspects of the training was the social exchange and they would have liked to see even more of it. One of the participants suggested that the theory presented in the training should be concise, and the focus should be on the interactions between the participants, *"monologues should be short, and dialogues should be longer" (I3-P4).* Throughout the interviews, the interactive part of the training rose as the most important part for the participants.

The virtual training format was seen as something that contributed to the feeling of burden. Many of the participants felt that the training would be more appropriate in a face-to-face format, but they recognized that this wasn't an option now due to the Covid-19 pandemic.

> *It would be also one of those trainings, I think, it could be even better when we could do it face-to-face instead of, we're remote. But as we have no alternative yet, so it's fine as it is (I3-P4)*

The preference for the face-to-face format was linked to it being easier to discuss this kind of topic where facial expressions and body language play a vital role in building an emotional connection and essentially build trust within the training group.

> *I think having the cameras on, being able to see expressions and interact that way built a level of trust that I was just thinking about if I have when there are people without cameras on the meetings for whatever reason (I4-P1)*

The participants also highlighted that the virtual format of the training brings with it more distractions that potentially can lead to people losing their attention. Being mentally present and participating with an all-in attitude was seen as essential.

> *Especially this virtual is sometimes often, how to say, distracting, distracting the focus, and then you need the kind of determination that no, I close down other things, that it's not popping up (I4-P3)*

In this way also another prominent type of burden namely cognitive burden seemed to increase the participant's perceptions of burden in relation to the intervention. In addition to losing the attention due to distractions, the participants felt that trust and empowerment was a broad topic to address within the limited time of the training leading to an abundance of new information for the participants to process causing a high cognitive load, *"I know that the trust and empowering, well, it's a little bit, it's a big topic for two hours, I think you can just touch a few of component of that" (I4-P2).*

There were several reasons that the participants brought up as to why the training didn't feel like a burden. Many felt that it did not require too much because they found the topic interesting and exciting *"I also agree that it was in that way quite exciting and time went faster because it was a good subject to do" (I4-P3).* Another reason that the participants brought up as lowering the feeling of burden was being well prepared going into the training due to the pre-work.

it's a good idea to get aware of what's coming. Because a lot of material shown was also in the e-learning already available. And this was good that you could follow up certain graphs and theories already before in the preparation. (I3-P4)

Many of the participants expressed valuing participating in the training by stating that finding time for the training was a matter of will and that the time spent was worth it and an investment for the future. Valuing the participation was often linked to wanting to learn.

So, it's like it's worth it. I mean, how much time and effort you put into these trainings, it's worth it, because there are always different modes of learning. You either go by virtual learning, you go by some kind of practical learnings. And there are learnings where you can actually learn within a group. I would say it's worth the time and effort (I1-P1)

All in all, I can conclude that the participants didn't feel like the training had demanded too much from them, although they could identify some aspects that contributed to feelings of burden. These feelings of burden were centered around the uneven distribution of time and active and passive involvement of the participants within the training, as well as the virtual training format that caused cognitive burden. Reasons lowering the feelings of burden included training duration being suitable, being well prepared before the training due to the pre-work as well as valuing the participation in the training. The positive aspects that contributed to lowering the feeling of burden seemed to outweigh the aspects contributing to some level of burden. Based on this, I would be able to expect that the effort required to participate in the intervention was considered manageable from the participants' point of view.

6.1.3 Ethicality

The TFA domain of ethicality encompasses how well an intervention is aligned with an individual's values (Sekhon, et al., 2017). To understand how compatible this intervention was with the participants' values they were asked to evaluate the statement: "the training was a good fit with my personal values and beliefs".

All participants felt that the training was aligned with their personal values and beliefs, and nobody felt that the training would have contradicted what they believed in. Many saw trust and empowerment as values and something worth striving for. Some participants also shared that they personally valued some of the trust and empowerment related behaviors that the training was focusing on, e.g., courage, taking calculated risks, and speaking up. In addition

to the training feeling compatible with their personal values, the participants also felt that the training was very much aligned with their company views and values and that the training, therefore, served the company well.

> *it's really important, it's really at the center of my heart that trust and empowering, I think it's perfect timing and aligned with my personal value. And also, the strategy, the strategy of [name of business area] and [name of company] as well. (I4-P2)*

The personal values of the participants were very strongly connected to the company values. It was very clear that the participants embraced the company values as their own and it was at times difficult to distinguish if there was a line between their own personal and company values or if they in fact were completely intertwined, *"it's aligned with the strategy. It's aligned, and it's also aligned with our value that we can relate a lot of trust and empowering with all the value" (I4-S2).*

Another value that the participants appointed to the training was a value of togetherness. The togetherness value describes a more social dimension of values including collaboration, interaction, and communication. The most important thing that all the participants highlighted was that the training was interactive and brought people together as well as promoted open and transparent communication. They liked that the training encouraged the participants to talk about values, share their own experiences and possible problems or challenges and that they could get support and help from the rest of the group, *"it made me realize sometimes if I'm struggling with something, I have people I talk to" (I4-P1).*

Most of the participants felt that the training promoted collaboration and they liked that the training was built in such a way that the participants were to work together in the activities. Some of the participants also saw the training as an opportunity to work together with people from different parts of the organization. Doing things together was important for these participants.

> *I really liked the collaboration because I think it would be a good exercise on the team so that you could bring out things that team members might feel about the immediate team, that like I said earlier like I learned a lot from talking with you all and hearing ideas or when we did the action plan for the short, medium, and long-term goals. (I4-P1)*

Most of the participants expressed that they value learning by stating that they feel it is important to learn and develop and that the training enabled this by providing an opportunity for gaining new perspectives and learning from others.

> *when I saw, for example, that [name of person in the interview] that was together there in the discussions, then I saw that she has a little bit different reality than I have here. It was nice to have these discussions and these new point of view of the things. (I3-P3)*

It seemed to be important for the participants to move from thoughts to action and therefore it is no surprise that one aspect of the training that the participants especially valued was the pragmatic character of the training. This appreciation of pragmatism was showcased in a series of values rooted in action. On the one hand, some of the participants talked about already practicing the trust and empowerment related behavior while others on the other stated that they would try them out with their team in the near future, *"I think it's an empowerment of the team doing this. And I think that's what I would like to do" (I4-P2).*

The participants also valued the daily life relevance of the training and it being easy to adopt the behaviors into their routine. One participant expressed that she valued the fact that the training was turning the strategy from word into actions, since this many times was overseen. Finally, tying everything together the participants felt that trust should be at the center of what they should do at work, being the base for all their actions, *"I think trust and empowerment, they are the kind of centerpiece of what we should do" (I4-P3).*

When the participants took a stance on the statement related to ethicality, they mainly talked about the training being aligned with both their personal as well as company values. None of the participants felt that the training contradicted anything they believed in and that they therefore could stand behind it completely. Furthermore, the participants opened up about what kind of values they thought that the training represented, and these included a set of togetherness values and values rooted in action. The togetherness values included e.g., collaboration, interaction, and communication, while the values rooted in action were related to moving from thoughts or words to action. Trust as the foundation seem to be at the core of how these participants see this intervention in terms of their values. It links together personal, company, and values rooted in action. On the one hand, the participants personally valued basing their work on trust, but at the same time, they felt that this should be broader, that this is how the company also should see things.

6.1.4 Intervention Coherence

The TFA domain of intervention coherence reflects how well an individual understands the intervention and how it is supposed to work. This domain investigates whether the intervention recipients perceive the components of the intervention to fit together with the intended goal of the intervention. (Sekhon et al., 2017) To evaluate intervention coherence the participants were asked to comment on the statement: "it was easy to understand the purpose and nature of the training".

When asked to comment on the statement the participants mainly talked about three themes. They talked about what the training was like or the character of the training as well as through what mechanisms the intervention aims to achieve its goals. On the other hand, they also talked about what the training should be like and ways of improving the training to become more like their vision. When talking about what the training is like, the participants' mentioned the purpose of the training and the content and flow of the workshop.

In relation to whether the purpose of the training was easy to understand, the participants were split in two. Some of the participants felt that the purpose was well explained, easy to understand, and thus very clear.

> *I think it [the purpose] was well explained at the beginning. In the beginning, I think you did a good summary of what is the purpose, what is the goal that we want to achieve. And I think for me, it was very well explained (I4-P2)*

While others felt the complete opposite way. They stated that the purpose of the training was unclear at the beginning of the workshop and that it because of that was hard to understand the things presented. Some participants also felt that it was hard to understand what was going to happen in the training and with what kind of mindset they should approach the topics.

> *I'm unable to understand that what is going to happen in that training. What is the mindset or something, we have to bring it before we come to that training? Once the training started, in many of the areas, sometimes it is feeling blank, because the curtain-raiser or the stage was not completely clear. (I1-P2)*

The content, nature, and flow of the workshop were regarded as good and the participants stated that they liked the tasks and activities, *"I was pretty much convinced and satisfied with the tasks" (I1-P1).*

The participants recognized several different mechanisms through which the intervention aims to achieve its goals. Among these were social learning, raising awareness, implementation of strategy, showing how to build trust and empowerment, cultural change, multi-layer development, and working as a practical development tool.

What could be termed the most important mechanism for the participants was social learning. All participants felt that learning from others, understanding different points of view, gaining new perspectives, interacting, and working together was the virtue of the training, *"you brought everyone together and creating an ambiance while giving the training" (I1-P2).* The second most common mechanism was raising awareness. The participants felt that the training functioned as a good first touch upon the topic raising awareness, *"if you want to build a culture, people need to talk about it and be aware of this" (I4-P2),* while still falling short on the more practical side on how to implement the learnings into their daily life and applying it to their teams.

> *We had a lot of the tools and information, but no practical way how to implement to that, how to use these ones. We were presented, but we were not training in a practical way to implement that (I3-P3)*

The participants indicated that the training still gave a good core understanding of the ideal way of building trust and empowerment and that it, therefore, helped to increase their understanding, *"the first step is to understand how it works in our mind in the organization, the characteristic that we needed to know" (I3-P2).* To gain a deeper understanding of how building trust and empowerment work in the real world some improvement suggestions were made (see later in this chapter).

Despite this, the participants still felt that the training functioned as a practical development tool providing them a way for reviewing their behavior and unveiling their development needs. They also stated that the training showed them how they should behave and helped them set behavior targets for achieving change.

> *It is showing continuous improvements where you are lagging and how to take up those laggings. It is showing where we can step and move forward, and we can improve faster. (I2-P4)*

Some participants felt that the training helped them turn theory into practice while others felt that they would have needed more concrete tips and tricks. Another very welcome

mechanism was helping to implement the company strategy. A couple of participants expressed that the training helped them see how they can be part of implementing the strategy and that it provided a way of going from words to action, "*that just helps us become stronger and stronger and it solidifies what we're hearing as our strategies and actions where we feel like we can be a part of it" (I4-P1).*

In connection to this, the participants also recognized that the training was driving a cultural change and that they would be part of building their organizational culture to incorporate trust and empowerment, *"because it's a culture that we're trying to build" (I4-P2).*

Although the participants overall liked the nature of the training, they presented many ideas on how the improve it to become even better. Among these improvement suggestions the participants mentioned setting the stage for the training, structuring the content more clearly, increasing the target group, adding practical tasks, and showing what building trust and empowerment looks like in the real world, not just the ideal way.

The improvement idea of setting the stage for the training was linked to some of the participants feeling that the purpose was unclear, and they described ways of making the purpose clearer at the beginning of the training. Some examples that were discussed were for example clarifying that the motivation for the training was coming from the company strategy, setting clear expectations for the participants, and showing what benefits the training is supposed to provide for the participants.

> *it's really important as well to set the tone when you do a training like that, what are the expectation, what are the purpose, the nature, and the goal, and what are also the expectations of the person in the training as well. (I4-P2)*

It was also mentioned that the content of the workshop could be structured in a clearer and better way by keeping the agenda concise and not focusing so heavily on theory. Another aspect that also was related to the purpose of the training was the fact that many participants felt that for achieving the purpose the target group for the training should be expanded. Almost all participants felt that trust and empowerment as a topic is something that concerns all employees within the company and that the target group thus should be expanded to include all employees in the organization, not just specific groups. They also highlighted that it would be helpful to include people from different levels in the organization as well as

people with different amounts of work experience in the company, in the same training session to be able to learn from their experiences.

> *[the training] has to be like a throughout approach. I mean, like a training where we can include people not only at one particular level, but it should be people from all different levels, like a plant manager, like a GM, so that we can have their views. (I1-P1)*

One improvement suggestion that came from all the participants was that they wanted to add practical tasks into the training. They wanted to get to practice what they just learned, and many felt that the practical tasks would increase their learning by making it easier to remember leading at the same time to an increase in the impact of the training. Many participants suggested adding case examples or stories about best practices and others wanted to try to apply the trust and empowerment related behaviors in different, even difficult situations. In many instances, the participants suggested adding games or role-play where they would get to try out the different behaviors.

> *You know that you give, for example, a task to do, to all of them. And the task shows that how you would build the trust for example, or how the real empowerment works as a task or a game or something. (I4-P3)*

Closely linked to the longing for practical tasks was the fact that a few participants felt that the training represented the ideal way of building trust and empowerment and they felt that things in normal life didn't always work like that. These participants would have liked to see examples of how building trust and empowerment in the real world looks like and what to do when things are not going according to plan and there are difficult situations. The dark side of trust of when to hold back and not trust fully was considered a missing piece that they would like to include in the training.

> *This what we have seen is the nice weather version, but there's also the real weather. Sometimes it rains and sometimes it's flashing, cloudy. And what we have seen is the high, shiny way of to build trust and empowerment. It sounds super and everyone embraces that but it's not always that nice. And people know that. People know that it's not always shiny and this less shiny should have a bit of space there. (I3-P4)*

To recap, the participants perceived the intervention coherence in terms of three themes. They talked about the training character, the intervention mechanisms through which the intervention worked as well as ways of improving the training. The training character both

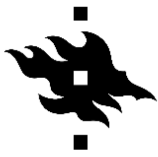
hindered and facilitated the understanding of the intervention. Especially the purpose and the nature of the topic divided the participants into those who felt they helped and those who felt they hindered. All intervention mechanisms that the participants mentioned were viewed as facilitating the understanding of the intervention while the improvement suggestions naturally represented areas the participants felt complicated the understanding. The most important intervention mechanisms that were mentioned were social learning and raising awareness, while the most mentioned way of improving the training was adding practical tasks.

6.1.5 Opportunity Costs

The TFA domain of opportunity costs refer to whether the participants feel that they must give up benefits, profits or values in order to participate in the intervention (Sekhon et al., 2017). To understand how the participants' perceived the opportunity costs of the intervention they were asked to answer if they thought that the training had interfered with their other priorities and interests. When answering the question, the participants mainly talked about the training not interfering with their other priorities and interest and the reasons why they felt that it didn't interfere, but they also talked about how it possibly could be interfering for someone else and how to reduce the impact of those imagined barriers.

All participants felt that the training didn't interfere with their other priorities and interest in a negative way. Some felt that it had influenced rather than interfered and the interference was framed as a positive thing. One major reasoning for why the training didn't feel like interfering was that the participants explained that they had accommodated the training with their other work and thus made room for the training. Some participants stated that the training was as important as their other work tasks, while others even seemed to prioritize the training as more important by stating that other priorities could be set aside to enable participation in the training, "*I think you can put other priorities regarding your work and everything just a bit behind I think and attend this one with full focus to really achieve something." (I1-P1)*

Other reasons that the participants used to explain why the training didn't feel like interfering with other priorities were personal development, gaining benefits, having high daily life relevance as well as the training showing the direction of the company. As we could see in the ethicality chapter (6.1.3 Ethicality) most of the participants valued learning as something very important and that was then again reflected here when the participants mentioned that



the opportunity cost was perceived as low because they felt that it was their responsibility to learn and to develop themselves and become better. Gaining benefits was viewed as counteracting the disturbance of the training. Another reoccurring theme from previous chapters that was used to justify the training, was the perceived daily life relevance. Many participants highlighted that the topic was very relatable and has a strong connection to real life. Some participants also felt that the trust and empowerment related behaviors would fit easily into their daily routine.

> *it was not different from what we experience so we could really relate to all the topics quite well and the kind of integration to what really happens and what should be was on my part where I could connect well to the topics being discussed. (I2-P3)*

Since the participants themselves didn't perceive the training to interfere with their other priorities and interests they were asked a follow-up question if they could think of any barriers that would prevent people from participating in the training. The few barriers to participation mentioned were the purpose being unclear and some organizational barriers. One participant was convinced that not knowing what to expect from the training could cause hesitation to participate, *"if you don't have the proposal of the training shown in the beginning maybe people don't think to attend or people would be a little bit holding to attain to the training" (I3-P3).*

Some participants said that different kinds of organizational barriers like having a certain work role like for example working in production could be perceived as a barrier for participation. Other organizational barriers mentioned were lack of time due to an abundance of managerial responsibilities, big organizational changes, or even working under a lot of pressure.

> *I think if you reach out to levels where people who are involved in production, day-to-day dispatch, day-to-day, what you can say, regular work, this would kind of feel a barrier, a bit of a barrier to them. (I1-P1)*

The participants also proposed solutions for reducing or overcoming the barriers to participation by for example planning the training ahead in good time, the manager preparing the team beforehand, and making the training voluntary instead of mandatory. The manager's role was seen as essential in overcoming the barriers, *"if we are interested to be a part of it, I think all those issues can be sorted out with the... there is a tool, which is a manager" (I1-P2).*

In addition to the barriers to participation, the participants also proposed barriers that could prevent the training from achieving its goals. These barriers included being unable to convince the participants, the purpose being unclear, psychological, or cognitive factors including the participants' lacking agency, issues related to change, lack of accountability, and being unable to implement the learnings of the training.

The purpose being unclear and not being able to convince the participants were perceived to challenge the training reaching its goals. Ways of being more convincing included relating the training to daily life and clearly explaining the purpose and benefits of the training. The psychological and cognitive factors that were highlighted were, not feeling in control of the change, forgetting what was being taught, being close-minded about trust and empowerment, and the training topic being difficult to talk about, *"and one concrete barrier, I think, is that people, they don't want to talk about such things. Because they say, OK, I never trust anyone" (I3-P4).*

Making a change is often difficult and this was also recognized by the participants. They expressed concerns about not achieving change, people getting upset when things are changing and even that existing levels of trust will affect how people judge the changes being made.

> *I think that the barrier would be that, you know, this training is very important, good, but at the end of the day, we wanted to see that two-hour spent, to make a small change in what I am doing. And to me, it's very easy that I will go back in my day-to-day life. And then, I will forget this. (I4-P3)*

Another big concern raised by the participants related to not achieving change was how to ensure implementation. The participants felt that implementation would be the biggest challenge for them personally and for others participating in the training as well. One participant brilliantly summarized that accepting what they need to change and achieve isn't going to be the problem, but rather how they will be able to make it happen through implementation, "*I would see that the implementation might be the barrier, not the adaptation of accepting what we are expected to achieve" (I4-P3).*

Factors seen as making the implementation challenging, were having low confidence related to implementing the things learned and realizing that theory not always translates into practice. Related to implementation also accountability was seen as challenging and some of

the participants suggested ways of improving the accountability by for example adding a check-in after the training.

> *would you be willing to participate in like a month or three months later for that accountability to make sure we're implementing what we say we're going to in that two hours? (I4-P1)*

It can be concluded that none of the participants associated any significant opportunity costs with engaging in the training and that they on the other hand listed many reasons why the training didn't feel like interfering by explaining what had motivated them to participate. One of the most important reasons they mentioned was prioritizing the training and accommodating it with their other work. Other reasons mentioned was the possibility to develop oneself, gaining benefits, the training having high daily life relevance as well as the training showing the direction of the company. Since the participants themselves didn't feel like the training had caused them opportunity costs, they hypothesized things that someone else could consider barriers. These barriers included both barriers to participation and to achieving the goal of the training. The biggest barrier to both participation and achieving the training goal was the purpose of the training being unclear. Other barriers standing in the way of achieving the goal of the training that the participants highlighted were psychological or cognitive factors such as the participants lacking agency as well as the participants being unable to implement the learnings of the training. The participants also provided suggestions of how to reduce the imagined barriers.

6.1.6 Perceived Effectiveness

The TFA domain of perceived effectiveness reflects to which extent an individual perceives an intervention to be likely to achieve its purpose (Sekhon et al., 2017). To understand how the participants perceived the effectiveness of the training they were asked to answer if they thought that the training had achieved its purpose and goals.

When talking about the effectiveness of the training the participants talked about three main themes. They reflected on the aims of the training, the type of impact they felt that the training had as well as ways of increasing the impact. Most of the participants started by stating that they felt that the training was highly effective or somewhat effective. Reasons that were mentioned as making the training effective were having a clear purpose and goal as well as achieving them, the content being useful, and gaining benefits from the training in

form of e.g., the participants being able to utilize the learnings. All in all, the training was regarded as having a positive impact on the participants and helping them, *“after taking the training it helped my daily life also how to handle the team and my co-workers also. It definitely helped me” (I2-P2).*

Another type of impact that also was mentioned by many participants was the daily life impact. Some of the participants even went that far as saying that the training was impacting not only their work life but also their personal lives and, in that sense, even going beyond the purpose and goals of the training.

> *I don't think it's only applicable in an organization. I think it's applicable at your home, with your friends, with your extended families, everywhere. This subject, so it's even wider, wider perspective. (I4-P3)*

On the other hand, a couple of participants needed reminding of what the purpose and goals of the training were before making up their minds of its effectiveness. Once again, the unclear goals and purpose at the beginning of the training were brought up highlighting the division of different experiences between the participants, *“that was my answer to say, look I don't know the goals. The purpose yes, but the goals no. How I can evaluate what was?” (I3-P3).*

Putting aside the intended purpose and goals of the training the participants constructed their understanding of what the training achieved in their minds. When building this understanding the participants mainly talked about improving their team leader skills, achieving cultural change, raising awareness, so all in all creating a common understanding, *”the goal of the training is to really include as many people as possible and to have them this common feeling of this trust and empowerment” (I1-P1).*

Some participants felt that the training had not quite reached its goal because they either felt that it lacked the practical aspect or that it hadn’t reached out to enough people yet. Another reason that the participants mentioned for the training not reaching its goals was the fact that it had not done that yet. They felt that the training was at the beginning of its journey and that it therefore still had low maturity. One participant still highlighted that the company was taking a step in the right direction due to the training, but also, he felt that big changes were still needed. A few participants recognized that the training still had a way to go and that

changes like building a culture take a long time and that the training eventually would achieve its goal when giving some time.

> *I think it has to just achieve its maturity, so once that happens, I can say that it's in the right direction. So, once the direction is right, ultimately you will walk the distance to achieve the final goal (I1-P1)*

Although the participants generally were pleased with the effectiveness of the training, they suggested many ways of improving the impact even further. First and foremost, they once again highlighted that it was important to focus on making the beginning of the training clearer by stating the goals in an understandable and free-flowing way.

> *I don't remember so well that you brought that up so clear and so free speaking as you did it now. It can also be a part of the training the voice, this computer voice which is always having the same melody in the voice. (I3-P4)*

The practical aspect, as well as implementation, was yet again mentioned now in the light of making the training more effective and impactful although here the discussion also touched upon whose responsibility the implementation is. Some participants felt that the responsibility for implementing the things learned in the training was on the participants themselves and that they needed to be active, while one other participant felt that the trainer was responsible for guaranteeing successful implementation.

> *It seems like the difference between hear and listen. So, hear, we are hearing that, okay, if that purpose is completely, it has to be completed it means we have to listen it. It has to be implemented, right, it has to be reviewed, it has to be charactered, so then it can reach the purpose (I1-P2)*

Finally, the participants also indicated that some repetition would be needed to maximize the impact of the training. Some participants suggested increasing the number of sessions and having time between them to enable the participants to try out the learnings of each session in practice. One other participant expressed that discussing trust and empowerment should not be limited to this training but should instead be continuous. Others also highlighted the importance of continuous reinforcement of the learnings, *"keeping the check on this topic which I mentioned that it's not left behind after these two hours" (I4-P3).*

It can be concluded that when talking about whether the training had achieved its purpose and goals, the participants reflected on the aims of the training, the type of impact they felt that the training had, and ways of improving the impact. The participants felt that the training had

helped them improve their team leader skills, start a cultural change, and raise awareness. Most of the participants felt that the training was effective, while some still felt that there were things to be improved to enable the training to reach its purpose and goals. The main reasons that made the training effective in the eyes of the participants were the positive impact it had on the participants as well as the training having a daily life impact. The main thing that was mentioned as a reason for the training not reaching its purpose and goals was the lack of a practical side to the training and the still low maturity level. The main improvement suggestions centered around setting the stage of the training in the beginning and reinforcing the learning by repetition.

6.1.7 Self-efficacy

The TFA domain of self-efficacy describes the level of confidence that a participant feels about performing the behaviors required to participate in an intervention (Sekhon et al., 2017). To understand how confident the participants felt they were asked to comment the statement: “I feel confident in being able to perform the trust and empowerment related behaviors required in the training”.

No participant expressed complete confidence on all levels, but all participants expressed confidence in relation to some of the behaviors required by the training. There were individual differences between the participants about what they felt confident about. Some felt confident about sharing what they had learned with their team as well as building trust on a wider level than inside the team, while others namely highlighted this as an area where they felt less confident. One participant expressed that building trust relationships with individual persons came easily to him but continuing to develop a culture or an environment where everybody trusts each other still felt challenging and that he would need some further information as well as training about this part of the training. Generally, the participants had higher confidence in terms of personal influence or adopting the behaviors individually as compared to having wider influence or helping their team members adopt the behaviors.

> *For me, I think building the trust with my employee, with other colleagues, I think I feel very comfortable with this. But putting the environment that each other trusting each other, I think it's a different story here. (I4-P2)*

The participants reflected on their capability to perform the things required by the training. On one hand, some participants saw that their organization played a role in enabling their

capability of participating in the training, and on the other hand other participants wanted to make sure they would be able to achieve change by being sure that they would be capable to implement the planned actions.

> *I would want to make sure that we were able to implement the things that we put in place for each of those so that we were able to follow through on the actions and still meet the business goals and all that (I4-P1)*

Although expressing lower confidence when coming to the implementation, interestingly, many participants indicated that they were planning actions and were excited about getting to make improvements with the team. It seems like some participants were confident in making an implementation plan on the thought-level, but less confident when it comes to making things happen. Still, there were also some participants who expressed that they felt confident in both areas.

> *I would feel very comfortable sharing what we went through yesterday. Even that slide with the activity with my team. It would be something I would be excited to do and kind of see their perspective on which one was our weakest area that needed work, so that we could really start addressing that. So, I would feel very confident there. (I4-P1)*

Several of the participants also expressed that they were unsure of their confidence because they felt that they would need to test what they had learned before being able to say whether they felt confident or not, "b*ecause yes, I'll try to put them in practice with my team now and to discuss with them and see how this will be developed and then I can say that I'm able or not able*" (I3-P3).

Then again areas, where the participants felt confident, were e.g., processing what they learned, following up their progress, and reviewing their behavior to find out how they would be able to develop even further.

> *Once you implement something, don't stop it. Nothing is perfect, you have to again review. So, that you'll come to know that there are some more things. Maybe either you can self-review, otherwise you can put that in front of the users, which is going to use that. So that they'll give a review to you. (I1-P2)*

Another thing that seemed to boost the confidence of the participants was that they felt that the training was showing them the way by summarizing what they need to do and where they

needed to develop. Many participants felt that the training had helped them become better at regulating their behaviors, which had led them to feel more confident. A couple of participants stated that they had wanted to analyze their behavior and get validation of whether they were doing the right things already.

> *So, I'm highly confident that we don't have to change our way. So, we work like that already, not perfectly, but the way we go, we trust on each other, we build on empowerment, or you have to, otherwise, you cannot manage things. So, for me, I sound confident that this is the right way. (I3-P4)*

Another prominent thing that many participants highlighted was the fact that the training program was still an ongoing process and that their confidence most certainly was going to grow with time. A couple of participants also added that these types of learnings shouldn't stop after the training program is finished but that they should continue every day when facing different situations and challenges, "e*very day is new learning, every day is a new challenge. So, this is an ongoing process" (I2-P3).*

Many participants also expressed that they wanted to continue improving themselves related to trust and empowerment. They felt that their journey had just begun and that they wished to learn more and become even better, and they felt that this also would increase their confidence.

> *I think at this point in time, I feel a little bit more equipped with tools and idea that we share, but I would like to learn a little bit more about it, how we build this culture (I4-P2)*

All in all, the participants seemed to be quite confident about being able to perform the behaviors required in the training. The area where the participants seemed most confident were adopting the behaviors themselves and regulating their behaviors. What they felt more insecure about was the wider influence related to changing the environment. The biggest insecurity was related to implementation and making change happen. Another prominent thing was that some participants were unsure of their confidence and indicated that they would need to test their learnings before being able to judge it. Many also highlighted that their confidence would grow with time when getting to turn their learnings into practice. No participant indicated that they wouldn't feel able to perform the behaviors required.

6.1.8 General acceptability

According to Sekhon et al. (2017), intervention acceptability is built around seven components: affective attitude, burden, ethicality, intervention coherence, opportunity costs, perceived effectiveness, and self-efficacy. Understanding how intervention recipients perceive each of these components is theorized to reveal how they assess the acceptability of an intervention. Since I have applied the TFA in an area outside of the area it was developed for, namely an organizational setting instead of a healthcare setting, I wanted to see if the individually asked acceptability domains would reflect the same answers as asking the participants about acceptability in general. By doing this I can evaluate the acceptability in a more comprehensive way as well as take a stance on how well the acceptability domains apply for a non-healthcare-related intervention. The participants were asked to comment on whether they had found the training in all acceptable and appropriate.

All participants stated that they found the training acceptable, *"I think it is appropriate and acceptable for me. Acceptable and appropriate" (I2-P2)*. Some participants expressed their acceptance by commenting that they thought the training was well-prepared and met their expectations while others said they liked the training. Some participants also commented that they felt that the training was going in the right direction and that the training was acceptable and appropriate as a pilot. By incorporating the improvement suggestions provided by the participants into the final version of the training before rolling it out company-wide, was going to make the training even more acceptable according to one participant. On the other hand, another participant gave the advice of not changing the training too much since he felt that the core of the training was good.

> *So, in my opinion, the training as a guinea pig one was absolutely acceptable and appropriate and if you can implement some of the inputs from this group and maybe you have another interview group too, that would really help. (I3-P4)*

Many participants also highlighted the training content when commenting on the general acceptability. They felt that it was important for the participants to believe in the training content and concepts. One participant also explained that he had perceived the content as reliable due to it being reviewed by an expert in the company.

> *So, that content, if there's a right content, okay, we would like to believe that, and that those contents are acceptable with that line, if you keep that line, that contents are acceptable and appropriate. (I1-P2)*

It was interesting to notice that some of the participants clearly separated the word acceptable from the word appropriate. *"Yes. And it is acceptable, and more than acceptable, it is appropriate. There is a difference between these two words" (I1-P1).* For these participants, the word appropriate was related to the training being suitable and they felt that it is not easy to achieve, but that this training had done so. They stated that the training was suitable for everyone no matter what work role the person has. Acceptability, on the other hand, was for these participants related to the content of the training.

They felt that it is not possible to achieve complete acceptability because it is very rare for an individual to accept everything presented in a training and more likely that the individual will accept some proportion. How much each individual accepts the contents is depended on individual characteristics like the character or views of the person. For some other participants, the appropriateness was related to the training being appropriate for the purpose and meeting their expectations.

> *Acceptability usually comes with the fact, okay, to some degree, 65 % is acceptable, but then the rest 35 %, okay, but the appropriate part is the one where you will have to be, you have to like give more with it because it is appropriate for everyone. (I1-P1)*

Other main reasons that the participants used to explain their high perceived acceptability were the topic being relatable, current, and important; the training being aligned with the their values both on individual and company level; gaining benefits and practical tools for implementing the company strategy as well as getting to develop their respective teams. Although the participants felt that the training was acceptable, they once again provided some suggestions for making the training even more acceptable. These suggestions included adding practical examples and showing how to build and maintain trust and empowerment in tough situations, are following the previously stated improvement suggestions.

> *So, those kinds of things, you know, it's an easy environment, it's okay to build trust, but when the things get more complex or bad, something has to be chosen against other. And if that environment also gives that trust and transparency, that's the ultimate goal. (I4-P3)*

Summarizing, the participants' comments about the general acceptability of the intervention we can see that all participants stated that they felt that it was acceptable. The main reasons that the participants used to justify their opinion were that they felt the training was aligned

with their values and provided them different sorts of benefits like e.g., becoming part of the strategy. Some ways to improve the acceptability of the intervention even further included adding practical examples as well as showing the dark side of trust and empowerment. Some of the participants also separated the word acceptability from appropriateness. They indicated that the word appropriate was related to the training being suitable, while acceptability on the other hand was related to the content of the training.

6.2 Interpretative analysis

Next, I will move to the interpretative part of the analysis, where I compare the participants' perceptions of the individual TFA domains with their perception of general acceptability. I will also reflect on whether the perceptions of the individual TFA domains fit together with the acceptability definition provided by Sekhon et al. (2017). Further, I will judge how well the TFA was suited for assessing the acceptability of an organizational intervention.

6.2.1 Comparison of the individual TFA domains and general acceptability

When commenting on the general acceptability of the training the participants used references aligned with some of the individual TFA domains, namely affective attitude, ethicality, intervention coherence, and perceived effectiveness. The affective attitude dimension was expressed through the participants saying they liked the training and that it met their expectations when asked to comment on the general acceptability. Ethicality, on the other hand, showed when the participants used their values and beliefs to explain why they thought that the training had high perceived acceptability. They mentioned that the topic was important and that the training was aligned with both their individual and their company values.

I interpret that the dimension of intervention coherence was used as a prerequisite for acceptability, as the participants expressed that they thought that it was important for the participants to believe in the training content and concepts, as they had done also when asked to comment on intervention coherence separately. Finally, the participants also made references to the perceived effectiveness of the intervention, since they stated being able to gain benefits and practical tools for implementing the company strategy and being able to develop their teams, as reasons explaining their high experienced acceptability.

The TFA dimensions that weren't referred to when the participants talked about the general acceptability of the intervention were burden, opportunity costs, and self-efficacy. It would thus seem that these dimensions were seen as less important compared to the other ones when the participants built their opinion about the acceptability of the intervention. I didn't find any indication in the data of why some TFA domains had a more significant role than others, so the only thing I can do is speculate. Maybe it has to do with the context of the intervention? People participating in an organizational intervention, are getting paid for it as part of their job, while people participating in a healthcare intervention are doing it completely voluntarily. Seeing the intervention as part of their job might explain why the domains of burden and opportunity costs had a small role in the participants' construction of acceptability. On the other hand, this doesn't explain the small role of self-efficacy. Further speculations of the possible reasons why some domains had a smaller role than others can be found in the discussion and conclusions chapter (chapter 7). The summary of how the participants of this study constructed their view of acceptability can be found in figure 2.

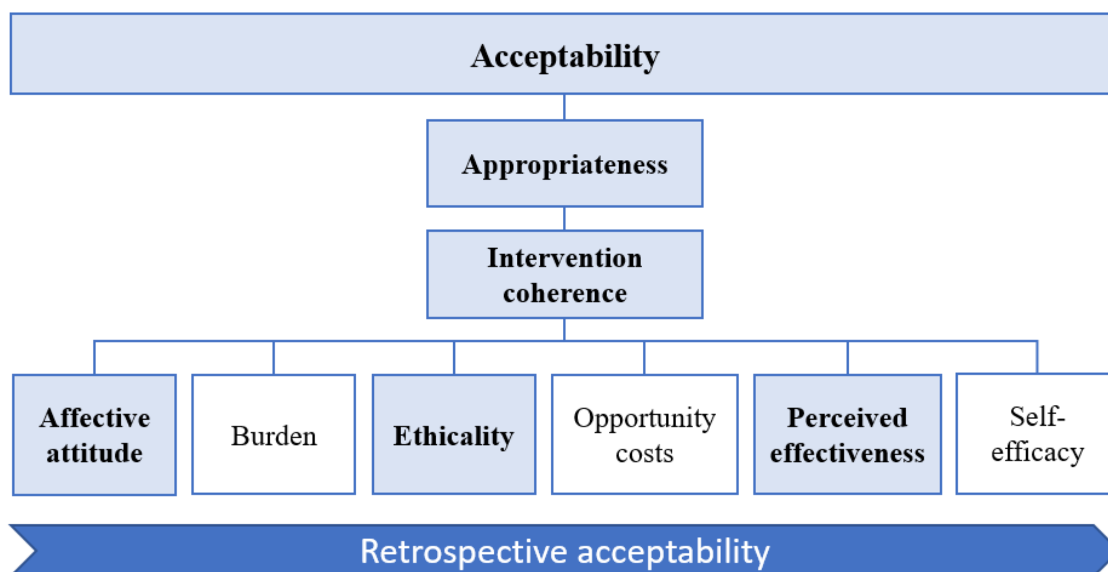


Figure 2. *Summary of the domains that the participants used to construct their view of the acceptability of the trust and empowerment intervention.*

It appears as if the participants constructed their general view of acceptability using certain individual TFA domains as building blocks. The different individual TFA domains seemed to have different purposes in this construction of acceptability in general. The affective attitude functioned as a way of expressing whether they accepted or didn't accept the training, which seems to represent a positioning of satisfaction or dissatisfaction against the intervention.

Intervention coherence functioned as a prerequisite for general acceptability and seemed to be the main building block for the participants when constructing their view. In order for the participants to gain acceptability, they stated that the contents of the training must reason with them. This part seemed to be a make-or-break aspect in terms of finding the intervention acceptable. Without being able to endorse the training content and concepts, it seems that the roles of the other TFA domains are diminished. The role of intervention coherence in the participants' construction of acceptability is showcased in figure 2.

When asked to talk about intervention coherence as an individual TFA domain, the participants talked about the nature of the training, which included among others the training content as well as the purpose of the training. What is interesting, is that talk about the nature of the training was a reoccurring theme within the interviews, it being mentioned in many other parts of the intervention than relating to the question focusing on intervention coherence. For example, in relation to affective attitude, the participants talked about the nature of the training by discussing what the training in their opinion was supposed to do and what it achieved in their opinion. The purpose of the training was mentioned in relation to as many as three other TFA domains, namely intervention coherence, opportunity costs, and perceived effectiveness. For both intervention coherence and perceived effectiveness, the comments related to the purpose of the training concerned whether the purpose of the training was clear, while the discussion in relation to opportunity costs reflected barriers that could stand in the way of achieving the purpose. It is safe to say that the nature of the training is important for the participants when constructing their view of acceptability, which is demonstrated by the frequent notations found in relation to many individual TFA domains and by highlighting it when commenting on the general acceptability.

What is noticeable is, that finding it important to believe in the intervention content, seems to be conceptually very close to the TFA domain of ethicality, since the participants express their valued belief against the intervention. Ethicality was used by the participants as a justification for their high perceived general acceptability. The training being aligned with the participant’s own values seemed to reinforce their experience of acceptability. Since all participants in this study indicated that they felt the training was aligned with their values, I don’t know how it would have affected if they hadn’t felt this way. I can only speculate that it possibly would have impaired the participants’ perception of acceptability. It thus seems that the values alone are not definitive for the participants’ experience of acceptability, but instead

have a reinforcing (or possibly deteriorating) effect on the perceptions of acceptability. The TFA domain of ethicality doesn't alone seem to be sufficient to create a sense of acceptability but must be combined with the TFA domain of intervention coherence, which acts as the foundation for creating the experience of acceptability. The role of ethicality in the participants' construction of acceptability is showcased in figure 2.

In addition to ethicality also, the TFA domain of perceived effectiveness was used as a justification for their high perceived general acceptability. It seemed that it is important that the training provides benefits for the participants. As with the nature of the training, benefits were mentioned repeatedly throughout the interviews. Mentions can be found in relation to intervention coherence, opportunity costs, perceived effectiveness, and general acceptability. The notion of gaining benefits was used as a source of motivation for participating in the training, functioning at the same time also as a reason for lowering the experience of opportunity costs. Not knowing the benefits of the training were seen as a threat to the training reaching its goals and therefore it was suggested that it clearly should be stated at the beginning of the training, what's in it for the participants. Gaining benefits was also both used as a reason for making the training effective as well as a justification for finding the training acceptable when asked to comment on the general acceptability of the training. Something that seemed less important for the participants was whether the training fulfilled the purpose determined by the organization. The focus was rather on gaining practical tools for developing trust and empowerment in their daily lives.

The intervention content is once again referenced when commenting on the general acceptability when some of the participants separated acceptability from appropriateness. They connect the contents of the training to acceptability while the appropriateness is related to the training being suitable. The training being suitable was also highlighted in other parts of the interview when the participants felt that everyone in the company should be included in the training. In this context, it seems that these participants value appropriateness higher than acceptability.

The relationship between acceptability and appropriateness, or the content and the suitability, seems to be that, in order to gain acceptance, the content must reason with the participants. The agreement doesn't have to be 100 %, but there needs to be a sufficient degree of approval. Appropriateness on the other hand goes beyond acceptability and must be matched according to the target audience. Even if the content would be regarded as important and well

planned, it doesn't matter if it doesn't suit the target group. Without finding the intervention appropriate it seems that it doesn't matter how the participants perceive the other TFA domains, so before moving into acceptability it seems like the appropriateness of the intervention should be ensured. The role of appropriateness in the participants' construction of acceptability is showcased in figure 2.

When constructing their view of acceptability, appropriateness functioned as an overarching domain inside acceptability for the participants. They treated appropriateness as its own distinct dimension of acceptability and stated that for the intervention to be acceptable it needs to be suitable for the participants. Ensuring that this dimension is fulfilled, the participants moved on to intervention coherence, which functioned as the foundation for the remaining dimensions. Ethicality and perceived effectiveness had a reinforcing effect on the experience of acceptability, while affective attitude was used to express satisfaction toward the intervention. Burden, opportunity costs, and self-efficacy seemed to have an insignificant role in the construction of acceptability.

6.2.2 Using the TFA to assess acceptability of organizational interventions

As the TFA was designed for assessing the acceptability of healthcare interventions and the domains were constructed according to research found in the health promotion sector, it becomes important to understand if the framework is suitable for assessing the acceptability of an organizational intervention. It might be that some of the TFA domains are less relevant, or it might be that relevant domains are missing when evaluating the acceptability of an organizational intervention instead of a healthcare intervention. Next, I will therefore evaluate how suitable the TFA is for assessing the acceptability of an organizational intervention.

The participants of this study constructed their view of acceptability by using the domains provided by the TFA. Most of the time they followed the statements and questions provided without venturing into discussions outside of the topic asked. Some might argue that a semi-structured interview which in addition to using pre-determined questions, uses statements to provoke discussion on a certain topic, most probably will lead the participants to talk about the things they have been asked to talk about. It is also possible that the interview participants might deny what has been asked of them and instead steer the discussion in a different direction, which might indicate that they didn't see the proposed question or statement as

relevant or correct in terms of how they construct their view of acceptability. Since this didn't happen in the interviews conducted for this study, it therefore seems that the domains provided by the TFA were quite suitable for assessing acceptability.

Something that the participants discussed, that doesn't fit the TFA, is how the participants talked about trust and empowerment, the topic of the training. When reflecting on what they felt about the training (affective attitude), the participants discussed what trust and empowerment mean and how the concepts work. It seemed that the participants when trying to construct their opinion about the training were using trust and empowerment as a way of meaning-making. Also, in relation to ethicality and intervention coherence, trust and empowerment are mentioned. When taking a stance on whether the training is aligned with their personal values, the participants expressed that trust and empowerment are values that are important to them. While discussing about the intervention coherence, trust and empowerment are again mentioned by two participants. They talk about the challenges of trust and separate trust into professional trust, which is reserved for dealing with customers and colleagues, and personal trust, which is reserved for interacting with family and friends. This discussion leads the participants to suggest the improvement idea of including real-world trust and empowerment in the training.

In all instances, trust and empowerment are used as a way of building their stance as a response to the provided prompt (question or statement) in the interview. They function as a way of supporting and justifying the participants' arguments either for or against the claims made by the interviewer but also by the other participants. Having said this, it can be concluded that the participants don't treat trust and empowerment as a distinct domain when constructing their view of acceptability, but rather as a way of adopting the domains of the TFA. I, therefore, don't think it is justified to treat it as its own domain.

As we saw in the previous chapter, not all TFA domains were equally important for the participants when constructing their view of acceptability. Especially ethicality, intervention coherence, and perceived effectiveness had central roles, while affective attitude only was used as a way of expressing satisfaction. Burden, opportunity costs, and self-efficacy were not seen as relevant. Even though some domains rose above others, I wouldn't interpret that as an indication of the TFA being unsuitable for understanding how participants of an organizational intervention perceive acceptability. It might just be that the framework needs to be adjusted to suit the organizational setting better. In the discussion chapter I propose

some adjustments to the TFA to improve it even further for assessing the acceptability of organizational interventions (see chapter 7.1).

In addition to the TFA domains, the participants also constructed their view of acceptability around appropriateness. In the TFA appropriateness is only mentioned in the definition of acceptability and it seems that it is implied for all domains, rather than being a domain of its own. In this study, the appropriateness got such an important role in the participants' construction of acceptability that it justifies adding appropriateness as a distinct domain in the TFA when assessing the acceptability of organizational interventions.

Summarizing, it can be concluded that based on this sample, the TFA by Sekhon et al. (2017) is mostly suitable for understanding the acceptability of an organizational intervention that focuses on trust and empowerment. The participants in this study constructed their view of acceptability using mainly the TFA domains. The only instance where the participants ventured outside the TFA was when they highlighted appropriateness as an important part of how they view acceptability. As appropriateness could be found at the core of the participants' construction of acceptability, it could be worth adding appropriateness into the TFA when evaluating the acceptability of organizational interventions.

7 DISCUSSION AND CONCLUSIONS

In this chapter, I will start by summarizing the aim of the study as well as the results. I will then continue with discussing possible explanations for the domains that the participants used when constructing their view of acceptability. I will also contemplate why some of the TFA domains were less relevant than others. Next, I will propose adjustments to the TFA to optimize it for organizational interventions, before moving on to discussing the strengths and limitations of the study. I end this chapter by drawing some conclusions.

The aim of this study was to examine the retrospective intervention acceptability of an organizational pilot intervention focusing on trust and empowerment, from the perspective of the intervention recipients. I further investigated how well the different acceptability domains of the TFA reflected the study participant's construction of acceptability, as well as assessed the suitability of the TFA for evaluating the acceptability of an organizational intervention.

As many organizations have tried implementing trust and/or empowerment initiatives but failed, it is important to understand where the problems lie (Maynard et al., 2012). Understanding how intervention recipients perceive the acceptability of an intervention is recognized as important for designing and implementing successful interventions (Hagger et al., 2020). Intervention acceptability thus provides a set of tools that can be used for identifying the problems within trust and empowerment interventions. Furthermore, as the management and organizational science lack a scientifically rigorous framework for intervention acceptability, it was of paramount importance to either develop or adopt an already existing framework to be able to apply it for organizational interventions. This study is the first of its kind since the Theoretical Framework of Acceptability (TFA) by Sekhon et al. (2017) was applied for an organizational intervention instead of a healthcare intervention, which it was originally designed for.

The research questions of this study were:

1) How do the recipients of the intervention perceive the acceptability of the intervention in the different acceptability domains of the TFA (affective attitude, burden, ethicality, intervention coherence, opportunity costs, perceived effectiveness, and self-efficacy)?
2) How well can the TFA be applied for assessing the acceptability of an organizational intervention?

Based on the findings of this study, it can be concluded that the intervention is perceived as acceptable on all acceptability domains of the TFA. There were no obstacles too big to overcome for the participants, although they were able to name a few barriers related to participation and for achieving the goal of the training. The positive aspects thus seemed to counterbalance the negative ones, leaving the participants content with the training.

When constructing their view of acceptability, appropriateness rose as a distinct subdomain of acceptability. Of the existing TFA domains, intervention coherence had the most influence on how the participants constructed their view of acceptability, as it functioned as a prerequisite and foundation for the remaining TFA dimensions. Also, ethicality and perceived effectiveness played an important role as they reinforced the participants' experience of acceptability. Affective attitude was used as a way of expressing satisfaction toward the

intervention. The other TFA domains played only a small or even insignificant role in the participants' construction of acceptability.

This study showed that the TFA was suitable for assessing the acceptability of an organizational intervention focusing on trust and empowerment. In addition to using the TFA domains, the participants used appropriateness as an important additional domain when constructing their view of acceptability. As appropriateness was at the center of how the participants perceived the acceptability of the intervention, I suggested adding appropriateness as its own domain to the TFA when evaluating the acceptability of organizational interventions.

It might be that, as this study was centered around a trust and empowerment intervention, the same results wouldn't be obtained for another type of organizational intervention. It is therefore not only important to duplicate this study for other trust and empowerment interventions, but also for other types of organizational interventions, to be able to validate whether using appropriateness as an important domain of constructing acceptability of organizational interventions was specific for this study only or more broadly generalizable for other studies as well.

Leaning on the results of this study, I proposed adding appropriateness as a domain in the TFA, meaning that appropriateness is treated as a part of acceptability. Further supporting this is the fact that appropriateness and acceptability are at times treated in the literature as the same concept (Proctor et al., 2011). On the other hand, there is also an indication in the literature that appropriateness and acceptability might be distinct concepts (Proctor et al., 2011). Proctor et al. (2011) argue for a distinction between the two concepts as they state that interventions can be perceived as appropriate but not acceptable as well as the other way around.

In the healthcare sector, appropriateness is used for determining the level of net benefit a patient receives from a certain course of treatment. A treatment is seen as appropriate when it maximizes the benefit and minimizes the risk for the patient. (Sanmartin, Murphy, Choptain, et al., 2008) Based on the findings in this study it seems that the appropriateness of an intervention could have other meanings in addition to the established one, especially when talking about organizational interventions where this above-mentioned definition doesn't apply. Having said this, I don't think that the idea about expanding the concept of

appropriateness should be excluded from healthcare interventions since I don't see any reason why appropriateness couldn't have two different meanings.

If appropriateness is a separate construct from acceptability, it could have effects on the rate of participation as well as the rate of follow-through of the whole program in the same way as acceptability has. Or it might even have broader consequences for implementing successful interventions, that haven't even been considered before. I, therefore, call for more research on this area, both when it comes to healthcare interventions, but especially when it comes to organizational interventions. As the jury is out according to the literature, on whether appropriateness is an aspect of acceptability or a distinct construct, I lean on the results of this study and treat appropriateness as a domain within the TFA.

As the domain of intervention coherence had such an important role in the participants' construction of acceptability, the question is why? A possible explanation could be found in the sensemaking literature. Talking about intervention coherence, the participants recurringly brought up the nature of the training throughout the interviews. In many instances, it seemed like the participants used the nature of the training as their anchor when trying to make sense of the intervention and its acceptability. Sensemaking is recognized both in the social psychological (e.g., Weick 1979) and management and organizational literature (e.g., Weick, 1995; Sandberg & Tsoukas, 2015). It is a social process used by individuals to give meaning to events and experiences (Mills, Thurlow & Mills, 2010). The sensemaking process involves assigning meaning to new or equivocal experiences and events, as well as finding plausible explanations for them with the aim of creating order out of them (Kramer, 2016). Sensemaking occurs when individuals together create their reality of their everyday life (Weick, Sutcliffe & Obstfeld, 2005), which was what the participants did in the focus group interviews.

In a workplace setting, organizational experiences are constantly changing which leads employees and employers to partake in sensemaking on a regular basis, trying to understand themselves and their surroundings (Kramer, 2016). The intervention in this study was created as a way of implementing the new company strategy, which was imposed by organizational changes. The intervention also focused on teaching the participants ways of changing their behavior in the direction of becoming more trusting and empowering. It is safe to say that the participants were faced with new and maybe even equivocal experiences and events, needing

to be made sense of, possibly explaining why intervention coherence got such an important role in their construction of acceptability.

Further, I suggest that as organizational interventions often are used as a way of implementing organizational change, it might be that the TFA domain of intervention coherence will rise as a central domain for constructing acceptability in relation to other organizational interventions as well. To understand if this suggestion is valid, further research applying the TFA to organizational interventions is needed. It would also be beneficial to better understand the relationship between the TFA domain of intervention coherence and sensemaking, to be able to further strengthen the TFA framework and make it more suitable for assessing the acceptability of organizational interventions.

Ethicality was one of the central domains that the participants of this study used when constructing their view of acceptability. The participants felt that the intervention was aligned with both their personal and company values, which in turn seemed to reinforce their experience of acceptability. The importance of value congruence between personal and organizational values is well recognized in the literature. Research suggests that this kind of value congruence leads to e.g., higher levels of job satisfaction, organizational identification, and lower turnover rates. (Edwards & Cable, 2009) The results of this study spark the idea of a relationship between acceptability and person-organization value congruence in the context of organizational interventions. The findings of Lamm, Gordon, and Purser (2010) support the idea as they found indications of value congruence being associated with behavioral support for organizational change, which often is the cause for organizational interventions.

The participants of this study used perceived effectiveness as a justification for their experience of high acceptability. It was important for the participants that the training provided them benefits, and they highlighted that providing answers for the question, what's in it for them, clearly should be highlighted at the beginning of the training. A possible explanation of why the participants placed great value on gaining benefits from the training, can be found in the expectancy theory of motivation. According to the expectancy theory of motivation by Vroom (1964), the level of motivation can be determined based on an individual's perception of the desirability of the outcome. The theory builds on the premise of expectancy, instrumentality, and valence. The expectancy component can be described as the belief that higher effort will result in the attainment of better results. The instrumentality component describes the belief that when performance expectations are met the individual

will receive a reward. Lastly, the component of valence can be described by the belief that the reward that is being offered for good performance is perceived as desirable by the individual. (Purvis, Zagenczyk & McCray, 2015)

When using the expectancy theory as a lens for understanding why perceived effectiveness and gaining benefits were seen as important by the participants of this study, we can see that the components of instrumentality and valence seem to be guiding the participants. The participants might feel that, since they put in effort, by participating in the training and learning new ways of working, they expect a reward for that effort, which is in accordance with the component of instrumentality. The reward the participants find desirable, is gaining some benefits themselves, which in turn is in accordance with the component of valence. What we learn from the expectancy theory is that the desirability of the outcome, or in other words, to which extent an individual values the outcome, plays an important role in determining the level of motivation (Vroom, 1964). As ethicality, that reflects the values of the intervention recipients, in addition to perceived effectiveness are TFA domains, it seems that ensuring the congruence between these two domains should be ensured to be able to obtain high levels of acceptability.

The TFA domains that were less important in the participants' construction of acceptability were burden, opportunity costs, and self-efficacy. Why were these domains less important than the others? A possible explanation could be that because both the burden and opportunity cost of engaging in the intervention were perceived as low, and the self-efficacy could be interpreted as quite high for the participants, these dimensions weren't seen as essential in constructing the their view of acceptability and thus were excluded. If the burden and opportunity cost domains instead would have been perceived as high, and the self-efficacy would have been seen as low, they might have been mentioned. To be able to understand if highlighting certain TFA domains when constructing the opinion of acceptability is affected by whether the evaluation is positive or negative, it would require further investigation.

A further reason for the participants perceiving both burden and opportunity costs as low could be due to the sample. The sample was a convenience sample, meaning that the participants chosen were individuals who expressed interest in volunteering for the intervention. It is impossible for me to determine why the participants chose to participate,

but I assume that they were motivated in learning about trust and empowerment, which might explain why they didn't see the training as burdensome and intervening.

This however doesn't explain why the role of self-efficacy was low when the participants constructed their view of acceptability. A somehow possible explanation can be drawn from the self-efficacy theory of Bandura (1977). According to the theory, self-efficacy expectations are defined as an individual's belief in their ability to perform specific tasks or behaviors. Self-efficacy beliefs strongly rely on an individual's previous performance. When an individual performs well, so-called mastery experiences are achieved. By achieving mastery experiences repeatedly, the individual can form positive self-efficacy expectations, which can reduce the degrading effects of eventual failure on self-efficacy. (Bandura, 1977) If the participants of this study previously have gained repeated mastery experiences, it might be that their positive self-efficacy beliefs buffer the small concerns that they had regarding performing the behaviors required by the training. Leading to the lowered importance of the self-efficacy domain in the participants' construction of acceptability. Another possibility is that the participants might have participated in a similar training before and gained mastery experiences there. As positive efficacy expectations tend to generalize to similar situations (Bandura, 1997), this could explain why the role of the self-efficacy domain was low.

As there is no way of definitively determining why the TFA domain of self-efficacy wasn't as important as other domains when the participants constructed their view of acceptability, I can only speculate. To better understand why some TFA domains are more central than others, further research is needed.

According to Sekhon et al. (2017) acceptability consists of seven different domains that together reflect either the intervention participants' or receiver's cognitive and emotional responses toward an intervention. In line with the classical dispute in psychology, in terms of whether it is the head or the heart that decides when making decisions (Luo & Yu, 2015), I would also assume that certain TFA domains are more influential in certain contexts. It is possible that a certain TFA domain would be more influential than others when it comes to impacting the effectiveness of the intervention, the adherence to the intervention, or even the intention to participate in the intervention. Understanding the effects of the individual TFA domains would enable researchers to tailor the intervention to suit the participants even better, leading us one step closer to designing effective interventions.

7.1 Optimizing the TFA for organizational interventions

Based on the results of this study, it seems that the TFA is suitable for assessing the acceptability of an organizational intervention, but some small adjustments to the framework might improve the suitability even further. I have therefore both, based on the results of this study, as well as using social psychological- and management and organization literature made an effort to improve the framework.

In figure 3, the proposed adjustments to the TFA when using the framework for assessing acceptability for organizational interventions, can be found. This adjustment includes adding appropriateness as a distinct overarching domain in the TFA, following the arguments presented previously in the discussion chapter. In this study burden, opportunity costs, and self-efficacy had only minor roles in the participants' construction of acceptability, but as I don't have a definitive answer for why this was, I don't think it is justified to remove them from the framework and therefore they remain unchanged. Based on the results of this study, I judge that the domains of ethicality, intervention coherence, and perceived effectiveness fill their purpose well and they thus also remain unchanged in the updated framework. For the affective attitude domain, I kept the domain name but slightly altered the domain definition. Finally, I also changed the overall definition of acceptability to better suit the updated framework.

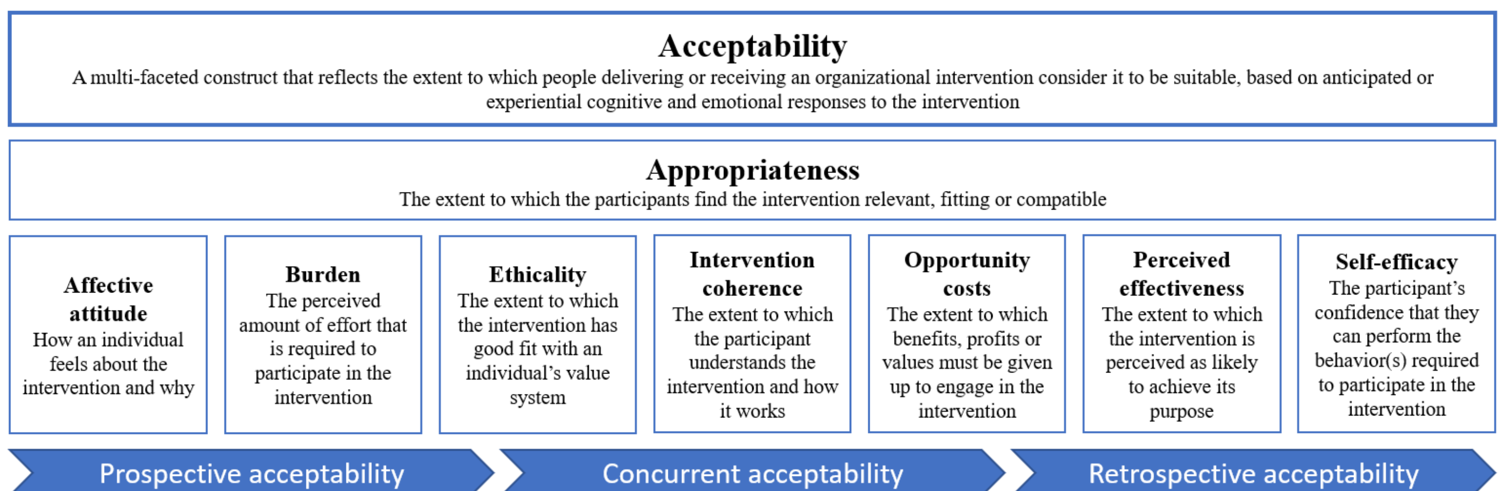


Figure 3. *Proposed adaptation of the Theoretical Framework of Acceptability for organizational interventions.*

In this new proposed version of the TFA, the domain of appropriateness is defined as the extent to which the participants find the intervention relevant, fitting, or compatible. This definition is inspired by the taxonomy of implementation outcomes by Proctor et al. (2011), where acceptability and appropriateness among others are included. Appropriateness in this new proposed version functions as an overarching domain that needs to be ensured before moving on to the remaining domains.

The participants of this study used the TFA domain of affective attitude as a way of expressing satisfaction toward the intervention. This is aligned with how acceptability in the past has been assessed, relying heavily on using measures of satisfaction. The overview of Sekhon et al. (2017) revealed that acceptability often has been confounded with satisfaction, but they continue by counteracting this by stating that they believe the two constructs are different from each other and therefore shouldn't be used as synonyms.

The definition of affective attitude as reflecting how an individual feels about an intervention by Sekhon et al. (2017) conforms to the definition of satisfaction provided by Locke (1976) as he states that satisfaction is an emotional response expressing affection toward an object. I, therefore, claim that Sekhon et al. (2017) mirror satisfaction in their TFA domain of affective attitude. Despite their earlier claims, it seems that Sekhon et al. (2017) treat satisfaction as a part of acceptability. The results of this study are coherent with this latter idea, as satisfaction and acceptability were closely related and overlapping in the participants' talk. The design of this study doesn't allow for further claims in terms of whether the two constructs can be considered as one or if they should be considered as two separate constructs. Further research with quantitative methods could be useful for gaining insights on this.

Based on the finding of this study, I wonder whether the TFA domain of affective attitude should be changed to satisfaction instead? In addition to the definition of satisfaction by Locke (1976), the concept seems to include fulfillment of expectations. Festinger (1942; 1954) implies that, by balancing between expectations and the real experience, satisfaction can be achieved. In practice, it means that an individual will be satisfied when the expectations regarding an outcome are fulfilled. Expectations and fulfillment of them can be found in the interviews of this study, when the participants commented on the question for affective attitude, which further strengthens the idea of changing the domain of affective attitude in the TFA to satisfaction.

On the other hand, Sekhon et al. (2017) make a good argument against satisfaction as it only can be assessed retrospectively, based on the fact that expectations are compared with a real experience, while acceptability can be assessed also prospectively, thinking about how the intervention would be. The domain of affective attitude is derived from the use of attitudinal measures for evaluating acceptability (Sekhon et al., 2017), but despite this, the domain lacks references to two of the three main components of attitudes recognized by the social psychological literature. The three components of attitudes are: affect, behavior, and cognition (Breckler, 1984), of which only affect is present in the domain of affective attitude, while the component of behavior and cognition aren't. The affective component of attitudes refers to how an individual feels about an attitude object. The behavioral component includes the way the attitude influences the behavior of the individual holding the attitude, while cognition refers to an individual's belief or knowledge about an attitude object (Breckler, 1984). Redefining the TFA domain of affective attitude to include all three components of attitudes would make the domain more rigorous as it would capture more than just one aspect of attitudes, tipping the scale in the direction of keeping the affective attitude domain as is and not changing it into satisfaction.

Further, if we compare the results of affective attitude in this study with other studies using the TFA, we can see that e.g., Chen (2019) had similar findings in her study as in this study. Instead of indicating how the intervention made them feel the participants in the study by Chen (2019) expressed satisfaction or dissatisfaction toward the intervention. The findings of Gerbild et al. (2021) on the other hand, support the conceptualization of affective attitude since their study participants didn't express satisfaction but expressed interest using a broad range of emotions. As we can see, there are arguments supporting both ways, rendering it important to further investigate which term would be most suitable for understanding how the participants of an intervention feel about it. Before gaining more insights, I would suggest keeping the affective attitude domain as is, but redefining the definition: "how an individual feels about the intervention and why". This way the domain covers a little bit more of the complexity of attitudes than before. The affective attitude domain and its definition are displayed in figure 3.

Concerning opportunity costs, the participants of this study didn't perceive the intervention to interfere with their other priorities and interests and therefore they were asked a follow-up question if they could think of any barriers to participation for other people. The participants

were able to come up with not only barriers to participation but also barriers to achieving the training goal. Barriers to participation in interventions (see e.g., Ross, Grant, Counsell, et al., 1999) as well as barriers to intervention implementation (see e.g., McGoey, Rispoli, Venesky, et al., 2014) have been studied even before intervention acceptability. Taking the barriers into account when designing and implementing interventions will lead to more people participating in interventions as well as more successful interventions (Matthews & Simpson, 2020).

The significance of understanding possible barriers increases if the sample size is small and all participants answer re-affirmatively to the questions. Of course, it is possible that the intervention is well designed and that the opinions of the participants can be representative on a larger scale, but as with all qualitative studies, we won't know for sure. Trying to understand both the positive and negative sides of the coin, therefore, becomes important. To achieve this, there are a few different options available. You can try to "optimize" the sample to represent different sorts of people that are included in the target group for the intervention. Again, it is important to remember that you won't be able to collect a representative sample in a qualitative study, but you can include variety in your sample. Another option is to use a sort of theoretical sampling, commonly used in Grounded Theory. A key feature in theoretical sampling is to fill gaps in the data already collected, by collecting additional data guided by the analysis (Ligita, Harvey, Wicking, et al., 2020). The same kind of principles could be used for collecting varying insights on the topic of intervention acceptability. Finally, it is also possible to add a question regarding barriers, either representing a distinct domain in the TFA or as a part of some already existing domain.

Supporting the idea of adding barriers as a domain of its own into the TFA, is the fact that different sorts of barriers still are being studied, even after the introduction of intervention acceptability. Intervention acceptability has by no means replaced understanding different sorts of barriers. For example, Renko et al. (2020) evaluated both acceptability using the TFA and barriers to implementation. The challenge with a dedicated barrier domain is to specify what kind of barriers the domain is referring to. In this study barriers to participation and barriers to achieving the training goal were mentioned, but as seen from the study by Renko et al. (2020) also barriers to implementation can provide useful insights. This challenge could be resolved by instead incorporating barriers into an existing TFA domain. On the other hand, that isn't completely problem-free either, since the TFA builds upon a set of common barriers

found in relation to healthcare interventions (e.g., burden and self-efficacy). Incorporating the aspect of barriers into these domains doesn't make any sense. The only sensible domain that I come up with, where the aspect of barriers could be incorporated is opportunity costs, the same domain where the participants of this study talked about different sorts of barriers.

As the arguments for either adding barriers as its own domain into the TFA or incorporating it into an existing domain are vague, I will not include the concept of barriers in the updated version of the TFA. Instead, I would suggest opting for either "optimizing" the sampling or using the adaptation of theoretical sampling as a way of obtaining a diverse data set. Another option is to use the concept of barriers as a supplementary question to be asked if the researcher deems it needed.

As appropriateness in the proposed updated model is treated as a distinct domain, the definition of acceptability is slightly changed to avoid confusion. The new definition is: a multi-faceted construct that reflects the extent to which people delivering or receiving *an organizational intervention* consider it to be *suitable*, based on anticipated or experiential cognitive and emotional responses to the intervention. The new definition of acceptability is displayed in figure 3. The difference between this new definition and the one by Sekhon et al. (2017) is that healthcare intervention is changed to organizational intervention and that appropriateness is changed to suitable. The Oxford dictionary defines acceptability as the quality of being tolerated or allowed which I don't think that reflects the concepts of acceptability very well. The Oxford dictionary on the other hand defines appropriateness as the quality of being suitable or proper in the circumstances, which I think reflects acceptability as a concept much better. Therefore, I opted for using suitable instead of tolerated or allowed in the new definition.

7.2 Strengths and limitations of the study

As with all studies, this one has some limitations while at the same time compensating them with some strengths. When choosing a research method, the researcher makes a conscious and thoughtful decision of how to collect and analyze the data. Included in this decision is the weighing of the possibilities and limitations of different kinds of research methods. (Tuomi & Sarajärvi, 2018) When looking at the limitations of the research method for this study, we can see for example that the participants were chosen using a convenience sample, which might have affected their experiences of the acceptability of the trust and empowerment related

pilot intervention. Further, as the language used in the interviews was English and the participants chosen for the study had many different nationalities with differing levels of English language fluency, it made it at times challenging for the participants to express themselves as they would have liked to. On the other hand, the diversity in terms of nationalities can also be considered as a strength, since that provided a broad variety of participants with different experiences.

In addition, the varying levels of English fluency in combination with conducting the interviews online, with occasionally poor sound quality, made it hard sometimes to understand the recording and transcribe the interviews. This might have caused me to misinterpret certain sections of the data, but I tried to minimize the risk by re-listening to the inaudible parts and extracting the meaning based on the context of the discussions as well as leaving out the parts that I was not able to comprehend. It is also worth noticing that face-to-face interviews weren't possible to conduct due to the worldwide Covid-19 pandemic. It is also important to remember that, I as the researcher have influenced the data analysis, as I have interpreted the data based on my previous experiences and knowledge. Based on the interpretations I have constructed an understanding of how the participants of this study perceived the acceptability of the intervention, meaning that the analysis doesn't represent an objective truth, but rather a version of the social reality that I have constructed (Gibbs, 2007). To showcase my line of thought and to ensure transparency of the data analysis, I have described it in as much detail as possible and the data can be viewed on request.

More broadly, using a qualitative method means that the results of this study cannot be generalized to the whole organization where the training is planned to be rolled out. The organization can instead use the results of this study in an indicative way and readjust the final training based on the experiences of this sample, to raise the likelihood of achieving a successful intervention. Furthermore, this study provides insights into the applicability of using the TFA in a new context, namely for assessing the acceptability of an organizational intervention focusing on trust and empowerment. As the organizational field, lacks an acceptability framework, this study showcased that the TFA can be applied for organizational interventions as well. By better understanding, the intervention acceptability of organizational interventions in general, and especially trust and empowerment interventions, that traditionally suffer from failing, the success rate of these kinds of interventions can be increased.

The insights of this study ignite the possibility of further being able to apply the TFA to other contexts as well, so I hope that this study inspires other researchers to experiment with the TFA in different contexts. The results of this study show that some TFA domains can have a more significant role, for the intervention recipients when they construct their view of acceptability, than others. This insight can in the future be used to better understand the impact of intervention acceptability on intervention effectiveness, as well as to improve and tailor the TFA to operationalize acceptability even better. This study also brought to light the importance of appropriateness in addition to acceptability, possibly opening up a whole new dimension to intervention acceptability or even intervention evaluation on a broader scale.

7.3 Conclusions

Based on the results of this study, the trust and empowerment related intervention has high retrospective acceptability from the perspective of the intervention recipients. Based on the suggestion of the study participants some small adjustments related to the perceived effectiveness of the intervention could be made in the final intervention to further improve its acceptability. For example, clarifying the training purpose by setting the stage at the beginning of the intervention as well as focusing on helping the participants implement the learnings, would help strengthen the perceived effectiveness. But overall, no major problems in terms of how the participants perceived the TFA domains could be identified. It seems that the intervention is designed to suit the target group well, which increases the likelihood for a successful full-scale intervention when and if the organization decides to roll it out in the organization. However, it is important to note that this study didn't evaluate the effectiveness of the intervention, and I would therefore recommend that an effectiveness evaluation would be performed before rolling out the intervention on a larger scale.

It also seems that the TFA by Sekhon et al. (2017) designed for assessing the acceptability of healthcare interventions, works well for understanding how the participants of a trust and empowerment intervention conducted in an organizational setting, perceive its acceptability. The participants mainly used the existing TFA domain in their construction of acceptability, and they only ventured outside them by including appropriateness as a central domain. As appropriateness can be found in the definition of acceptability provided by Sekhon et al. (2017), I don't consider the inclusion of appropriateness as a sign of misfit of the TFA. It just showcases that some additions or adjustments might be needed when adopting the framework

in new contexts. I therefore recommend using the adjusted version of the TFA (found in chapter 7.1), when assessing the acceptability for organizational interventions.

It, therefore, seems that the TFA has a lot of potential as an acceptability framework, that others outside the healthcare context can use for improving their interventions as well as to ensure their successful implementation. Only time and more research on the topic will tell. Only then will it be possible to know to what extent the TFA can be applied outside healthcare interventions.

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APPENDIX

Appendix 1: Interview schedule

This appendix displays the interview schedule used by the researcher to guide the focus group interviews. It includes also the interview prompts and the additional questions, only visible for the interviewer, used to extend the discussion where needed.

Introduction to the research

- Welcome to the focus group
- This group will discuss the "Developing Communities built on Trust and Empowerment" pilot program that you participated in (insert time).

Introduction of the researcher

- My name is Katja von Schoultz and I am at the end of my studies in social psychology at the University of Helsinki. I am also working here at (company name) as a trainee in the (name of department, team and location), as well as working on my thesis in the (name of business area) Talent & learning team.
- This focus group interview will be part of my master's thesis where I study the effectiveness of a training intervention by assessing its acceptability from the perspective of the intervention recipients.
- This discussion will take maximum 60 minutes.

Ethical issues

Confidentiality

- All data arising from this focus group will remain confidential. The data will be securely stored and any information you give will be completely anonymized and none of what has been said can be linked back to you.

Informed consent

- Before we begin, I need to get your informed consent to participate in the research. If you agree with the statements that I am going to read to you, please raise your virtual hand or thumbs up as a sign of agreement.
    - The purpose and research methods of the study have been explained to you.

- You are aware that participation in the research is voluntary and that you can withdraw your participation at any time without having to justify your decision.
- You agree to be interviewed and that the information you provide will be used for the purposes of this study.

- Go ahead, you can now raise your virtual hands or thumbs up to show that you agree.

<u>Recording</u>

- I would like to make you aware that our discussions today will be recorded. This is just to make sure that I'm not missing out on anything we talk about. I hope this is okay for everybody, if not please say now.

Ground rules

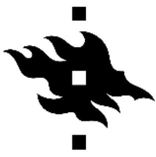
- Please contribute to the discussion. Everything you say is valued and there are no right or wrong opinions. I want to keep this discussion as relaxed as possible, so you are very welcome and even encouraged to add to something that somebody else said, just like a normal conversation.
- Of course, please remember to respect other people's opinions, even if they are different from your own.
- To lead the discussion, I will be presenting you with questions or statements that I want you to discuss. There will be 9 questions in total that I want you to discuss. I also posted the interview questions in the chat so that you can follow where we are going.

Icebreaker

- Let's start with a very short icebreaker. (insert ice breaker relevant for group)

Interview Prompts

1. How do you feel about the training? Did you like it or not? Did it live up to your expectations?
2. The training demanded too much time and effort from the participants. Please comment this statement!
3. The training was a good fit with my personal values and beliefs. Please comment this statement!
4. It was easy to understand the purpose and nature of the training. Please comment this statement!



5. Do you think that the training has interfered with your other priorities and interests?
    a. Are there any barriers that would prevent people from attending the training?
6. Did the training achieve its purposes and goals?
7. I feel confident in being able to perform the trust and empowerment related behaviors required in the training. Please comment this statement!
8. Do you find the training, in all, acceptable and appropriate?
9. Is there anything you would have changed about the training? Anything that we could have done differently?

Ending focus group

- Thank you for participating in this focus group. Does somebody still have any comments about this discussion? Anything you would want to add?
- At any point if something comes to your mind relating to this focus group or this research don't hesitate to contact me. I will be leaving my contact info in the chat.
- Thank you very much for your time and for the insightful conversations.